MEDICAL BENEFITS MUTUAL LIFE INSURANCE CO.
MEDICAL BENEFITS ADMINISTRATORS, INC.
MEDBEN MARKETING SERVICES, INC.
VISIONPLUS OF AMERICA, INC.
("MedBen")

PHI DISCLOSURE ACCOUNTING REQUEST FORM

You have the right to receive an accounting of certain disclosures made by MedBen of your health and medical information. The following information is required in order for us to process your request.

Name and Social Security Number of Covered Person For Whom an Accounting is Requested:

_____

Address Where You Want MedBen to Send the Accounting:

Telephone Number Where You Can Be Reached: _____

Organizations From Which You Wish to Receive an Accounting:

Period of Time for Which You Wish an Accounting Made. Note that you can request a listing of disclosures for any time period after April 14, 2003 (April 14, 2004 for small group health plans).

_____

We are not required by law to include any of the following disclosures of your health information in an accounting to you:

- Disclosures made pursuant to an authorization signed by you or your personal representative.
- Disclosures to carry out our own or other Covered Entities treatment, payment and health care operations.
- Disclosures made to you or your personal representative.
- Disclosures made to persons involved in your care and/or payment or notification of next-of-kin or family members.

- Disclosures for national security or intelligence purposes.
- Disclosures to correctional institutions or law enforcement officials about inmates or others in custody.
- Disclosures that occurred prior to April 14, 2003 (April 14, 2004 for small group health plans).
- Disclosures that are otherwise not required to be disclosed under the law in effect at the time of the request.

If you request more than one accounting in a 12 month period, we will charge you $20.00 for each subsequent accounting request.

_____
Print Name of Covered Person

_____
Covered Person's Signature & Date Signed

If you are a **Covered Person's personal representative**, attach documentation and an explanation of your authority to act for the Covered Person and sign below.

_____
Print Name of Covered Person's Personal Representative

_____
Covered Person's Personal Representative's Signature & Date Signed

No accounting request will be processed unless the Covered Person or the Covered Person's Personal Representative have signed this form.

MedBen
Chief Privacy Officer
1975 Tamarack Road
Newark, Ohio 43055
(800) 423-3151
(740) 522-8425