DANIEL H. COOK
ASSOCIATES INC

Dependent Portal Opt-Out

Group Name: Yonkers CLSA Welfare Fund

Dependent Information

All fields are required. Please Print.

Last Name	First Name	Social Security No.	Date of Birth

Street Address	City	State	Zip

Name of Primary Member	Relation to Primary Member

Statement and Signature

I, _____ [insert your full name], am requesting that all medical claims information, Explanation of Benefits (EOBs), billing details, and related health information pertaining to me be withheld from view in the health insurance claims portal of the primary policyholder, _____ [insert Primary Member's Full Name].

I understand that under federal HIPAA rules, as an adult dependent (age 18+), I have the legal right to request confidential communications and limit disclosure of my protected health information. I further understand that by signing below, I am formally withdrawing permission for the viewing of my claims data to the primary policyholder and requesting that the insurer implement any applicable privacy measures (e.g. independent portal) to prevent unauthorized access.

Dependent Signature	Date

Please Return Your Complete Form to:
Yonkers CLSA Welfare Fund
c/o Daniel H. Cook Associates, Inc.
1040 6th Avenue, 24th Floor
New York, NY 10018

OR Email Your Complete Form to:

Eligibility.dept@dhcook.com

Questions? You can call our Customer Service Department at (914) 250 – 0700.