



1717 W. Broadway • P.O. Box 8190 • Madison, WI • 53708-8190



THE EPIC LIFE INSURANCE COMPANY

A WPS Company

Request for Amendment of Protected Health Information

You have the right to request that protected health information about you that is maintained by WPS be amended if you believe it is incorrect or incomplete. We will review your request and will either grant it or explain the reason why the request will not be granted. If your request is not granted, you will have the right to submit a statement of disagreement that will accompany future disclosures of the information by WPS.

I. MEMBER INFORMATION

Name: _____ Member Number: _____

Address: _____ Date of Birth: _____

_____ Telephone: _____

II. REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

I request amendment of the following *specific* protected health information about me held by WPS:

I believe that the information described above is incorrect or incomplete for the following reason:

I hereby request that the information identified above be amended as follows (use precise wording):

III. SIGNATURE OF MEMBER OR REPRESENTATIVE

Signature of Member or Member's Personal Representative

Date

If **Personal Representative**, print your name and state the legal authority for your status as Member's representative