CONFIDENTIAL COMMUNICATION REQUEST FORM

This form is for use by a person who is covered by insurance and wishes to make a reasonable request to receive communications of insurance claim-related information from Wesco Insurance Company by alternative means or at alternative locations if disclosing claim-related information could endanger the person.
Send completed form to: AmTrust North America, 800 Superior Avenue 21st Floor, Cleveland, OH 44114, Fax 800.585.9303 or email dbclaims@amtrustgroup.com.

SECTION A: Covered individual requesting confidential communication:

Name: _____ Claim #: _____

Relationship to Primary Insured or Subscriber: _____

Current Address: _____

SECTION B: To the covered individual – please read the following and complete the information requested.

You have the right to make a reasonable request that you receive communications of claim-related information from us by alternative means or at alternative locations if disclosing the claim-related information could endanger you. "Claim-related information" means all claim or billing information relating specifically to you, including your name, address, any services received, and the name and address of the provider of any services (such as your doctor). Your request will remain in effect until you revoke the request.

I, the covered individual, request that Wesco Insurance Company send communications of claim-related information to me by the following alternative means or at the following alternative locations because disclosing the claim-related information could endanger me:

In care of:

_____
(If you are using someone else's address, then enter his or her name here.)

Alternative Address: _____

Alternative Phone Number: _____ Alternative Email Address: _____

Signature: _____ Date: _____

SECTION C: Parents, Guardians, or Legal Representatives

If the covered individual is a child younger than 18-years-old and the person making this request is the child's parent or guardian, then please provide:

Parent or Guardian's Name: _____ Relationship to Covered Individual: _____

If a legal representative, such as an attorney, is making this request on behalf of the covered individual, then please provide:

Legal Representative's Name: _____ Relationship to Covered Individual: _____

Organization or Firm Name: _____

Business Address: _____
Business Phone Number: _____ Business Email Address: _____

NYS Domestic Violence Hotline and Sexual Violence Hotline number is 800.942.6906 (Spanish 800.942.6908).