

**Group Insurance Trust of the  
California Society of Certified Public Accountants  
Request for Accounting of Disclosures**

Please provide the information below. We cannot respond to your request without this information.

Your name: \_\_\_\_\_

Employee's name: \_\_\_\_\_ Employee's ID: \_\_\_\_\_

Use this form to request an accounting of certain disclosures of your health information maintained by the Health Plans and used to make decisions about your Health Plan benefits. Please note that this accounting will not include:

1. Disclosure of your information in the regular course of Health Plan administration and operations or for payment purposes.
2. Disclosures we make to you or your personal representative.
3. Disclosures made pursuant to your written authorization.
4. Disclosures to friends or family members made in your presence.
5. Disclosures made in an emergency situation.
6. Disclosures for national security reasons or to a law enforcement officer or institution for health or safety reasons while you are in custody.

In addition, **your accounting will not include disclosures made prior to April 14, 2003.**

You must specify the time period for which you would like an accounting (not to exceed six years from the request date). Be sure to provide your address below. Your accounting will be mailed to that address. **[optional e-mail]**

Provide an accounting for the period starting \_\_\_\_\_ and ending \_\_\_\_\_ (not to exceed six years).

Apply this request to the following Health Plans:

- |   |   |
|---|---|
| <input type="checkbox"/> ProtectPlus Medical Plans (PPO)      | <input type="checkbox"/> Delta Dental (Dental Plan) |
| <input type="checkbox"/> Anthem Blue Cross Medical Plan (HMO) | <input type="checkbox"/> Other                      |
| <input type="checkbox"/> Vision Service Plan (Vision Plan)    |   |

You are entitled to one free accounting for a 12-month period. If you make a second request within a 12-month period, you may be charged a fee for the cost of creating the accounting. You will be notified in advance of any such charges.

**For internal use only:**

- |                                   |   |
|-----------------------------------|---|
| <input type="checkbox"/> Approved | Notice of extension sent: _____           |
| <input type="checkbox"/> Denied   | Date received: _____ Response Date: _____ |

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I hereby request an accounting of Health Plan disclosures of my health information, as described above. If I have already requested an accounting within the last 12-months, I understand that I may be charged for the cost of creating the accounting.

\_\_\_\_\_  
Signature\*

\_\_\_\_\_  
Date

*\*If you are making this request on behalf of another individual, a completed Personal Representative Form must be on file with the Health Plans unless you are the individual's parent or guardian and you are also a participant in a Health Plan.*

Please provide the address where the written accounting should be sent:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Send this completed request form to:

**Banyan Administrators, LLC  
Managers for the CalCPA ProtectPlus Programs  
1215 Manor Drive, Suite 200  
Mechanicsburg, PA 17055  
Fax – (877) 237-4519  
CPAProtectPlus@banyan-llc.com**

If you have questions about this form or your right to request to inspect or receive copies of your health information, contact Banyan Administrators, LLC at (877) 480-7923.