Restriction Request Form

As a customer of Mutual of Omaha, you have the right to request certain restrictions on the uses and disclosures of your protected health information (medical information). Mutual of Omaha and its affiliated companies are not required to approve any restrictions requested by its customers. We will accommodate reasonable requests within the limits of our processes and systems.

Name:_____

Address:_____

_____

City: _____ State: ____ Zip:_____ - _____

Home Telephone Number: ( ) _____

Policy/Group Number: _____

If this coverage is provided through an employer, provide the

Subscriber Number: _____

Describe your request in as much detail as possible:

Print Name: _____

Relationship: _____

Signature: _____

Date: _____

Note that no restriction request will be processed unless you or your authorized representative have signed this form.

If you are an authorized representative (other than a parent of a minor child), you will need to provide documentation or an explanation of your authority to act for the customer (e.g., Power of Attorney).

Please return completed form and any additional attachments to Mutual of Omaha at:

Mutual of Omaha
Attn: Privacy Office
Mutual of Omaha Plaza
Omaha, NE 68175-1029