Appendix B

CONFIDENTIAL

CAREFIRST NY, INC.
WHISTLEBLOWER DISCLOSURE STATEMENT

Date of Report: _____

REPORTER'S CONTACT INFORMATION: *Not required if being submitted anonymously*	
Name	Position/Title
Dept/Location	Work #
Home Address	Home/cell #
Best time to reach you	Email
Preferable method of communication:	

PERSON AGAINST WHOM THE REPORT OF ACTUAL OR SUSPECTED COVERED CONDUCT IS BEING MADE: *If more than one, please complete additional form(s).*	
Name	Position/Title
Dept/Location (if applicable)	Phone # (if known)

WITNESS(ES) TO ACTUAL OR SUSPECTED COVERED CONDUCT: *Attach additional sheets if necessary.*	
Name	Position/Title
Dept/Location	Phone # (if known)
Name	Position/Title
Dept/Location	Phone # (if known)

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The Whistleblower Disclosure Statement provides an avenue for all directors, officers, current and former employees and independent contractors, employees of independent contractors, and volunteers to report actual or suspected wrongful conduct without fear of retaliation. Please refer to the Whistleblower Policy for additional information.

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DESCRIPTION OF KNOWN OR SUSPECTED COVERED CONDUCT: (Please be as specific as possible including who, what, where, when and how?) *Attach additional sheets of paper if necessary.*

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