WEA trust
PO Box 259537 | Madison, WI 53725-9537
800.279.4000 WEAtrust.org

REQUEST YOUR HEALTH INFORMATION

To ask for a copy of your complete WEA Trust health record, fill out the **Request Your Health Information** form.

INSTRUCTIONS FOR COMPLETION

1. Print or type.

2. Use blue or black ink.

3. **Participant/Subscriber's Name:** Whose health record do you want? Often, your name or your dependent's name.

4. **Participant/Subscriber's Number:** The subscriber number for this individual (person from #3).

5. **Requested Information:** What information do you want? Check all of the information you want.

6. **Requested Dates:** Do you want information for a specific date? Write "all records" to request all past records.

7. **Method of Receipt:** How do you want to receive your information?

8. **Participant/Subscriber's Signature:** The person from #3 must sign the form.
- If a dependents is under 18, the parent/legal representative must sign the form.
- If an adult cannot sign the form, the parent/legal representative must sign the form and write why they are signing (disability or health condition).

9. **Date:** What date are you signing the form?

Send the completed form to:

Address envelope: WEA Trust
Attn.: Office of General Counsel
P.O. Box 259537
Madison, WI 53725-9537

Or Fax: 608.276.9119, Attn.: Office of General Counsel

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2. Send it to: **WEA Trust**
   Attn.: Office of General Counsel
   P.O. Box 259537
   Madison, WI 53725-9537

Participant/Subscriber Name _____ Subscriber Number _____

Requested Information:

I would like a copy of my health information: *(check all requested information)

☐ Health ☐ Long Term Care ☐ Other _____

Requested Dates:

I want information from the following dates: _____

Method of Receipt:

I understand that I can receive my health information in different ways. If I ask for copies of my health information, I must pay a fee of $.20/page, if there are more than 30 pages. I must also pay for postage.

☐ Please copy my health information and send it to me at this address:

_____

_____

_____

☐ Please copy the information. I will pick up the copies. I understand that you will contact me when the copies are ready for pick-up.

☐ I want to look at my health information in person. I will call the Office of General Counsel 800.279.4000 to schedule a time.

☐ I do not want the complete record. Please write a summary of my health information. I understand that I must pay WEA Trust for the time it takes to prepare the summary.

Signature of Participant/Subscriber _____ Date _____

For Personal Representatives (Parents and Legal Representatives):

Signature of Personal Representative _____ Date _____

Printed Name of Personal Representative _____ Relationship to Participant _____

*You must send proof of personal representative status with this form.