Telephone: 414-223-4847 Fax: 414-231-1090

CONSENT TO RECEIVE MATERIALS ELECTRONICALLY

I, _____, **D.O.B** _____/_____/_____,

consent to receive *i*Care materials in electronic format. All *i*Care materials transmitted to me electronically should be sent to the following e-mail address:

Email: _____

INFORMATION TO BE TRANSMITTED ELECTRONICALLY

The following materials may be sent to me electronically:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

MEMBER RIGHTS

I understand that I do not have to sign this form and that my health care benefits, payment, or enrollment will not be affected if I don't. I understand that I, or my authorized representative, am entitled to receive a copy of this completed form. I understand I can request to cancel this consent form at any time, but I must do so in writing. I can contact the *i*Care Member Advocate/Member Rights Specialist to help cancel the consent. I am aware that my cancellation will not be effective for any material that has already been transmitted to me electronically.

INDEPENDENT CARE HEALTH PLAN

EXPIRATION DATE and RIGHT TO CANCEL CONSENT

At any time I can cancel this consent by submitting a letter in writing to the Care Management Department at Independent Care Health Plan. Unless cancelled in writing, this consent will expire upon disenrollment from *i*Care.

SIGNATURES

X_____ X_____

Signature of *i*Care Member or Legal Representative* Date

Signature of Witness is only required if member is signing with a mark such as "X".

X_____ X _____

Signature of Witness Date

***If signed by legal representative:**

PLEASE CIRCLE: 1) the relationship to member and 2) authority to do so:

1) Member is one or more of the following (circle all that apply):

Minor Incompetent Incapacitated Deceased

2) Nature of Legal Authority (circle all that apply):

Custodial Parent/Legal Guardian/Activated Power of Attorney for Healthcare/Executor of Estate of Deceased

NOTE: When the member is an adult and you are signing as the legal representative, proof is required of the legal representative relationship in order to release information. Attach Guardianship, Power of Attorney – Health Care, or Executor paperwork as documentation.

THIS DOCUMENT WILL NOT BE HONORED UNLESS ACCOMPANIED BY THE REQUIRED DOCUMENTATION.

English – For help to translate or understand this, please call 1-800-777-4376 (TTY 1-800-947-3529).

Spanish – Si necesita ayuda para traducir o entender este texto, por favor llame al teléfono 1-800-777-4376 (TTY 1-800-947-3529).

Russian – Если вам не всё понятно в этом документе, позвоните по телефону 1-800-777-4376 (TTY 1-800-947-3529).

Hmong – Yog xav tau kev pab txhais cov ntaub ntawv no kom koj totaub, hu rau 1-800-777-4376 (TTY 1-800-947-3529).

Form rev 07/2018