KAISER PERMANENTE® *HAWAII REGION*

DISCLOSURE FOR CONFLICTS OF INTEREST EVALUATION

The following information is provided in order to ensure that the Independent Review Organization (IRO) assigned to conduct my external review does not have a conflict of interest:

Member Name:	
Appointed/Authorized Representative, if any:	
Member's Immediate Family Members (spouse, reciprocal beneficiary, civil union partner, parents, children):	
Health Carrier:	Kaiser Foundation Health Plan, Inc. ("Kaiser")
If your health care coverage is provided by your employer, name of employer:	
If you are a union member, name of union and trustees (include additional sheet as needed)	
If you are an employee of the State, county, or legislature, the EUTF and trustees (include additional sheet as needed)	
Plan employees (i.e., benefit plan administrator and staff, if any)	
Healthcare providers who are or have treated you for the condition that is the subject of the external review, and their medical group(s)	
Healthcare provider and facility where requested health care service or treatment would be provided	
Developer or manufacturer of the principal drug, device, procedure or other therapy that is the subject of the external review	

I certify that the foregoing information is true and correct.

Date

Signature of Member or Member's Representative