

California consumers should use this form to make requests to know or to delete the Personal Information that Teladoc holds about them. The information you provide below will be used to process your CCPA request and for no other purpose. Teladoc will maintain a record of your request pursuant to Cal. Civil Code § 1798.105(d) and CCPA Regulations § 999.317(b).

Name: _____ Member ID: _____

Date of Birth: ___/___/___ Contact phone#: _____ Email Address: _____

Postal Address: _____

City: _____ State: _____ Zip Code: _____

If you have only used our websites, please provide us with your IP Address or Device ID: _____

What Teladoc services or websites have you used or accessed?

- Telehealth Expert Medical Services MyStrength InTouch Livongo (Chronic Condition Management)
- Other, please state: _____

Are you a California resident or an authorized agent submitting on behalf of a California resident?

- Yes.
 No.

If you are an authorized agent submitting a request on behalf of a California resident, you must attach written proof that you have been authorized to act on his/her behalf.

Request type:

- Request to know my data.
 Request to delete my data.

During what time frame do you believe Teladoc may have collected or held your personal information:

Describe any interactions you've had with Teladoc that may help us locate your information:

Signature of Consumer or Authorized Agent

Date

If signed by Authorized Agent, provide relationship to Consumer and proof of Consumer Authorization.

Please submit completed form by:

- **Mail:** Privacy Officer, Teladoc Health, Inc.
1250 Hancock Street, Suite 501N Quincy, MA 02169, or
- **Email:** privacy@teladochealth.com
(Email may not be a secure way to transmit sensitive information)