Step by Step Guide to Anthem Blue Cross Enrollment Application
FOR Adding/Dropping Dependents for Anthem Medical

For members of the California Association of REALTORS®

Use this form to:

- Add or drop dependents
- Change name
- Change coverage following a qualifying event

Please mark the changes you are making at the top of the page.

Section A: General Information (page 1)

- Enter your name and Social Security Number, and indicate language choice.

Section B: Employee/Member Information (page 1)

- Fill in the reason for your change, check the change you're making, and mark the event reason and event date.
- Complete your personal information and provide your email address. We frequently communicate with you via email so your updated email address is important.

Section C: Type of Coverage (page 2) – Complete ONLY if making a plan change.

- Select your Anthem plan name from the drop down

Section D: Family Information (page 3)

LIST ONLY THE INFORMATION FOR THE DEPENDENT(S) YOU ARE ADDING, DROPPING OR MAKING CHANGES FOR

Select the Add or Drop button to the left to indicate the family member you are adding/dropping

If you are enrolling a dependent, you must provide their personal information in the spaces provided.

For HMO Plan enrollment ONLY: Complete the "PCP Name" and "PCP ID No." to designate the Primary Care Physician for each family member. The PCP ID No. can be found by looking up your doctor on the Anthem website. Visit: www.Anthem.com/ca and click on "Find a Doctor" on the right hand side of the web page. Be sure you select "California Care HMO/Small Grp" as the network for the HMO.

Section E: Prior and Other Coverage (page 3) – Complete ONLY if adding coverage for a family member

- Complete this section if adding a family member to report whether they have other coverage

Section F Waiver/Declination of Coverage (page 4)

Waiver/Declining Coverage

You must complete this section for all eligible family members who are declining coverage. By declining coverage you are waiving your eligibility for enrollment at this time. If you are dropping a dependent, you must complete this section to reflect their information.

- Check a box to indicate who you are waiving/cancelling/declining coverage for and to give the reason you are cancelling/declining coverage.
- Sign and date the bottom of this page **only if you are waiving/cancelling/declining medical coverage** for a family member.

Section G Terms, Conditions and Authorizations (pages 5 & 6)

Review, sign and date this page.

If you have questions, please contact us at (800) 939-8088

California Employee Enrollment Application For Small Groups Medical, Dental, and Vision

Use this form to:
* **Enroll or Change Coverage**
* **Add/Drop Dependents**

Health care plans offered by Anthem Blue Cross and Insurance plans offered by Anthem Blue Cross Life and Health Insurance Company. You, the employee, must complete this application. You are solely responsible for its accuracy and completeness. To avoid the possibility of delay, answer all questions and be sure to sign and date your application. Submit application to your employer.

Please complete in black ink only.

CA Real Estate License #:

Requested Effective Date:

Group/Case no. (if known)

Section A: Application Type — select one.

☐ New enrollment ☐ Open enrollment ☐ Qualifying event
☐ COBRA/Cal-COBRA ☐ Rehire date (MM/DD/YYYY)

If you select **Qualifying event or COBRA/Cal-COBRA**, please select one event reason.

☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Divorce or legal separation ☐ Death
☐ COBRA ☐ Cal-COBRA — Cal-COBRA applicants must submit first month's premium.
☐ Involuntary loss of coverage — please explain (required): _____
☐ Other — please explain (required): _____

Qualifying event or COBRA/Cal-COBRA date — Required (MM/DD/YYYY):

Section B: Employee /Member Information

Last name	First name	M.I.	Social Security no.[1] (required)

Home address - (P.O. Box not acceptable unless rural address)	City	State	ZIP code

County	Marital status	Employment status	Primary phone no
	☐ Single ☐ Married ☐ Domestic Partner (DP)	☐ Full-time ☐ Part-time	

Employer name (if enrolling as a W2 employee)	Occupation

Employee's physical work address (required)	City	State	ZIP code

Date of hire[2] (MM/DD/YYYY)	Date of full-time employment (MM/DD/YYYY)	Date waiting period begins[2] (MM/DD/YYYY)	No. of hours worked per week

Language choice (optional): ☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Vietnamese ☐ Tagalog
☐ Other - please specify: _____
Do you read and write English? ☐ Yes ☐ No If no, the translator must sign and submit a Statement of Accountability/Translator's Statement.

Employee email address: _____

1 Anthem is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) regulations to collect this information.
2 If your employer imposes an orientation period for new hires, the "date of hire" is the first day after completion of the orientation period.

Social Security no.[1] _____

Section C: Type of Coverage — Your employer will advise you of your plan options and contract codes.	
1. Medical Coverage	
Please Note: All health plans[2] include the required coverage for the dental and vision pediatric essential health benefits.	
Medical plan name[3]: ***SELECT ONE***	Contract code, if known:
Member medical coverage — select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family	

1 Anthem is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) regulations to collect this information.
2 These plans are offered by Anthem Blue Cross and regulated by the Department of Managed Health Care.
3 Enrollment in the selected plan is dependent upon the employee residing or working within a plan's geographic service area, and the network, provider, and physician availability within the geographical service area. If at the time of enrollment the network, or physician/medical group is not available or an employee does not reside or work in the geographical service area of the plan you may be assigned to or be required to choose a different provider, network, and/or plan.
4 Dental PPO and Vision plans are offered by Anthem Blue Cross Life and Health Insurance Company and regulated by the California Department of Insurance.

Social Security no.[1] _____

Section D: Family Information — Complete this section for yourself and all dependents. All fields required. Attach a separate sheet if necessary. Please access *Find Care* at anthem.com/ca to determine if your physician is a participating provider. For HMO plans: provide 3- or 6- digit Primary Care Physician no.

Dependent information must be completed for all additional dependents (if any) **to be covered under this coverage**. An eligible dependent may be your spouse or domestic partner, your children, children for whom you've assumed a parent-child relationship[2] (not including foster children) or your spouse or domestic partner's children (to the end of the calendar month in which they turn age 26). In the case of your child, the age limit of 26 does not apply when the child is and continues to be (1) incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition and (2) chiefly dependent upon the subscriber for support and maintenance. The employee will be required to submit certification by a physician of the child's condition. List all dependents beginning with the eldest.

Member/Employee Last name	First name	M.I.

Sex ☐ Male ☐ Female	Birthdate (MM/DD/YYYY)

Primary Care Physician (PCP) name (if selecting an HMO[3] plan)	PCP ID no.	Existing patient ☐ Yes ☐ No

Primary Care Dentist (PCD) name (If selecting Dental net DHMO plan)	PCD ID no	Existing patient ☐ Yes ☐ No

Add ☐ Drop ☐

Spouse/Domestic Partner Last name	First name	M.I.	Social Security no.[1] (required)

Sex ☐ Male ☐ Female	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Spouse ☐ Domestic Partner

PCP name (if selecting an HMO[3] plan)	PCP ID no.	Existing patient ☐ Yes ☐ No

PCD name (If selecting Dental net DHMO plan)	PCD ID no.	Existing patient ☐ Yes ☐ No

Does this dependent have a different address? ☐ Yes ☐ No
If yes, full address and ZIP code: _____

Add ☐ Drop ☐

Dependent Child Last name	First name	M.I.	Social Security no.[1] (required)

Sex ☐ Male ☐ Female	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Child ☐ Other[4] If other, what is relationship? _____

PCP name (if selecting an HMO[3] plan)	PCP ID no.	Existing patient ☐ Yes ☐ No

PCD name (If selecting Dental net DHMO plan)	PCD ID no.	Existing patient ☐ Yes ☐ No

Does this dependent have a different address? ☐ Yes ☐ No
If yes, full address and ZIP code: _____

Add ☐ Drop ☐

Dependent Child Last name	First name	M.I.	Social Security no.[1] (required)

Sex ☐ Male ☐ Female	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Child ☐ Other[4] If other, what is relationship? _____

PCP name (if selecting an HMO[3] plan)	PCP ID no	Existing patient ☐ Yes ☐ No

PCD name (If selecting Dental net DHMO plan)	PCD ID no.	Existing patient ☐ Yes ☐ No

Does this dependent have a different address? ☐ Yes ☐ No
If yes, full address and ZIP code: _____

1 Anthem is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) regulations to collect this information.
2 As defined in 2 CCR § 599.500(o).
3 Enrollment in the selected plan is dependent upon the employee residing or working within a plan's geographic service area, and the network, provider, and physician availability within the geographical service area. If at the time of enrollment the network, or physician/medical group is not available or an employee does not reside or work in the geographical service area of the plan you may be assigned to or be required to choose a different provider, network, and/or plan.
4 Eligibility subject to Evidence of Coverage

Social Security no.[1] _____

Section E: Prior and Other Group Coverage

1. Is anyone applying for coverage currently enrolled in Medicare? ☐ Yes ☐ No If yes, give name: _____

Medicare ID no.	Part A effective date (MM/DD/YYYY)	Part B effective date (MM/DD/YYYY)
Medicare Part D ID no.	Medicare Part D carrier	Part D effective date (MM/DD/YYYY)

2. Does anyone on this application intend to continue other coverage if this application is accepted? ☐ Yes ☐ No
3. Is anyone applying for coverage covered by other health, dental, or orthodontia coverage? ☐ Yes ☐ No
4. On the day your coverage begins, will you or a family member be covered by other dental coverage? ☐ Yes ☐ No

If yes to any of these questions, please provide the following:

Name of Person covered (Last name, First, M.I.)	Type (select one)	Coverage (select all that apply)	Carrier name.	Policy ID no.	Dates (if applicable) (MM/DD/YYYY)
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia			Start End
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia			Start End
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia			Start End
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia			Start End

Section F: Waiver/Declining Coverage — Proof of coverage will be required.

Type of coverage/Declined for: Select all that apply.

☐ ~~Employee~~	☐ ~~Medical~~	☐ ~~Dental~~	☐ ~~Vision~~
☐ Spouse/ Domestic Partner	☐ Medical	☐ ~~Dental~~	☐ ~~Vision~~
☐ Dependents	☐ Medical	☐ ~~Dental~~	☐ ~~Vision~~

List name of dependents to be waived: _____

Reason for declining/refusing coverage: Select all that apply.

- ☐ No coverage
- ☐ Covered by Spouse's/Domestic Partner's group coverage
- ☐ Spouse/Domestic Partner covered by their employer's group coverage
- ☐ Enrolled in individual coverage
- ☐ Medicare/Medicaid/VA
- ☐ Enrolled in other Insurance — Please provide company name and plan: _____
- ☐ Other — please explain: _____

I acknowledge that the available coverages have been explained to me by my employer and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily, and no one, including but not limited to my employer, or agent, has tried to influence me or put any pressure on me to waive coverage. BY WAIVING THIS GROUP MEDICAL, DENTAL, OR VISION COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL, DENTAL, OR VISION COVERAGE ELSEWHERE) I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UNTIL THE NEXT OPEN ENROLLMENT TO BE ENROLLED IN THIS GROUP'S MEDICAL, DENTAL VISION, PLAN UNLESS I QUALIFY FOR A SPECIAL OPEN ENROLLMENT. Please note Spouse/Domestic Partner and Dependent coverage will not be available if the Employee has waived/declined.

Special Open Enrollment

If you declined enrollment for yourself or your dependent(s) (including a spouse/domestic partner), you may be able to enroll yourself or your dependent(s) in this health benefit plan or change health benefit plans as a result of certain triggering events, including: (1) you or your dependent loses minimum essential coverage; (2) you gain or become a dependent; (3) you are mandated to be covered as a dependent pursuant to a valid state or federal court order; (4) you have been released from incarceration; (5) your health coverage issuer substantially violated a material provision of the health coverage contract; (6) you gain access to new health benefit plans as a result of a permanent move; (7) you were receiving services from a contracting provider under another health benefit plan, for one of the conditions described in Section 1373.96(c) of the Health and Safety Code and that provider is no longer participating in the health benefit plan; (8) you are a member of the reserve forces of the United States military or a member of the California National Guard, and returning from active duty service; or (9) you demonstrate to the department that you did not enroll in a health benefit plan during the immediately preceding enrollment period because you were misinformed that you were covered under minimum essential coverage. You must request special enrollment within 60 days from the date of the triggering event to be able to enroll yourself or your dependent(s) in this health benefit plan or change health benefit plans as a result of a qualifying triggering event

Sign here only if you are declining coverage. DO NOT SIGN HERE IF YOU ARE APPLYING FOR COVERAGE

Signature of Applicant X	Printed name	Date (MM/DD/YYYY)

1 Anthem is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) to collect this information.

Social Security no.[1] _____

Section G: Electronic Delivery of Materials.

For Medical and all Dental Net DHMO plans offered by Anthem Blue Cross and regulated by the Department of Managed Health care.
I (primary applicant) agree to receive my plan-related communications for myself and any dependents, either by email or electronically. This may include my certificate, evidence of coverage, explanation of benefits statements, required notices or helpful information to get the most out of my plan. I agree to provide and update Anthem with my current email address. I know that I can change my mind and request a copy of these materials (or any specific materials) at any time by mail or by contacting Anthem. I (or my enrolled dependents) will change our communication preferences by going to anthem.com/ca or calling the Member Services number on my ID card.

Dental & Vision not applicable to C.A.R. plans

For Dental PPO and Vision plans offered by Anthem Blue Cross Life and Health Insurance Company and regulated by the California Department of Insurance. Anthem will deliver plan materials and related items by mail.

☐ By signing below, I (primary applicant) agree to receive my plan-related communications for myself and any dependents, either by email or electronically. This includes my certificate, evidence of coverage, explanation of benefits statements, legally required notics, or helpful information to get the most out of my plan. I agree to provide and update Anthem with my current email address. I understand that this consent is voluntary, and that I (or my enrolled dependents) can opt out of electronic delivery at any time and receive these materials (or any specific materials) by mail, and/ or change my email address by going to anthem.com/ca or calling the Member Services number on my ID card.

Applicant signature _____Date_____

☐ I do not wish to receive my plan-related communications, either by email or electronically and request to receive these items by mail.

Section H: Terms, Conditions and Authorizations — Please read this section carefully before signing the application.

As an eligible employee, I am requesting coverage for myself and all eligible dependents listed and authorize my employer to deduct any required contributions for this insurance from my earnings. To the best of my knowledge or belief, all statements and answers I have given are true and complete. I understand it is a crime to make or cause to be made a knowingly false or fraudulent material statement or material representation to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. I understand all benefits are subject to conditions stated in the Group Contract and coverage document.

In signing this application I represent that:

I have read or have had read to me the completed application, and I realize any acts of fraud or intentional misrepresentation of material fact in the application may result in loss of coverage within 24 months following the issuance of the coverage.

I certify each Social Security number listed on this application is correct.

I understand that I may not assign any payment under my Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company program. I agree to have money taken from my wages, if necessary, to cover the premium cost for the coverage applied for.

I am asking for the coverage I chose on this form. If I made choices that are not available to me, I agree that my choices may be changed to those on the employer's application or sold case coverage documents.

I understand that, to the extent allowed by law, Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company reserves the right to accept or decline this application for coverage (and that Anthem Blue Cross Life and Health Insurance Company may accept only certain people or terms for coverage), and that no right is created by my application for coverage.

I agree that I will let my employer know right away of any changes that would make me or any dependent(s) ineligible for this coverage.

I understand that coverages will become effective on the date established by the provisions of the group policy, contract and certificates issued thereunder.

By signing this application, I agree to the taping or monitoring of any phone calls between Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and myself.

By providing a phone number, I agree and consent that Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and its affiliates may call or text me at the phone number included on this application using an automated telephone dialing system and/or prerecorded message to help keep me informed about my benefits.

For Health Savings Account enrollees: I authorize the Health Savings Account (HSA) financial custodian (provided I am enrolling in an HSA) to provide Anthem Blue Cross with information about my HSA, including account number, account balance and information regarding account activity. I understand that my authorization is required before the financial custodian may provide Anthem Blue Cross with information regarding my HSA and that I may provide Anthem Blue Cross with a written request to revoke my authorization at any time.

Social Security no.[1] _____

For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Read carefully — Signature required

REQUIREMENT FOR BINDING ARBITRATION

ALL DISPUTES BETWEEN YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY, INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. For claims that exceed the jurisdiction of the small claims court that are subject to binding arbitration under this Agreement, California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AGREE TO BE BOUND BY THIS ARBITRATION PROVISION. YOU ACKNOWLEDGE THAT FOR DISPUTES THAT ARE SUBJECT TO ARBITRATION UNDER STATE OR FEDERAL LAW THE RIGHT TO A JURY TRIAL, THE RIGHT TO A BENCH TRIAL UNDER CALIFORNIA BUSINESS AND PROFESSIONS CODE SECTION 17200, AND/OR THE RIGHT TO ASSERT AND/OR PARTICIPATE IN A CLASS ACTION ARE ALL WAIVED BY YOU. If your plan/policy is subject to 45 CFR 147.136, this agreement does not limit your rights to internal and external review of adverse benefit determinations as required by that law. Enforcement of this arbitration clause, including the waiver of class actions, shall be determined under the Federal Arbitration Act ("FAA"), including the FAA's preemptive effect on state law. By signing, writing or typing your name below you agree to the terms of this agreement and acknowledge that your signed, written or typed name is a valid and binding signature.

Sign here	Applicant signature X	Date (MM/DD/YYYY)

1 Anthem is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) to collect this information.

Get help in your language

Language Assistance Services

Anthem.

Curious to know what all this says? We would be too. Here's the English version:
IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish
IMPORTANTE: ¿Puede leer esta carta? De lo contrario, podemos hacer que alguien lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721. (TTY/TDD: 711)

Arabic
مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاستعانة بشخص ما ليساعدك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم1-888-254-2721. (TTY/TDD: 711)

Armenian
ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող ենք նաև այս նամակը Ձեզ գրավոր տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-888-254-2721 հեռախոսահամարով: (TTY/TDD: 711)

Chinese
重要事項：您能看懂這封信函嗎？如果您看不懂，我們能夠找人協助您。您有可能可以獲得以您的語言而寫的本信函。如需免費協助，請立即撥打1-888-254-2721。(TTY/TDD: 711)

Farsi
مهم: آیا می‌توانید این نامه را بخوانید؟ اگر نمی‌توانید، می‌توانیم شخصی را به شما معرفی کنیم تا در خواندن این نامه شما را کمک کند. همچنین می‌توانید این نامه را به صورت مکتوب به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، همین حالا با شماره 1-888-254-2721 تماس بگیرید. (TTD/TTY: 711)

Hindi
महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम आपको इसे पढ़ने में मदद करने के लिए किसी को उपलब्ध करा सकते हैं। आप यह पत्र अपनी भाषा में लिखवाने में भी सक्षम हो सकते हैं। निःशुल्क मदद के लिए, कृपया 1-888-254-2721 पर तुरंत कॉल करें। (TTY/TDD: 711)

Hmong
TSEEM CEEB: Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwm tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

Japanese
重要：この書簡を読めますか？もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたものを入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。 1-888-254-2721 (TTY/TDD: 711)

107750CAMENABC 05/18 DMHC3 DMHCW #CA-DMHC-001#

Khmer
សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ យើងអាចឲ្យនរណាម្នាក់អានវាជូនអ្នក។
អ្នកក៏អាចទទួលលិខិតនេះដោយសរសេរជាភាសារបស់អ្នកផងដែរ។ ដើម្បីទទួលជំនួយឥតគិតថ្លៃ
សូមហៅទូរស័ព្ទភ្លាមៗទៅលេខ 1-888-254-2721។ (TTY/TDD: 711)

Korean
중요: 이 서신을 읽으실 수 있으십니까? 읽으실 수 없을 경우 도움을 드릴 사람이 있습니다. 귀하가 사용하는 언어로 쓰여진 서신을 받으실 수도 있습니다. 무료 도움을 받으시려면 즉시 1-888-254-2721로 전화하십시오. (TTY/TDD: 711)

Punjabi
ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸੀਂ ਸ਼ਾਇਦ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵਬੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਫੋਰਨ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Russian
ВАЖНО. Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

Tagalog
MAHALAGA: Nababasa ba ninyo ang liham na ito? Kung hindi, may taong maaaring tumulong sa inyo sa pagbasa nito. Maaari ninyo ring makuha ang liham na ito nang nakasulat sa ginagamit ninyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai
หมายเหตุสำคัญ: ท่านสามารถอ่านจดหมายฉบับนี้หรือไม่ หากท่านไม่สามารถอ่านจดหมายฉบับนี้ เราสามารถจัดหาเจ้าหน้าที่มาอ่านให้ท่านฟังได้ ท่านยังอาจให้เจ้าหน้าที่ช่วยเขียนจดหมายในภาษาของท่านอีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อที่หมายเลข 1-888-254-2721 (TTY/TDD: 711)

Vietnamese
QUAN TRỌNG: Quý vị có thể đọc thư này hay không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc thư này. Quý vị cũng có thể nhận thư này bằng ngôn ngữ của quý vị. Để được giúp đỡ miễn phí, vui lòng gọi ngay số 1-888-254-2721. (TTY/TDD: 711)

It's important we treat you fairly
That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.