Employee Change Form
For 1–100 Employee Small Groups
California

Anthem BlueCross

Instructions:

If you are cancelling coverage for a dependent or changing a name, please provide a reason in the designated sections. Complete electronically or in black ink and return to your employer. Please use extra sheets of paper if necessary.

Note: Anthem Blue Cross (Anthem) is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) to collect Social Security numbers.

Submit application to your employer.

Section A: General Information

Employer name			Group/Case no. (if known)
Employee last name	Employee first name	M.I.	Employee Social Security no.* (required)

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.

Section B: Employee Information – Required

Reason for change – Required. Check all that apply.

☐ Address change ☐ Add spouse/Domestic Partner or dependent ☐ Enrollment in Medicare (Fill in Section E) ☐ Cancel coverage
☐ Name change ☐ Cancel spouse/Domestic Partner or dependent ☐ COBRA
☐ Benefit change ☐ Change Primary Care Physician (PCP) ☐ Cal-COBRA ☐ Other: _____

Event reason – Required. Select one: ☐ Add ☐ Change ☐ Cancel (Complete Section F)

If you select **Add** or **Change**, please select one event reason.

☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Open enrollment (not applicable for Life) ☐ Divorce or legal separation ☐ Death
☐ Involuntary loss of coverage – please explain: _____ ☐ Other – please explain: _____

Qualifying event date – Required: _____ (MM/DD/YYYY)

Home address – Street and PO Box if applicable	City	State

ZIP code	Birthdate (MM/DD/YYYY)	Sex ☐ Male ☐ Female	Marital status ☐ Single ☐ Married ☐ Domestic Partner (DP)	Number of dependents

Phone no.	Email address	Occupation

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

Section C: Family Information – Spouse/Domestic Partner and dependents to be added/changed/cancelled. Attach a separate sheet if necessary.

Event reason – Required. Select one: ☐ Add ☐ Change ☐ Cancel (Complete Section F)

If you select **Add** or **Change**, please select one event reason.

☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Open enrollment (not applicable for Life) ☐ Divorce or legal separation ☐ Death
☐ Involuntary loss of coverage – please explain: _____ ☐ Other – please explain: _____

Qualifying event date – Required: _____ (MM/DD/YYYY)

Spouse/Domestic Partner last name	First name	M.I.	Social Security no.* (required)

Sex ☐ Male ☐ Female	Disabled? ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Spouse ☐ Domestic Partner

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

Does the Spouse/Domestic Partner have a different address? ☐ Yes ☐ No
If yes, provide full address and ZIP code below.

Street address, if different	City	State	ZIP code

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

Employee name	Social Security no.*

Section C: Family Information — Continued

Event reason — Required. Select one: ☐ Add ☐ Change ☐ Cancel (Complete Section F)

If you select **Add** or **Change**, please select one event reason.
☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Open enrollment (not applicable for Life) ☐ Divorce or legal separation ☐ Death
☐ Involuntary loss of coverage – please explain: ____________ ☐ Other – please explain: ____________

Qualifying event date – Required: ____________ (MM/DD/YYYY)

Dependent last name	First name	M.I.	Social Security no.* (required)

Sex	Disabled	Birthdate (MM/DD/YYYY)	Relationship to applicant
☐ Male ☐ Female	☐ Yes ☐ No		☐ Child ☐ Other If other, what is relationship? ____________

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

Does this dependent have a different address? ☐ **Yes** ☐ **No**
If yes, provide full address and ZIP code below.

Street address, if different	City	State	ZIP code

Event reason — Required. Select one: ☐ Add ☐ Change ☐ Cancel (Complete Section F)

If you select **Add** or **Change**, please select one event reason.
☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Open enrollment (not applicable for Life) ☐ Divorce or legal separation ☐ Death
☐ Involuntary loss of coverage – please explain: ____________ ☐ Other – please explain: ____________

Qualifying event date – Required: ____________ (MM/DD/YYYY)

Dependent last name	First name	M.I.	Social Security no.* (required)

Sex	Disabled	Birthdate (MM/DD/YYYY)	Relationship to applicant
☐ Male ☐ Female	☐ Yes ☐ No		☐ Child ☐ Other If other, what is relationship? ____________

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

Does this dependent have a different address? ☐ **Yes** ☐ **No**
If yes, provide full address and ZIP code below.

Street address, if different	City	State	ZIP code

Event reason — Required. Select one: ☐ Add ☐ Change ☐ Cancel (Complete Section F)

If you select **Add** or **Change**, please select one event reason.
☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Open enrollment (not applicable for Life) ☐ Divorce or legal separation ☐ Death
☐ Involuntary loss of coverage – please explain: ____________ ☐ Other – please explain: ____________

Qualifying event date – Required: ____________ (MM/DD/YYYY)

Dependent last name	First name	M.I.	Social Security no.* (required)

Sex	Disabled	Birthdate (MM/DD/YYYY)	Relationship to applicant
☐ Male ☐ Female	☐ Yes ☐ No		☐ Child ☐ Other If other, what is relationship? ____________

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

Does this dependent have a different address? ☐ **Yes** ☐ **No**
If yes, provide full address and ZIP code below.

Street address, if different	City	State	ZIP code

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

Employee name	Social Security no.*

Section D: Plan/Type of Coverage

1. Medical Coverage – Select from only the coverages offered by your employer. Medical plans offered by Anthem Blue Cross.

Please Note: All health plans include the required coverage for the dental and vision pediatric essential health benefits.

Enter network name, product plan name and contract code selected:

Network name	Product plan name	Contract code, if known

Member medical coverage – select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family

2. Dental Coverage – Select from only the coverages offered by your employer. Dental PPO plans are offered by Anthem Blue Cross Life and Health Insurance Company. Dental HMO plans are offered by Anthem Blue Cross.

Product plan name	For all Dental HMO plans, you must enter your Dental office no.: _____	Contract code, if known

Member dental coverage – select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family

Optional dental plans do not include coverage for dental pediatric essential health benefits.

3. Vision Coverage – Select from only the coverages offered by your employer. Offered by Anthem Blue Cross Life and Health Insurance Company.

Product plan name	Contract code, if known

Member vision coverage – select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family

Optional vision plans do not include coverage for vision pediatric essential health benefits.

4. Life and Disability Coverage – Select from only the coverages offered by your employer. Offered by Anthem Blue Cross Life and Health Insurance Company.

☐ Basic Life and AD&D
☐ Basic Dependent Life
☐ Optional Supplemental/Voluntary Life and AD&D $_____ (employee amount)
☐ Optional Supplemental/Voluntary Dependent Life Spouse $_____ (spouse amount)
☐ Optional Supplemental/Voluntary Dependent Life Child $_____ (child amount)

☐ Short Term Disability
☐ Long Term Disability
☐ Voluntary Short Term Disability
☐ Voluntary Long Term Disability

Current annual income $_____	Life & Disability class no.

Primary Beneficiary – Attach a separate sheet if necessary

Last name	First name	M.I.	Relationship	Social Security no.	Percentage

Contingent Beneficiary – Attach a separate sheet if necessary

Last name	First name	M.I.	Relationship	Social Security no.	Percentage

Total percentages should add up to 100%. If no percentages are indicated, the proceeds will be divided equally. If no Primary beneficiary survives, the proceeds will be paid to the contingent beneficiary(ies) listed above.

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

Employee name	Social Security no.*

4. Life and Disability Coverage — Continued

Spousal Consent for Community Property States Only (Note: The insurance company is not responsible for the validity of a spouse's consent for designation.) If you live in a community property state (AZ, CA, ID, LA, NM, NV, TX, WA and WI), your state may require you to obtain the signature of your spouse if your spouse will not be named as a primary beneficiary for 50% or more of your benefit amount. Please have your spouse read and sign the following. I am aware that my spouse, the Employee/Retiree named above, has designated someone other than me to be the beneficiary of group life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.

Spouse signature **X**	Spouse name	Date

I authorize the release of any medical records or information concerning claims, conditions or treatment of myself and for any dependents listed herein, by any provider of health services, pharmacy related service organization, medical or medically-related facility, or the MIB, Inc., to Anthem Blue Cross Life and Health Insurance Company (Anthem Life), its affiliates, and any administrators, reinsurers, agents, or other entity providing services on behalf of Anthem Life. This information will be used for purposes which include but are not limited to: processing this application for enrollment; group risk classification; detecting or preventing fraud or misrepresentation; internal and external audits; administration of claims; and quality improvement programs. Anthem Life will advise such entities that such information must be kept confidential to the extent necessary or as otherwise provided by law, and should not be used for any unlawful purpose. This information includes any records or knowledge about medical history, including sensitive services such as mental health, psychiatric, substance abuse, reproductive health, information relating to ARC or AIDS (excluding disclosure of HIV testing or HIV status), sexually transmitted or other communicable diseases contained in such records, including but not limited to, all records of office visits, examinations, treatment, evaluation, diagnostic and laboratory testing, reports, consultations, hospital records, prescription history, records for treatment of substance abuse, psychiatric counseling, notes, correspondence, insurance and billing information for treatment or services rendered by any provider. I understand that Anthem Life may collect personal information about me from outside sources, and that both personal and privileged information may be collected and disclosed to third parties without my further authorization, and may no longer be protected by Federal privacy laws. I also understand that I have a right to see and correct personal information that Anthem Life collects about me, and that I may receive a more detailed description of my rights under this law by writing to Anthem Life.

I acknowledge that I have read the foregoing provisions and I expressly accept such provisions as a condition of coverage. I also acknowledge receipt and understanding of the Notice of Exchange of Information explained above. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and I understand they are being relied on by the insurer in accepting this application. I understand that any misstatements or failure to report new medical information prior to my effective date may result in a material change to coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits or rescission or cancellation of my coverage(s). This authorization, for purposes of processing this application form, is valid from the date signed for a period of thirty months unless revoked by me in writing, which I may do at any time by contacting Anthem Life. A photocopy is as valid as the original.

I give this authorization for and on behalf of myself and my eligible dependents, including my children and my spouse (if spouse does not sign below), if covered by the Plan. I am acting as their agent and representative.

Incomplete applications will be mailed back to you for completion. This may delay the effective date of your coverage.

Section E: Other Coverage

1. Are you or anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No If yes, give name: _____

Medicare ID no.	Part A effective date	Part B effective date	Medicare eligibility reason (check all that apply) ☐ Age ☐ Disability ☐ ESRD: Onset date:

Medicare Part D ID no.	Medicare Part D Carrier	Part D effective date

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 vision 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 (check one)	Coverage (check all that apply)	Carrier name	Carrier phone no.	Policy ID no.	Policy holder name	Dates (if applicable)
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Vision					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Vision					Start: End:

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

Employee name	Social Security no.*

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

Medical coverage declined for – check all that apply:	☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)
Dental coverage declined for – check all that apply:	☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)
Vision coverage declined for – check all that apply:	☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)
***Life/AD&D** coverage declined for:	☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)
Dependent Life coverage declined for:	☐ Spouse/Domestic Partner ☐ Dependents
Short Term Disability coverage declined for:	☐ Myself
Long Term Disability coverage declined for:	☐ Myself
Optional Supplemental/Voluntary coverage declined for:	☐ Myself
Optional Supplemental/Voluntary Dependent Life coverage declined for:	☐ Spouse/Domestic Partner and Dependents
Voluntary Short Term Disability coverage declined for:	☐ Myself
Voluntary Long Term Disability coverage declined for:	☐ Myself

Reason for declining coverage – check all that apply:

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

List names of dependents to be waived: _____

I acknowledge that the available coverage's 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 has tried to influence me or put any pressure on me to waive coverage. BY WAIVING THIS GROUP MEDICAL, DENTAL, VISION, DISABILITY AND/OR GROUP LIFE COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL, DENTAL, VISION, DISABILITY AND/OR GROUP LIFE 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, DISABILITY AND/OR GROUP LIFE INSURANCE PLAN UNLESS I QUALIFY FOR A SPECIAL OPEN ENROLLMENT.

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.

*I hereby certify that I have been given the opportunity to apply for the available group life benefits offered by my employer, the benefits have been explained to me, and I and/or my dependent(s) decline to participate. Neither I nor my dependent(s) were induced or pressured by my employer, agent, or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for such coverage in the future, I may be required to provide evidence of insurability at my expense. Please examine your options carefully before waiving this coverage.

Sign here only if you are declining coverage for yourself or dependents.

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

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

Employee name	Social Security no.*

Section G: 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. 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 certify each Social Security number listed on this application is correct.

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 understand that I may not assign any payment under my Anthem Blue Cross (Anthem) 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.

I understand that, to the extent allowed by law, Anthem 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 also understand that I may not be covered for pre-existing conditions for Long Term Disability and Short Term Disability, if applicable. (See the policy/certificate for important information).

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.

By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself.

By signing below, I (primary applicant) agree to receive my plan-related communications 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 at any time I can change my mind and request a copy of these materials (or any specific materials) by mail, by contacting Anthem.

For Health Savings Account enrollees: Except as otherwise provided in any agreement between me and the financial custodian, the custodian of my Health Savings Account (HSA), I understand that my authorization is required before the financial custodian may provide Anthem with information regarding my HSA. I hereby authorize the financial custodian to provide Anthem with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide Anthem with a written request to revoke my authorization at any time.

If applying for Life and/or Disability insurance, I represent that I have read and agree to the terms in the *Life and Disability Coverage* in Section 4, above.

HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

Read carefully – Signature required

REQUIREMENT FOR BINDING ARBITRATION (Not applicable to Life and Disability coverage.)

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. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: 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. 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	Date (MM/DD/YYYY)
	X	

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

Get help in your language

Language Assistance Services

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.(TTY/TDD: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)

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 ਵਵੀ 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.