

# Employee Enrollment Application

## For 100+ employee groups

### Virginia



PPO health care plans, including dental and vision coverage, are insurance products offered by Anthem Blue Cross and Blue Shield, the trade name of Anthem Health Plans of Virginia, Inc. (Anthem); HMO health care plans are health maintenance organization products offered by HealthKeepers, Inc. (HealthKeepers).

**Instructions:**

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.  
 Please complete electronically or in blue or black ink only.  
 Application completed for (check company that applies)

- Anthem Health Plans of Virginia, Inc.**  
 2015 Staples Mill Road  
 Richmond, VA 23279
- HealthKeepers, Inc.**  
 2015 Staples Mill Road  
 Richmond, VA 23279

Employer name	Group no.	Subsection
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**Section 1: Employee information**

Last name		First name		M.I.	Social Security no.* (required)	
Birthdate (MMDDYYYY)		Home address				
City			County		State	ZIP code
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner — If available through your employer.			Primary phone no.	
Employment status <input type="checkbox"/> Full time			Hire date (MMDDYYYY)		No. of hours worked per week	
Primary Care Physician (PCP) name			PCP ID no.		Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**Consent to Opt-In for Electronic Delivery**

Employee email address

I am providing my email address because I, and my enrolled dependents, want to receive information about our benefits electronically. These communications may include Identification (ID) Cards, Certificates of Coverage or Evidence of Coverage, grievance, appeals, and medical necessity determination notifications, Explanation of Benefits, other required notices, and personalized information to help get the most out of the benefits. I understand I need to register on [anthem.com](http://anthem.com) or the Sydney Health mobile app to get the most out of my plan's digital tools, and I will make sure Anthem has my most up-to-date email address. I, and my enrolled dependents, understand that we can update our email addresses, change our communication preferences, and request free copies of any materials at any time by going to [anthem.com](http://anthem.com) or calling the Member Services number on my ID Card.

Opt-Out of Electronic Delivery  
 I have provided my email address, however I wish to opt-out of electronic delivery.

\*Anthem/HealthKeepers is required by the Internal Revenue Service to collect this information.

Social Security no.\* (required): \_\_\_\_\_

## Section 2: Reason for application — Select one

- New enrollment
- Annual open enrollment
- New hire
- Rehire — Rehire date: \_\_\_\_\_ (MMDDYYYY)
- Marriage — Date of marriage: \_\_\_\_\_ (MMDDYYYY)
- Birth of child
- Add dependent (Fill in section 4)
- Loss of eligibility for other coverage — Date previous coverage ended: \_\_\_\_\_ (MMDDYYYY)
- COBRA — Select qualifying event (not applicable to Life and/or AD&D and/or Disability)
  - Left employment
  - Reduction in hours
  - Death
  - Medicare
  - Loss of dependent child status
  - Divorce or legal separation
  - Covered employee's Medicare entitlementQualifying event date: \_\_\_\_\_ (MMDDYYYY)
- Waiver (To decline ALL coverage skip to section 7.)

## Section 3: Type of coverage

### Medical coverage — Check company(ies) and write in product that applies. Application completed for:

- Anthem Blue Cross and Blue Shield — Product name: \_\_\_\_\_
- HealthKeepers, Inc. — Product name: \_\_\_\_\_ Point of service (POS)
- Add HRA Wrap (Administered by Anthem)

### Member medical coverage — select one:

- Employee only
- Employee + Spouse or Domestic Partner
- Employee + one child
- Employee + children
- Family
- No coverage

If your employer/group offers Exclusive Provider Organization (EPO) coverage, you will also have the option at the time of your initial enrollment and at each renewal to choose a health care plan allowing you to access care from in and out-of-network providers. This should be a “preferred provider organization” or “PPO” plan offered by Anthem.

### Flexible Spending Account (FSA) coverage — More than one plan may be selected, depending on employer offerings.

- Healthcare FSA (excluded if you have an HSA plan)
  - Limited-Purpose FSA (for dental and vision services)
  - Dependent Care FSA
  - Commuter Parking
  - Commuter Transit
  - No FSA coverage at this time
- NOT APPLICABLE**

**Dental coverage: THIS IS AN EXCEPTED BENEFITS POLICY. IT PROVIDES COVERAGE ONLY FOR THE LIMITED BENEFITS OR SERVICES SPECIFIED IN THE POLICY. THIS IS A STAND-ALONE DENTAL POLICY THAT IS NOT EXCHANGE CERTIFIED AND MAY NOT PROVIDE MINIMUM ESSENTIAL PEDIATRIC DENTAL BENEFITS.**

- Prime Essential Choice
- Complete Essential Choice
- Other: \_\_\_\_\_

### Member dental coverage — select one:

- Employee only
- Employee + Spouse or Domestic Partner
- Employee + one child
- Employee + children
- Family
- No coverage

**Vision coverage: THIS IS AN EXCEPTED BENEFITS POLICY. IT PROVIDES COVERAGE ONLY FOR THE LIMITED BENEFITS OR SERVICES SPECIFIED IN THE POLICY.**

- Exam Only
- Full Service
- Other: \_\_\_\_\_

### Member vision coverage — select one:

- Employee only
- Employee + Spouse or Domestic Partner
- Employee + one child
- Employee + children
- Family
- No coverage

Social Security no.\* (required):

**Group Accident, Critical Illness, or Hospital Indemnity Insurance: THIS IS AN EXCEPTED BENEFITS POLICY. IT PROVIDES COVERAGE ONLY FOR THE LIMITED BENEFITS OR SERVICES SPECIFIED IN THE POLICY. NOT APPLICABLE**

- Group Accident Insurance** — Coverage option:  Employee only  Employee + Spouse or Domestic Partner  Employee + Children  Family  
If more than one Accident plan offered please select:  Low Plan  High Plan
- Group Critical Illness Insurance** — Coverage option:  Employee only  Employee + Spouse or Domestic Partner  Employee + Children  Family  
If more than one Critical Illness plan offered please select:  Low Plan  High Plan  
Have you smoked or used tobacco products in the last 12 months?  No  Yes, explain product used: \_\_\_\_\_
- Group Hospital Indemnity Insurance** — Coverage option:  Employee only  Employee + Spouse or Domestic Partner  Employee + Children  Family  
If more than one Hospital Indemnity plan offered please select:  Low Plan  High Plan

**If any person to be covered by a Critical Illness or Hospital Indemnity plan is a resident of CA, GA, NY, or CO, please answer the following question:**

Will all applicants who reside in CA, GA, NY, or CO, when such coverage is to become effective, be enrolled in comprehensive health benefits from an individual or group health insurance policy, an employer sponsored health plan, or an HMO that provides essential health benefits?  Yes  No  
(Please note that if the response is No, such applicants are not eligible for coverage)

**Group Accident, Critical Illness, and Hospital Indemnity Insurance beneficiary designation. Attach a separate sheet if necessary.**

<b>Beneficiary type</b> <input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Name of beneficiary	Percentage %	Social Security no.*	Relationship to applicant	Date of birth
	Street address	City		State	ZIP code
<b>Beneficiary type</b> <input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Name of beneficiary	Percentage %	Social Security no.*	Relationship to applicant	Date of birth
	Street address	City		State	ZIP code
<b>Beneficiary type</b> <input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Name of beneficiary	Percentage %	Social Security no.*	Relationship to applicant	Date of birth
	Street address	City		State	ZIP code
<b>Beneficiary type</b> <input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Name of beneficiary	Percentage %	Social Security no.*	Relationship to applicant	Date of birth
	Street address	City		State	ZIP code

Total percentages must add up to 100%. If the total percentages add up to less than 100%, the remaining percentage will be paid in equal shares to all named beneficiaries to total 100%. If the total percentages add up to more than 100%, each named beneficiary's share will be reduced equally to total 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. Beneficiaries may be changed by the insured's written notice to his or her employer.

Social Security no.\* (required): \_\_\_\_\_

**Section 4: Coverage information — All fields required. Attach a separate sheet if necessary.**

Dependent information must be completed for all additional dependents (if any) to be covered under this coverage. If available through your employer, an eligible dependent may be your spouse or domestic partner, your children, or your spouse or domestic partner's children (to the end of the calendar month in which they turn age 26 unless they qualify as a disabled person which means incapable of self-sustaining employment by reason of intellectual disability or physical handicap and chiefly dependent upon the employee for support and maintenance.) List all dependents beginning with the eldest.

<b>Spouse or Domestic Partner</b> last name		First name	M.I.	Social Security no.* (required)
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MMDDYYYY)	Relationship to applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	
PCP name		PCP ID no.	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>Dependent Child</b> last name		First name	M.I.	Social Security no.* (required)
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MMDDYYYY)	Relationship to applicant <input type="checkbox"/> Biological child of applicant or spouse or domestic partner <input type="checkbox"/> Other If other, what is relationship? _____	
PCP name		PCP ID no.	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does this dependent have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, please enter: _____				

<b>Dependent Child</b> last name		First name	M.I.	Social Security no.* (required)
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MMDDYYYY)	Relationship to applicant <input type="checkbox"/> Biological child of applicant or spouse or domestic partner <input type="checkbox"/> Other If other, what is relationship? _____	
PCP name		PCP ID no.	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does this dependent have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, please enter: _____				

<b>Dependent Child</b> last name		First name	M.I.	Social Security no.* (required)
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MMDDYYYY)	Relationship to applicant <input type="checkbox"/> Biological child of applicant or spouse or domestic partner <input type="checkbox"/> Other If other, what is relationship? _____	
PCP name		PCP ID no.	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does this dependent have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, please enter: _____				

Social Security no.\* (required): \_\_\_\_\_

**Section 5: Prior and other group coverage**

Are you or anyone applying for coverage currently eligible for Medicare?  Yes  No

If yes, give name: \_\_\_\_\_

Medicare ID no.	Part A effective date (MMDDYYYY)	Part B effective date (MMDDYYYY)	Medicare eligibility reason (check all that apply) <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD: Onset date: _____ (MMDDYY)
Medicare Part D ID no.	Medicare Part D carrier		Part D effective date (MMDDYYYY)

Are you or a family member previously or currently covered by a Medicare, medical and/or dental plan?  Yes  No

If yes, 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.	Policyholder name	Dates (if applicable) (MMDDYY)
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia					Start: _____ End: _____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia					Start: _____ End: _____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia					Start: _____ End: _____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia					Start: _____ End: _____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia					Start: _____ End: _____

**Section 6: Terms, Conditions, and Authorizations (TERMS).****Please read this section carefully before signing the application.****Eligible employee:**

- An active employee of the Employer who works the number of hours per week to be eligible for benefits as defined by the Employer and approved by Anthem/HealthKeepers as of the effective date. Employment must be verifiable from state or federal wage tax reports.
- An employee, as defined above, who enters into employment after the coverage effective date and who completes the group imposed waiting period for eligibility (if any) and applies for coverage within 31 days.
- Any other class of persons identified by the Employer, provided that written approval of their eligibility is obtained from Anthem/HealthKeepers; or
- Employees eligible for continuous coverage under state or federal laws.

Eligible employee does not include independent contractors (whose compensation is reported on IRS Form 1099) and directors and officers of the Group Policyholder if they do not work the required number of hours per week described above.

**Eligible dependent:**

- For Anthem Blue Cross and Blue Shield and HealthKeepers only, eligible dependents are employee's spouse or domestic partner or children younger than age 26, which includes a newborn, natural child, or a child placed with the employee for adoption, a stepchild, domestic partner's child, foster child, or any other child for whom the employee has legal guardianship or court-ordered custody. Coverage for children will end on the last day of the month in which the children reach age 26.
- The age limit of 26 does not apply for the initial enrollment or maintaining enrollment of a child who cannot support himself or herself because of intellectual disability or physical handicap that began prior to the child reaching the age limit. Coverage may be obtained for the child who is beyond the age limit at the initial enrollment if the employee provides proof of disability or handicap and dependence at the time of enrollment. (The employee may be asked to provide a physician's certification of the dependent's condition.)
- Dependents eligible for continuous coverage under state or federal laws.

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 all benefits are subject to conditions stated in the Group Contract and coverage document. ANY PERSON WHO, WITH THE INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY HAVE VIOLATED STATE LAW.

**In signing this application I represent that:**

I have read or have had read to me the completed application, and I realize any false statement or misrepresentation in the application may result in loss of coverage.

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

**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/HealthKeepers with information regarding my HSA. I hereby authorize the financial custodian to provide Anthem/HealthKeepers with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide Anthem/HealthKeepers with a written request to revoke my authorization at any time.

These coverages will become effective on the date established by the provisions of the group contract and certificates issued thereunder.

**If the application is incomplete, we will reach out to you for additional information. This may delay the effective date of your coverage.**

Employee signature

X

Date (MMDDYYYY)

**Important Accident Insurance eligibility information:**

The following notice applies to all Accident and Voluntary Accident coverage presented on this form:

**ACCIDENT INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT A QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.**

**Important Critical Illness Insurance eligibility information:**

The following notice(s) apply to all Critical Illness and Voluntary Critical Illness coverage presented on this form:

**CRITICAL ILLNESS INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.**

**Important Hospital Indemnity Insurance eligibility information:**

The following notice applies to all Hospital Indemnity and Voluntary Hospital Indemnity coverage presented on this form:

**HOSPITAL INDEMNITY INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT A QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.**

**Section 7: Waiver/Declining coverage**

**Medical coverage**

**Medical coverage declined for** — check all that apply:  Myself  Spouse or domestic partner  Dependent(s)  
**Reason for declining coverage** — check all that apply:  Covered by spouse's or domestic partner's group coverage  
 Enrolled in other insurance — Please provide company name and plan: \_\_\_\_\_  
 Enrolled in individual coverage  
 Spouse or domestic partner covered by employer's group medical coverage  
 Medicare/Medicaid/VA  
 Other — please explain: \_\_\_\_\_  
 No coverage

**Dental coverage**

**Dental coverage declined for** — check all that apply:  Myself  Spouse or domestic partner  Dependent(s)  
**Reason for declining coverage** — check all that apply:  Covered by spouse's or domestic partner's group coverage  
 Enrolled in other insurance — Please provide company name and plan: \_\_\_\_\_  
 Enrolled in individual coverage  
 Spouse or domestic partner covered by employer's group medical coverage  
 Medicare/Medicaid/VA  
 Other — please explain: \_\_\_\_\_  
 No coverage

**Vision coverage**

**Vision coverage declined for** — check all that apply:  Myself  Spouse or domestic partner  Dependent(s)  
**Reason for declining coverage** — check all that apply:  Covered by spouse's or domestic partner's group coverage  
 Enrolled in other insurance — Please provide company name and plan: \_\_\_\_\_  
 Enrolled in individual coverage  
 Spouse or domestic partner covered by employer's group medical coverage  
 Medicare/Medicaid/VA  
 Other — please explain: \_\_\_\_\_  
 No coverage

**Group Accident, Critical Illness, and Hospital Indemnity Insurance**

**Group Accident insurance declined for** — check all that apply:  Myself  Spouse or domestic partner  Dependent(s)  
**Critical Illness insurance declined for** — check all that apply:  Myself  Spouse or domestic partner  Dependent(s)  
**Hospital Indemnity insurance declined for** — check all that apply:  Myself  Spouse or domestic partner  Dependent(s)  
**Reason for declining coverage** — check all that apply:  Covered by spouse's or domestic partner's group coverage  
 Enrolled in other insurance — Please provide company name and plan: \_\_\_\_\_  
 Enrolled in individual coverage  
 Spouse or domestic partner covered by employer's group medical coverage  
 Medicare/Medicaid/VA  
 Other — please explain: \_\_\_\_\_  
 No coverage

**Sign here only if you are declining coverage.**

Signature of applicant <b>X</b>	Printed name	Social Security no. <input type="text"/>	Date (MMDDYYYY) <input type="text"/>
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## We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

### Spanish

Usted tiene derecho a obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

### Chinese

您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID 卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

### Vietnamese

Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của tài liệu này.

### Korean

귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인입니까? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

### Tagalog

May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

### Russian

У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

### French Creole

Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòm nan dokiman sa a.

### Arabic

لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجاناً. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضاً طلب تنسيقات أخرى لهذه الوثيقة.

### French

Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

### Persian

شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

### Armenian

Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Պարզապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցող էք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

### Japanese

あなたにはあなたの言語で無料で支援を受ける権利があります。ID カードに記載されている会員サービス番号にお電話ください。視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

### Italian

Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

### German

Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen Formaten anfordern.

### Polish

Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

### Pennsylvania Dutch

Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kannscht des do Schreiwes in en differnter Weg griege so as du's besser sehne kannscht.

### TTY/TTD:711

### It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or directly to 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. You can also call 1-800-368-1019 (TDD: 1-800-537-7697) or visit <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>