Employee Enrollment Application
For Administrative Services
Ohio

Anthem provides administrative claims payment services only, and does not assume any financial risk or obligation with respect to claims.
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. Anthem's Primary Care Physician (PCP) listings for HMO/POS products can be obtained through anthem.com.

Please complete electronically or in blue or black ink only.

Employer name	Group no.	Subsection

Section 1: Employee information

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

Birthdate (MMDDYYYY)	Home address

City	County	State	ZIP code

Sex	Marital status	Primary phone no.
☐ Male ☐ Female	☐ Single ☐ Married ☐ Domestic Partner	

Employee email address

Employment status	Hire date (MMDDYYYY)	No. of hours worked per week
☐ Full time ☐ Part time ☐ Disabled ☐ Retired		

Primary Care Physician (PCP) name	PCP ID no.	Existing patient?
		☐ Yes ☐ No

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
- ☐ Left employment
- ☐ Reduction in hours
- ☐ Death
- ☐ Medicare
- ☐ Loss of dependent child status
- ☐ Divorce or legal separation
- ☐ Covered employee's Medicare entitlement

Qualifying event date: _____ (MMDDYYYY)

☐ Waiver (To decline ALL coverage skip to section 8.)

*Anthem Blue Cross and Blue Shield (Anthem) is required by the Internal Revenue Service to collect this information.

Reset Form | Save and Print

Social Security no.* (required): _____

Section 3: Type of coverage

Medical coverage

Large Group 51–99 options

- ☐ Blue Access PPO
- ☐ Blue Access PPO HSA
- ☐ Blue Access PPO HSA with Copay
- ☐ Link Virtual First Blue Access PPO
- ☐ Blue Access Options PPO 3–Tier
- ☐ Blue Access Options PPO 3–Tier HSA
- ☐ Blue Access Options ERChealth PPO 3-Tier
- ☐ Link Virtual First Blue Access Options PPO
- ☐ Blue Access ERChealth PPO
- ☐ Blue Access ERChealth PPO HSA
- ☐ Blue Connection Link HMO
- ☐ Blue Connection Link HMO HSA

Large Group 100+ options

- ☐ Blue Access PPO
- ☐ Blue Access PPO HSA
- ☐ Blue Access PPO HSA with Copay
- ☐ Blue Access PPO HRA
- ☐ Blue Access PPO HRA with Copay
- ☐ Blue Access PPO Deductible First HRA
- ☐ Add HRA Wrap (Administered by Anthem)
- ☐ Link Virtual First Blue Access PPO
- ☐ Blue Access Options PPO 3–Tier
- ☐ Blue Access Options PPO 3–Tier HSA
- ☐ Blue Access Options ERChealth PPO 3-Tier
- ☐ Link Virtual First Blue Access Options PPO
- ☐ Blue Access ERChealth PPO
- ☐ Blue Access ERChealth PPO HSA
- ☐ Blue Connection Link HMO
- ☐ Blue Connection Link HMO HSA
- ☐ Other: _____

Member medical coverage — select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family ☐ No coverage

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

Dental coverage

☐ Prime Essential Choice ☐ Prime Consumer Choice ☐ Complete Essential Choice ☐ Complete Consumer Choice
☐ Other: _____

Member dental coverage — select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family ☐ No coverage

Vision coverage

☐ Vision

Member vision coverage — select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family ☐ No coverage

Group Accident, Critical Illness, and Hospital Indemnity Insurance

☐ **Group Accident Insurance —** Coverage option: ☐ Employee only ☐ Employee + Spouse ☐ 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 ☐ 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 ☐ 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)

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

Social Security no.* (required):

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

Beneficiary type	Name of beneficiary	Percentage %	Social Security no.*	Relationship to applicant	Date of birth
☐ Primary ☐ Contingent	Street address	City		State / ZIP code	Phone no.
Beneficiary type	Name of beneficiary	Percentage %	Social Security no.*	Relationship to applicant	Date of birth
☐ Primary ☐ Contingent	Street address	City		State / ZIP code	Phone no.
Beneficiary type	Name of beneficiary	Percentage %	Social Security no.*	Relationship to applicant	Date of birth
☐ Primary ☐ Contingent	Street address	City		State / ZIP code	Phone no.
Beneficiary type	Name of beneficiary	Percentage %	Social Security no.*	Relationship to applicant	Date of birth
☐ Primary ☐ Contingent	Street address	City		State / ZIP code	Phone no.

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.

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. 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). List all dependents beginning with the eldest.

Spouse/Domestic Partner last name	First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MMDDYYYY)	Email address (if applicable)
Relationship to applicant: ☐ Spouse ☐ Domestic Partner			
PCP name	PCP ID no.	Existing patient? ☐ Yes ☐ No	

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

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

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

Social Security no.* (required):

Section 4: Coverage information — Continued.

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

Sex	Disabled	Birthdate (MMDDYYYY)	Email address (if applicable)
☐ Male ☐ Female	☐ Yes ☐ No		

Relationship to applicant: ☐ Biological child of applicant/spouse/domestic partner ☐ Other If other, what is relationship? ______________________

PCP name	PCP ID no.	Existing patient?
		☐ Yes ☐ No

Does this dependent have a different address? ☐ Yes ☐ No

If yes, please enter: ____

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)
			☐ Age ☐ Disability ☐ 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)
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:

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

Social Security no.* (required):

Section 6: Terms, Conditions, and Authorizations (TERMS)

Please read this section carefully before signing the application.

Genetic Information Non-discrimination Act (GINA): When answering questions about a person on this form, only give answers about that person, and do not include any genetic information. Genetic information includes family health history, genetic testing, genetic services, genetic counseling, or genetic diseases for which the person may be at risk. All responses about a person will only be considered and used for that person.

Health Savings Account Notice: I authorize the financial custodian of my Health Savings Account (HSA) to give Anthem Blue Cross and Blue Shield (Anthem) facts about my HSA, including account number, account balance and account activity. I understand that I may take back my authorization by written request to Anthem at any time.

1. I understand that I may not assign any payment under my Community Insurance Company (Anthem) program, unless allowable by law.
2. I agree to have money taken from my wages/pension, if necessary, to cover the premium cost for the coverage applied for.
3. 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.
4. 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.
5. If applying for HIC/HMO coverage, I understand that I may cancel my membership by providing written notice to Anthem within 72 hours of signing this application.
6. By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself.
7. I understand that Anthem may collect personal information about me from outside sources, and that both personal and privileged information may only be disclosed to outside parties without my authorization if such disclosure is permitted by both the HIPAA Privacy Regulations (45 CFR. Parts 160 & 164) and the Ohio Revised Code § 3904.13. I also understand that under the HIPAA Privacy Regulations and Ohio law, I have a right to see and correct personal information that Anthem collects about me, and that I may receive a more detailed description of my rights under these laws by writing to Anthem.

Authorization Section — Read carefully before signing.

I authorize any licensed physician, any other medical practitioner or provider, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, including any health or other insurance company affiliated with Anthem, consumer reporting agency or employer having information available as to claims, diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me (but specifically excluding from this authorization any non-medical information that could be used to ascertain my sexual orientation or that I have a pending HIV test or that I have had negative HIV test results), to give any and all such information to authorized representatives of Anthem, its affiliates, and any administrators, reinsurers, agents, or other entity providing services on behalf of Anthem, and including, but not limited to any other mental or psychiatric records, medical, dental and hospital records (including psychiatric, alcohol, and drug abuse, and HIV/AIDS information) which may have been acquired in the course of examination or treatment. I understand that the information obtained by use of this authorization will be used by Anthem representatives to evaluate and adjudicate my current application for health coverage or any claims under such coverage, and may be re-disclosed to (a) any medical, investigative, financial or vocational specialist or entity, or (b) any other organization or person, employed by or representing Anthem solely to assist with the evaluation and adjudication of my current health insurance application or claim. Each such person or entity to whom this re-disclosure is made shall comply with the HIPAA Privacy Rule as regards any re-disclosed protected health information as applicable. I understand that Anthem 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 collects about me, and that I may receive a more detailed description of my rights under this law by writing to Anthem. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules.

This authorization, for purposes of processing this application form, is valid from the date signed for a period of 30 months unless revoked by me in writing, which I may do at any time by contacting Anthem. For the purpose of collecting information in connection with a claim for benefits under an insurance policy, this authorization shall remain for the duration of the claim. A photocopy and/or electronic copy is as valid as the original. The Applicant or the Applicant's authorized representative is entitled to receive a copy of this Authorization.

I give this authorization for myself and on behalf of my eligible dependents if covered by the Plan, including my Spouse/Domestic Partner/Civil Union Partner. I am acting as their agent and representative.

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

Social Security no.* (required):

Section 6: Terms, Conditions, and Authorizations (TERMS) continued

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

I have read and accept the Terms, Conditions and Authorizations as a condition of coverage. My answers to all questions are true to the best of my knowledge, and I understand that Anthem relies on these answers in accepting this application. I understand that any untrue answers or failure to report new medical information before my effective date may cause a material change in coverage or premium rates. Any material representation or significant omission found in this application may result in denial of benefits, rescission or cancellation of coverage. I agree to these terms for myself and on behalf of any dependents covered by the Plan. I am acting as their agent and representative.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I'm signing here because I want to get information about my benefits by email or electronically. This may include my certificate or evidence of coverage, explanation of benefits statements, required notices and helpful or personalized information to get the most out of my plan, so I will make sure Anthem has my most up to date email. These electronic communications may include specific details about me and my plan. I know I can change my mind at any time or request a free copy of specific materials by mail. I'll just contact Anthem to do either. I understand if I change my mind after 30 months, I will need to let Anthem know. The Applicant or the Applicant's authorized representative is entitled to receive a copy of this Authorization.

Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company.

Thank you for choosing Anthem Blue Cross and Blue Shield.

Section 7: Signature — Required if you are applying for coverage. Please review your application for errors or omissions.

Read section 6 carefully before signing.

I have read and understand the language in the TERMS section of this application and agree to all of its terms.

Employee signature	Date (MMDDYYYY)
X	

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.

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

Social Security no.* (required):

Section 8: Waiver/Declining coverage

Medical coverage

Medical coverage declined for — check all that apply: ☐ Myself ☐ Spouse/domestic partner ☐ Dependent(s)

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 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/domestic partner ☐ Dependent(s)

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 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/domestic partner ☐ Dependent(s)

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 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	Printed name	Social Security no.	Date (MMDDYYYY)
X			

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

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 recibir ayuda en su idioma en forma gratuita. Simplemente llame al número de Servicios para Miembros que figura en su tarjeta de identificación.

Chinese
您有權免費獲得透過您使用的語言提供的幫助。請撥打您的 ID 卡片上的會員服務電話號碼。若您是視障人士，還可索取本文件的其他格式版本。

Vietnamese
Quý vị có quyền nhận miễn phí trợ giúp bằng ngôn ngữ của mình. Chỉ cần gọi số Dịch vụ dành cho thành viên trên thẻ ID của quý vị. Bị khiếm thị? Quý vị cũng có thể hỏi xin định dạng khác của tài liệu này."

Korean
귀하는 자국어로 무료지원을 받을 권리가 있습니다. ID 카드에 있는 멤버 서비스번호로 연락하십시오.

Tagalog
May karapatan ka na makakuha ng tulong sa iyong wika nang libre. Tawagan lamang ang numero ng Member Services sa iyong ID card. May kapansanan ka ba sa paningin? Maaari ka ring humiling ng iba pang format ng dokumentong ito.

Russian
Вы имеете право на получение бесплатной помощи на вашем языке. Просто позвоните по номеру обслуживания клиентов, указанному на вашей идентификационной карте. Пациенты с нарушением зрения могут заказать документ в другом формате.

Armenian
Դուք իրավունք ունեք ստանալ անվճար օգնություն ձեր լեզվով: Պարզապես զանգահարեք Անդամների սպասարկման կենտրոն, որի հեռախոսահամարը նշված է ձեր ID քարտի վրա:

Farsi
"شما این حق را دارید تا به صورت رایگان به زبان مادری تان کمک دریافت کنید. کافی است با شماره خدمات اعضا (Member Services) درج شده روی کارت شناسایی خود تماس بگیرید." دچار اختلال بینایی هستید؟ می توانید این سند را به فرمت های دیگری نیز درخواست دهید.

French
Vous pouvez obtenir gratuitement de l'aide dans votre langue. Il vous suffit d'appeler le numéro réservé aux membres qui figure sur votre carte d'identification. Si vous êtes malvoyant, vous pouvez également demander à obtenir ce document sous d'autres formats.

Arabic
لك الحق في الحصول على مساعدة بلغتك مجانًا. ما عليك سوى الاتصال برقم خدمة الأعضاء الموجود على بطاقة الهوية. هل أنت ضعيف البصر؟ يمكنك طلب أشكال أخرى من هذا المستند.

Japanese
お客様の言語で無償サポートを受けることができます。IDカードに記載されているメンバーサービス番号までご連絡ください。

Haitian
Se dwa ou pou w jwenn èd nan lang ou gratis. Annik rele nimewo Sèvis Manm ki sou kat ID ou a. Èske ou gen pwoblèm pou wè? Ou ka mande dokiman sa a nan lòt fòma tou.

Italian
Ricevere assistenza nella tua lingua è un tuo diritto. Chiama il numero dei Servizi per i membri riportato sul tuo tesserino. Sei ipovedente? È possibile richiedere questo documento anche in formati diversi

Polish
Masz prawo do uzyskania darmowej pomocy udzielonej w Twoim języku. Wystarczy zadzwonić na numer działu pomocy znajdujący się na Twojej karcie identyfikacyjnej.

Punjabi
ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮੁਫ਼ਤ ਵਿੱਚ ਮਦਦ ਹਾਸਲ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਬਸ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਸਿਰਵਸ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। ਨਜ਼ਰ ਕਮਜ਼ੋਰ ਹੈ? ਤੁਸ ਇਸ ਦਸਤਾਵੇਜ਼ ਦੇ ਹੋਰ ਰੂਪਾਂਤਰ ਮੰਗ ਸਕਦੇ ਹੋ।

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. By calling Member Services, our members can get free in-language support, and free aids and services if you have a disability. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. 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 in any of these areas, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, 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