Anthem Blue Cross Enrollment Form

Anthem

Please return the completed enrollment form to your employer.

Effective date (MM/DD/YY)	Group no.

Purpose: ☐ New enrollment ☐ Re-hire ☐ Part-time to full-time ☐ Open enrollment ☐ Family addition ☐ Change ☐ COBRA ☐ Cal-COBRA

Section 1: Type of coverage – Select from only the coverages offered by your employer.

Medical

Anthem Blue Cross plans:

☐ HMO[1]
☐ Preferred HMO [1]
☐ Advantage HMO[1]
☐ Priority Select HMO[1]
☐ Select HMO[1]
☐ Vivity HMO[1]
☐ Clear Value
☐ Elements Choice (EQ) HMO[1]

Anthem Blue Cross Life and Health Insurance Company plans:

☐ PPO (Prudent Buyer)
☐ EPO (Prudent Buyer Exclusive)
☐ POS (Blue Cross Plus)[1]
☐ Elements Choice (EQ) PPO
☐ Medicare
☐ CareAdvocate PPO
☐ Select PPO
☐ BC PPO (non-California resident)
☐ BC Exclusive (non-California resident)
☐ BC CareAdvocate PPO
☐ Consumer Driven Health Plans: (select one of the following)
☐ H.S.A.[2] ☐ H.R.A.
☐ H.I.A. Plus
☐ Elements Choice (EQ) HSA (non-California resident)

☐ Other: _____

1 Indicate Medical Group/IPA no. in the ***Employee and family information*** section 3.
2 Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your employer.

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

☐ Healthcare FSA ☐ Limited-Purpose FSA (for members enrolled in HSA plans) ☐ Dependent Care FSA ☐ Commuter Transit ☐ Commuter Parking

Dental

Anthem Blue Cross plans:

☐ Dental Net HMO[3]
☐ Choice Dental (select one of the following)
☐ Dental Net HMO[3]
☐ PPO Dental

Anthem Blue Cross Life and Health Insurance Company plans:

☐ Dental Consumer Choice
☐ Dental Essential Choice
☐ Dental Prime
☐ Dental Complete
☐ Dental Prime Voluntary
☐ Dental Complete Voluntary
☐ Dental Consumer Choice Voluntary
☐ Dental Essential Choice Voluntary
☐ Voluntary PPO Dental
☐ Dental Blue Complete Incentive
☐ Dental Choice EPO
☐ Dental Choice EPO Voluntary
☐ Dental Blue PPO
☐ PPO Dental
☐ National Dental Blue PPO
☐ National PPO Dental
☐ National Voluntary PPO Dental

☐ Other: _____

3 Indicate Dental Office no. in ***Employee and family information*** section 3.

Vision

☐ Blue View Vision (offered by Anthem Blue Cross Life and Health Insurance Company)

Life insurance

All the coverages listed may not be offered by your employer. To elect dependent coverage, the corresponding employee coverage must be selected. List all life insurance beneficiaries in the ***Life insurance beneficiary designation information*** section.

Annual salary $

Elected benefit	Benefit amount	Elected benefit	Benefit amount	Elected benefit	Benefit amount
☐ Basic Life (AD&D)	$_____	☐ Optional Life - Employee	$_____	☐ Optional AD&D - Employee	$_____
☐ Dependent Life - Spouse	$_____	☐ Optional Dependent Life - Spouse	$_____	☐ Optional AD&D - Spouse	$_____
☐ Dependent Life - Child	$_____	☐ Optional Dependent Life - Child	$_____	☐ Optional AD&D - Child	$_____
		☐ Short Term Disability	$_____	☐ Voluntary Short Term Disability	$_____
		☐ Long Term Disability	$_____	☐ Voluntary Long Term Disability	$_____

Language choice (optional) ☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Other – please specify: _____

Section 2: Applicant's personal information

Social Security no. required under CMS Regulations and by the IRS.

Last name	First name	M.I.	Marital status ☐ Single ☐ Married ☐ Domestic Partner (DP)	Social Security or ID no.[4] (required)
Mailing address		Apt. no.	No. of dependents including spouse	Spouse/DP Social Security or ID no.[4] (required)
City		State	ZIP code	Home phone no.

Hire date/Rehire date Part-time to Full-time date (MM/DD/YY)	Employer name	Job title	Class	Dept. no.	Email address

To be eligible as a Domestic Partner, the Subscriber and Domestic Partner must have properly filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to the California Family Code, or have properly filed an equivalent document in accordance with the laws of another jurisdiction recognizing the creation of domestic partnerships.
4 Anthem is required by the Internal Revenue Service to collect this information.

Reset Form Save and Print

Social Security or ID no.[1] (required)

Section 3: Employee and family information – Please list yourself and all eligible family members to be enrolled. Attach additional sheets if necessary.

Sex	Last Name	First Name	M.I.	Birthdate (MM/DD/YY)	Social Security or ID no.[1] (required)	Full-time student (if applicable, for non-medical plans)	If children are age 26 or over you must check the appropriate boxes below	~~HMO & POS ONLY~~ ~~IPA/Primary Care Physician code~~	~~Current~~ ~~MD?~~	~~Dental Net~~ ~~ONLY~~ ~~Office no.~~
☐ M ☐ F	Employee								☐ Yes ☐ No	
☐ M ☐ F	Spouse/DP						IRS Qualified Dependent		☐ Yes ☐ No	
☐ M ☐ F						☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	
☐ M ☐ F						☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	
☐ M ☐ F						☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	
☐ M ☐ F						☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	

Section 4: Declination – Please complete if any coverage is declined or refused by an eligible employee and/or their eligible dependents.

A. Medical coverage declined for:
☐ Myself ☐ Spouse/DP ☐ Child(ren)

B. Dental coverage declined for:
☐ Myself ☐ Spouse/DP ☐ Child(ren)

C. Vision coverage declined for:
☐ Myself ☐ Spouse/DP ☐ Child(ren)

D. Life insurance coverage declined for:
☐ Myself ☐ Spouse/DP ☐ Child(ren)

Reason for declining coverage – check one
☐ Covered by spouse's group coverage
Insurer name and ID no.: _____
☐ Covered by Anthem Individual policy
☐ Spouse covered by employer's group medical coverage
Insurer name: _____
☐ Enrolled in Tricare
☐ Enrolled in any other insurance plan
Insurer name: _____
☐ Medicare
☐ Other (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 has tried to influence me or put any pressure on me to decline coverage. **BY DECLINING THIS GROUP MEDICAL COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL COVERAGE ELSEWHERE) I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UNTIL THE NEXT OPEN ENROLLMENT PERIOD TO BE ENROLLED IN THIS GROUP MEDICAL AND/OR GROUP LIFE INSURANCE PLAN.**

Signature if declining coverage for employee/dependent(s)
X

Date (MM/DD/YY)

Section 5: COBRA/Cal-COBRA coverage information – Complete only if enrolling in COBRA/Cal-COBRA.

Reason for COBRA/Cal-COBRA coverage

Federal COBRA qualifying event date (MM/DD/YY)	Federal COBRA coverage begin date (MM/DD/YY)	Federal COBRA coverage end date (MM/DD/YY)
Cal-COBRA qualifying event date (MM/DD/YY)	Cal-COBRA coverage begin date (MM/DD/YY)	Cal-COBRA coverage end date (MM/DD/YY)

Section 6: Other coverage for all enrolling employees and dependents – All questions must be answered.

A. Do any persons on this application intend to continue other group coverage if this application is accepted? ☐ Yes ☐ No
If yes, name of person(s): _____
Insurance company: _____ Policy no. _____ Phone no. _____

B. Does any person applying for coverage currently have **health** insurance coverage? ☐ Yes ☐ No
Has any person applying for coverage had health insurance coverage at any time in the past six months? ☐ Yes ☐ No
If yes, applicant/family member name(s): _____
Type of continuous coverage: ☐ Group ☐ Individual ☐ Other: _____
Insurance company: _____ Policy no. _____ Phone no. _____
Date coverage began: _____ Date ended: _____ (MM/DD/YY)

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

Social Security or ID no.[1] (required)

Section 6: Other coverage for all enrolling employees and dependents (Continued) – All questions must be answered.

C. Does any person applying for coverage currently have **dental** insurance coverage? ☐ Yes ☐ No

If yes, applicant/family member name(s): _____

Type of continuous coverage: ☐ Group ☐ Individual ☐ Other: _____ Includes orthodontia? ☐ Yes ☐ No

Insurance company: _____ Policy no. _____ Phone no. _____

Date coverage began: | | | | | | | | Date ended: | | | | | | | | (MM/DD/YY)

D. Does any person applying for coverage currently have **vision** insurance coverage? ☐ Yes ☐ No

If yes, applicant/family member name(s): _____

Type of continuous coverage: ☐ Group ☐ Individual ☐ Other: _____

Insurance company: _____ Policy no. _____ Phone no. _____

Date coverage began: | | | | | | | | Date ended: | | | | | | | | (MM/DD/YY)

E. Is any person applying for coverage eligible for Medicare or currently receiving Medicare benefits? ☐ Yes ☐ No

Note: If you are eligible for Medicare, Anthem may not duplicate Medicare benefits.

Section 7: Medicare – Complete if you, your spouse or dependent child(ren) have Medicare coverage. Attach additional sheets if necessary.

Name (last, first, M.I.)	Part A effective date (MM/DD/YY)	Part B effective date (MM/DD/YY)	Medicare claim no.

Section 8: Prior coverage for PPO and dental plans only – Attach additional sheets if necessary.

Please fill out the following information to receive proper credit for **previous coverage** (if immediately prior to becoming eligible for this plan, you have a dependent child(ren) over the age of 26 who cannot get a self-sustaining job due to a physical or mental condition and was covered under any public or private health care coverage, including MediCal or individual coverage). **Note**: If this section is left blank, there may be delays in the processing of claims for these dependents. If any coverage will remain in force once your dependent(s) enroll with Anthem, leave the end date blank.

Name (last, first, M.I.)	Type (check one)	Coverage (check all that apply)	Insurer name	Insurer phone no.	Policy ID no.	Date (if applicable) (MM/DD/YY)	Reason for ending coverage (if applicable)
	☐ 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 9: Life insurance beneficiary designation information

Note: Dependent Life payments are always paid to the employee.

Primary Beneficiary – First to receive payment (required) If two beneficiaries are named, enter a % for each. If no % is shown, equal shares are assumed.

Name	Birthdate (MM/DD/YY)	Social Security no.	Relationship		%
Street address		City		State	ZIP code
Name	Birthdate (MM/DD/YY)	Social Security no.	Relationship		%
Street address		City		State	ZIP code

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

Social Security or ID no.[1] (required)

Section 10: Electronic notice – Signature required to opt-in to electronic delivery.

Member email address: _____

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 at any time I can change my mind and request a copy of these materials (or any specific materials) by mail, by contacting Anthem. I or my enrolled dependents will update our communication preferences by going to anthem.com/ca or calling Member Services at 1-877-242-5659.

Member signature	Date (MM/DD/YY)
X	

Section 11: Please read carefully – Signature required.

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

Deduction authorization: If applicable, I authorize my employer to deduct from my wages the required subscription charges/premiums.

Non-participating provider: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

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.

Effective date: The effective date of coverage is subject to Anthem approval.

COBRA/Cal-COBRA Continuation Coverage

You may continue your health care coverage by: 1) completing the remainder of this form; 2) signing your name in the blank space below; 3) paying your Total Monthly Continuation Payment; and 4) mailing this form to Anthem, no later than sixty (60) days after the date you receive this notice. If you fail to choose COBRA Continuation Coverage within sixty (60) days after the date you receive this notice, your qualification for coverage will end. If you do choose COBRA Continuation Coverage, your current coverage will be continued until the earliest of the following dates:

1. The date eligibility for COBRA Continuation Coverage ends, or
2. The date you fail to make timely payments of your premium for COBRA Continuation Coverage, or
3. The date your employer discontinues coverage with Anthem, or
4. The date you become entitled to Medicare on the basis of age (65 years), or the date thirty (30) months after you become entitled to Medicare on the basis of end stage renal disease, or
5. The date you become covered under another group health plan as a result of employment, re-employment, remarriage, or otherwise.

If, at any time during the first sixty (60) days of your COBRA Continuation Coverage, you are determined under Title II or XVI of the United States Social Security Act to be disabled, you may be entitled to continue coverage while you are disabled for up to 29 months from the date you first qualified for Continuation Coverage under COBRA. Contact the Health Plan Administrator at your previous employer for full information.

The Monthly Continuation Payment is the cost of continued coverage for the month beginning on the date after the Date of Loss of Coverage. If you do not pay your initial monthly premium within 45 days after your election of COBRA Continuation Coverage, or if payment of succeeding premiums are not received within the 30-day grace period thereafter, your coverage will end.

Note: If you do not elect available COBRA Continuation of Medical Coverage, you will lose certain rights under federal law (HIPAA) to guaranteed issue individual coverage.

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

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 (ANTHEM), 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 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 providing your "handwritten or electronic" signature below, you acknowledge that such signature is valid and binding.

Signature (Required)

Applicant	Date (MM/DD/YY)
X	

1 Anthem is required by the Internal Revenue Service 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/TTY: 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/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.

Get help in your language

Notice of Language Assistance

Curious to know what all this says? We would be too. Here's the English version:
No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-888-254-2721. For more help call the CA Dept. of Insurance at 1-800-927-4357. (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
Servicios lingüísticos sin costo. Puede tener un intérprete. Puede solicitar que le lean los documentos y algunos puede recibirlos en su idioma. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-888-254-2721. Para obtener ayuda adicional, llame al Departamento de Seguros de California al 1-800-927-4357. (TTY/TDD: 711)

Arabic
يتم تقديم خدمات اللغة دون مقابل. يمكنك الاستعانة بمترجم. ويمكنك المطالبة بأن تُقرأ لك بعض المستندات وأن يُرسل بعضها بلغتك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة التعريف الخاصة بك أو على الرقم 1-888-254-2721.
للحصول على مزيد من المساعدة، يُرجى الاتصال بإدارة كاليفورنيا للتأمين على الرقم 1-800-927-4357. (TTY/TDD: 711)

Armenian
Թարգմանչական անվճար ծառայություններ: Մենք կարող ենք Ձեզ թարգմանչի ծառայություններ առաջարկել Կարող ենք տրամադրել ինչ-որ մեկին, ով փաստաթղթերը կկարդա Ձեզ համար և կուղարկի դրանք Ձեր լեզվով: Օգնություն ստանալու համար զանգահարեք մեզ Ձեզ ID քարտի վրա նշված հեռախոսահամարով կամ 1-888-254-2721 համարով: Լրացուցիչ օգնության համար զանգահարեք Կալիֆոռնիայի ապահովագրության նախարարություն հետևյալ հեռախոսահամարով՝ 1-800-927-4357: (TTY/TDD: 711)

Chinese
免費語言服務。您能獲得免費的譯員。您能聽到以您的語言讀出的文件內容，也能獲得以您的語言而寫的部分文件。如需協助，請撥打您的 ID 卡上的號碼或者1-888-254-2721聯絡我們。如需更多協助，請撥打1-800-927-4357 聯絡 CA Dept. of Insurance。(TTY/TDD: 711)

Farsi
خدمات رایگان زبانی. می‌توانید یک مترجم شفاهی بگیرید. می‌توانید بخواهید اسناد را برای شما بخوانند و برخی اسناد نیز به زبان خودتان برایتان ارسال شود. برای دریافت کمک، از طریق شماره فهرست شده در کارت شناسایی‌تان و یا از طریق 1-888-254-2721
با ما تماس بگیرید. برای دریافت کمکهای بیشتر با اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تماس بگیرید. (TTY/TDD:711)

Hindi
बिना लागत की भाषा सेवाएँ। आप दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेज़ पढ़वा सकते हैं और कुछ दस्तावेज़ आपको आपकी भाषा में भेजे जा सकते हैं। मदद के लिए, हमें अपने ID कार्ड पर सूचीबद्ध नंबर पर या 1-888-254-2721 पर कॉल करें। अधिक मदद के लिए 1-800-927-4357 पर CA बीमा विभाग कोकॉल करें। (TTY/TDD: 711)

Hmong
Tsis Xam Tus Nqi Cov Kev Pab Cuam Ntsig Txog Hom Lus. Koj muaj peev xwm tau txais ib tus neeg txhais lus. Koj muaj peev xwm tau txais cov ntaub ntawv nyeem ua koj hom lus rau koj mloog thiab yuav xa ib co ntaub ntawv sau ua koj hom lus tuaj rau koj. Txog rau kev pab, hu rau peb tus nab npawb xov tooj teev tseg cia nyob rau ntawm koj daim ID los sis 1-888-254-2721. Txog rau kev pab ntxiv, hu xov tooj rau Pab Kas Phais Lub Chaw Ua Hauj Lwm CA tus xov tooj 1-800-927-4357. (TTY/TDD: 711)

Japanese
無料言語サービス。通訳サービスを受けられます。希望する言語で文書を読み上げたり、文書を送るサービスも可能です。支援を受けるには、IDカードに記載された番号、または 1-888-254-2721 にお電話ください。支援の詳細は、カリフォルニア州保険局（1-800-927-4357）にお電話ください。(TTY/TDD: 711)

Khmer
សេវាភាសាឥតគិតថ្លៃ។ អ្នកអាចទទួលអ្នកបកប្រែម្នាក់។ អ្នកអាចឱ្យគេអានឯកសារផ្សេងៗជូនអ្នក និងផ្ញើឯកសារជូនអ្នកជាភាសារបស់អ្នក។ ដើម្បីទទួលជំនួយ សូមហៅ ទូរស័ព្ទមកយើងតាមលេខដែលបានរាយនៅលើប័ណ្ណ ID របស់អ្នក ឬក៏លេខ 1-888-254-2721។ ដើម្បីទទួលជំនួយបន្ថែម សូមហៅទូរស័ព្ទទៅ CA Dept. of Insurance តាមលេខ 1-800-927-4357។(TTY/TDD: 711)

Korean
무료 언어 서비스. 번역사를 이용하실 수 있습니다. 귀하의 언어로 녹음되어 작성된 문서를 받아보실 수 있습니다. 도움을 받으시려면 ID 카드에 기재된 번호 또는 1-888-254-2721로 전화하십시오. 다른 도움이 필요하시면 1-800-927-4357로 보험 CA 부서에 문의 주십시오. (TTY/TDD: 711)

Punjabi
ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਦੇ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਆ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਕੋਈ ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਪੜ੍ਹ ਕੇ ਸੁਣਾ ਸਕਦਾ ਹੈ ਅਤੇ ਕੁਝ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਤੁਹਾਨੂੰ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਸਾਨੂੰ ਤੁਹਾਡੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਸੂਚੀਬੱਧ ਨੰਬਰ ਜਾਂ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। ਜ਼ਿਆਦਾ ਮਦਦ ਲਈ, ਸੀਏ ਡਿਪਾਰਟਮੈਂਟ ਔਫ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 ਤੇ ਕਾਲ ਕਰੋ।(TTY/TDD: 711)

Russian
Бесплатные языковые услуги. Вы можете получить услуги устного переводчика. Вам могут прочитать документы или направить некоторые из них на вашем языке. Для получения помощи звоните нам по телефону, указанному на вашей идентификационной карте, или по номеру 1-888-254-2721. Для получения дополнительной помощи звоните в Департамент страхования штата Калифорния по номеру 1-800-927-4357. (TTY/TDD: 711)

Tagalog
Mga Libreng Serbisyo para sa Wika. Maaari kayong kumuha ng interpreter. Maaari ninyong ipabasa ang mga dokumento at ipadala ang ilan sa mga ito sa inyo sa wikang ginagamit ninyo. Para sa tulong, tawagan kami sa numerong nakalista sa inyong ID card o sa 1-888-254-2721. Para sa higit pang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. (TTY/TDD: 711)

Thai
ไม่มีค่าบริการเกี่ยวกับภาษา ท่านสามารถขอใช้บริการล่ามได้
ท่านสามารถขอให้เจ้าหน้าที่อ่านเอกสารได้ท่านฟังและเอกสารบางอย่างจะส่งถึงท่านโดยใช้ภาษาของท่าน
หากต้องการความช่วยเหลือ โปรดโทรหาเราตามหมายเลขที่ระบุอยู่บนบัตรประจำตัวของท่านหรือที่หมายเลข 1-888-254-2721
หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรติดตามแผนก CA Dept. of Insurance ที่หมายเลข 1-800-927-4357
(TTY/TDD: 711)

Vietnamese
Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có thông dịch viên. Quý vị có thể yêu cầu đọc tài liệu cho quý vị nghe và yêu cầu gửi một số tài liệu bằng ngôn ngữ của quý vị cho quý vị. Để được trợ giúp, hãy gọi cho số được ghi trên thẻ ID của quý vị hoặc số 1-888-254-2721. Để được giúp đỡ thêm, hãy gọi cho Sở Bảo Hiểm California (California Department of Insurance) theo số 1-800-927-4357. (TTY/TDD: 711)

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