Anthem
And Its Affiliate HealthKeepers, Inc.

Primary applicant name: _____

Welcome

Virginia Individual Application

Thanks for choosing us. We're glad you're here.
Supplemental Dental and Vision Plans are offered by Anthem Blue Cross and Blue Shield (Anthem).

If you have any questions while filling out this form, give us a call at 1 (877) 212-1793. But if you've worked with an agent or broker, contact them first.

About this form

Use this form to apply for **new** dental or vision coverage or to **change** existing coverage with Anthem.

You can add dependents or change coverage:

1. **During the annual Open Enrollment period**
   Your coverage will start based on when we receive your complete application; however, the earliest your coverage can start is January 1st.
2. **Due to a qualifying event**
   When you're done with this form, fill out **Appendix A: Special Enrollment,** which includes information about when coverage starts.

For new dental and vision:

- You can apply any time during the year.
- Your coverage will start based on when we receive your complete application. If we get it between the 1st and last day of the month, coverage is effective the 1st day of the following month.

Tips when filling out this form

1. Answer all questions. Please print clearly using blue or black ink only.
2. Please submit all pages.
3. You can also apply online at anthem.com.

Some frequently asked questions

1. **Do I need to include a payment?**
   Yes. We can't complete your application without your first month's premium payment. Without it, your enrollment will be delayed. Don't worry though – we won't charge your card or cash your check or money order until you've been enrolled.
2. **Why do you need my Social Security Number?**
   The IRS requires us to collect it. It won't be shared unless required by law.

Please indicate the reason you are submitting this application :
☐ Open Enrollment
☐ Special Enrollment Period – must also complete Appendix A

Step 1: Who is applying?

☐ New coverage
☐ Change coverage
☐ Add dependent to existing coverage
Subscriber ID no. _____

Primary Applicant

Last name (legal name)	**First name** (legal name)	**M.I.**	**Social Security No.** - -
Marital status ☐ Single ☐ Married ☐ Domestic Partner	**Sex** ☐ M ☐ F	**Date of birth** (mm/dd/yyyy) / /	**Legal resident of VA** ☐ Yes ☐ No
County (for home address)			
Home address (not a P.O. Box)	**City**	**State**	**ZIP**
Billing address (optional - if different than your home)	**City**	**State**	**ZIP**
Mailing address (optional - if different than your home)	**City**	**State**	**ZIP**
Primary phone	**Secondary phone**		

Email address

_____

For myself and any dependents, I'm adding my email address above because I agree to get my policy, certificate, or evidence of coverage electronically. I know I can change my mind at any time and request a free copy of specific materials by mail. I also understand that by adding my email address, information about my dependents may also be sent by email or electronically. To do either, I (or my enrolled dependent) will update our communication preferences by going to anthem.com or calling Member Services.

Preferred written language ☐ English (ENG) ☐ Spanish (SPA) | **Preferred spoken language** ☐ English (ENG) ☐ Spanish (SPA)

Coverage(s) selected ☐ Dental * ☐ Vision*
*Primary applicant must be included for Spouse or Domestic Partner and/or dependent coverage eligibility.

Spouse or Domestic Partner

Last name (legal name)	**First name** (legal name)	**M.I.**	**Social Security No.** - -
Relationship to applicant ☐ Spouse ☐ Domestic Partner	**Sex** ☐ M ☐ F	**Date of birth** (mm/dd/yyyy) / /	**Legal resident of VA** ☐ Yes ☐ No

Coverage(s) selected ☐ Dental* ☐ Vision*
*Primary applicant must be included for Spouse or Domestic Partner and/or dependent coverage eligibility.

Child dependent

Children must be under age 26.

Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves by reason of intellectual or physical disability. These Dependents must be allowed as a federal tax exemption by the subscriber or subscriber's Spouse or Domestic Partner.

Last name (legal name)	**First name** (legal name)	**M.I.**	**Social Security No.** - -
Relationship to applicant ☐ Child ☐ Other _____	**Sex** ☐ M ☐ F	**Date of birth** (mm/dd/yyyy) / /	**Legal resident of VA** ☐ Yes ☐ No

Coverage(s) selected ☐ Dental* ☐ Vision*
*Primary applicant must be included for Spouse or Domestic Partner and/or dependent coverage eligibility.

Child dependent

Last name (legal name)	**First name** (legal name)	**M.I.**	**Social Security No.** - -
Relationship to applicant ☐ Child ☐ Other _____	**Sex** ☐ M ☐ F	**Date of birth** (mm/dd/yyyy) / /	**Legal resident of VA** ☐ Yes ☐ No

Coverage(s) selected ☐ Dental* ☐ Vision*
*Primary applicant must be included for Spouse or Domestic Partner and/or dependent coverage eligibility.

Child dependent ☐ **Check here if you have more dependents**. Print an extra copy of this page and attach to your application.

Last name (legal name)	**First name** (legal name)	**M.I.**	**Social Security No.** - -
Relationship to applicant ☐ Child ☐ Other _____	**Sex** ☐ M ☐ F	**Date of birth** (mm/dd/yyyy) / /	**Legal resident of VA** ☐ Yes ☐ No

Coverage(s) selected ☐ Dental* ☐ Vision*
*Primary applicant must be included for Spouse or Domestic Partner and/or dependent coverage eligibility.

Eligibility The answer to this question is needed to determine your eligibility.

Are any applicants currently incarcerated (with more than 60 days left to serve before release) as a result of a conviction? (not just pending disposition of charges) ☐ No ☐ Yes **If yes, who?**

Step 2: What coverage would you like?

Dental Plans

Dental coverage for children under age 19 is already included in all our medical plans (Also known as Pediatric Essential Health Benefits). Choose a dental plan if you'd like to buy coverage that goes beyond these Pediatric Essential Health Benefits.

Dental plan options

☐ Anthem Dental Family Value (2J5G)
☐ Dental Prime A (1RCJ)
☐ Anthem Dental Family (1FVK)
☐ Dental Prime B (1RCK)
☐ Anthem Dental Family Enhanced (1FVL)
☐ Dental Prime C (1RCL)

Prior & other dental coverage

Name of person covered (Last, First, M.I.)	**Coverage (check all that apply)**	**Insurer name**	**Insurer phone no.**	**Policy ID no.**	**Dates (if applicable) (mm/dd/yyyy)**
	☐ Dental ☐ Orthodontia				**Start:** ____/____/_____ **End:** ____/____/_____
	☐ Dental ☐ Orthodontia				**Start:** ____/____/_____ **End:** ____/____/_____
	☐ Dental ☐ Orthodontia				**Start:** ____/____/_____ **End:** ____/____/_____
	☐ Dental ☐ Orthodontia				**Start:** ____/____/_____ **End:** ____/____/_____
	☐ Dental ☐ Orthodontia				**Start:** ____/____/_____ **End:** ____/____/_____

Will you be replacing this dental coverage if approved for Anthem's coverage? ☐ Yes ☐ No

If **Yes,** what is the termination date? (mm/dd/yyyy) / /

Note: You cannot be covered by more than one Anthem individual dental policy at the same time.

Vision Plan

Vision coverage for children under age 19 is already included in all our medical plans (Also known as Pediatric Essential Health Benefits). Choose a vision plan if you'd like to buy coverage that goes beyond these Pediatric Essential Health Benefits.

Vision plan options

☐ Blue View Vision Individual (1RYB)

Step 3: Please read and sign

Important legal information

I understand that:

- I must send my first (initial) premium with this application, but it does not mean coverage has been approved. I'm applying for the coverage I chose on this form. To the extent permitted by law, Anthem has the right to accept or decline this application, and that there are no guarantees of any kind just because I filled out this form. If my application is denied, my bank account or credit card will not be charged, and if I paid with a money order, it will be returned to me.
- I'm responsible to let Anthem know, in a timely manner, of any change that would make me or any dependent ineligible for coverage.
- Anthem may change check payments to electronic Automated Clearinghouse (ACH) debit transactions. If this happens, my original check will be destroyed. This charge will appear on my bank statement but my check won't be given to my financial institution or sent back to me. This charge will not enroll me in any Anthem automatic debit process and will only occur each time I send a check to Anthem. Any resubmissions due to insufficient funds may also occur electronically. All checking transactions will remain secure, and my payment by check means I agree to these terms.
- I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.
- I'm applying for individual dental and/or vision coverage which is not part of any employer sponsored plan and I'm responsible for all of the premium payments and making sure that all premiums are paid.
- I certify that each Social Security number listed on this application is correct.
- My domestic partner, if applicable, is only eligible for coverage if: he or she has been my sole domestic partner for 12 months or more; he or she is at least 18 years of age; he or she is mentally competent; he or she is not related to me in any way (including by blood or adoption) that would prohibit us from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with me.
- I certify to the best of my knowledge and belief, the responses herein are accurate. I certify that I have read, or had read to me, the completed application and that I realize that any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact in the application may result in the denial of benefits or cancellation of coverage(s).

I sign this application for and on behalf of any eligible dependents and myself if covered by Anthem. I am acting as their agent and representative.

This application cannot be altered by the applicant after submission to Anthem absent the acknowledgement and consent of Anthem.

By signing this application, I certify that the premium for my coverage will not be paid by a provider of health care services, hospital, non-profit organizations (including religious organizations) that have or whose primary donors have a financial interest in the benefits of the Evidence of Coverage, commercial entity with a direct or indirect financial interest in the benefits of the Evidence of Coverage or an employer that offers coverage under an employer health plan. I understand that if a third party is paying my premium, Anthem may decline to accept such premium payment if it is made by a person or entity from which it is not required by law to accept.
The undersigned applicant and the agent certify that the applicant has read, or had read to him, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in the loss of coverage under the policy.
Dental plans may contain waiting periods for certain types of services as disclosed in marketing materials and your policy. A waiting period is the length of time you must be covered under your dental policy and pay premiums before we will pay for covered services. You are eligible for payment of covered services once your waiting period has been met.

Please sign below

Primary Applicant (or legal representative)	Date
Spouse or Domestic Partner (or legal representative)	Date
Dependent Child (age 18 or over)	Date
Dependent Child (age 18 or over)	Date
Dependent Child (age 18 or over)	Date
Agent/Broker signature	Date

Did an agent help you? ☐ Yes ☐ No If yes, make sure they fill out this section.

Agent (or broker) Certification	All fields required		
Agent name (please print clearly)			
(A) Writing Agent TIN/SSN (encrypted TIN is ok)	**(B) Writing Agent/Agency/General Agency TIN** (encrypted TIN is ok)*		
Agent address	**City**	**State**	**ZIP**
Agent phone no.	**Agent fax no.**	**Agent email**	

* Always provide your Writing Agent TIN/SSN in Field (A). If you are a Direct Agent with no relationship to an Agency or General Agency, also enter your Agent TIN/SSN in Field (B). If this policy is sold through an Agency without a General Agency, enter the selling Agency TIN in Field (B); if this policy is sold through a General Agency, enter the General Agency TIN in Field (B).

Here's what's next.

1) Can you check a few items? When incorrect, they're the most frequent reasons for delays in enrollment.
   - Your name and address information should be clear and readable
   - You've included your first month's premium payment
   - Everyone 18 and older signed this form
   - Please make sure you submit all the pages of the application
   - If enrolling due to a qualifying event, you've completed Appendix A: Special Enrollment

2) All good? Send this to us by mail to Anthem Blue Cross and Blue Shield, P.O. Box 659960, San Antonio, TX 78265-9146 or by fax to 1 (800) 848-2512.

3) We'll be in touch in the next few weeks. If you have questions before then, call us at 1 (855) 330-1108.

Thank you!

Appendix A: Special Enrollment

If you're applying for coverage due to a qualifying event, please fill out this section along with your application.

Qualifying event date	
Date of qualifying event / /	For Loss of Coverage, this is the last date of existing or prior coverage. For all other events, please enter the date based on the qualifying event.

You must apply for coverage within 60 days after your qualifying event for the following events (except in cases of domestic violence or spousal abandonment). If you have existing coverage and are adding one or more dependents due to marriage, birth, or adoption, you may add the new dependent(s) to your existing plan or apply for another plan for the dependent(s) who doesn't have current coverage.

Qualifying events	Coverage effective date
☐ **1. Marriage or Domestic Partnership** Got married or in a domestic partnership that becomes eligible for coverage (see step 3 for description of eligibility). One or both of the spouse(s) or domestic partner(s) must have had Minimum Essential Coverage for one or more days in the 60 days prior to the marriage or domestic partnership, unless one or both of the individuals has moved from a foreign country or U.S. territory within the 60 day period before the marriage/domestic partnership.	First day of the month after we receive your complete application.
☐ **2. Birth or adoption** Had a baby, adoption of a child or placement of a child with you for adoption.	**Select an effective date:** ☐ Same as the event date ☐ First day of the month after we receive your complete application ☐ Based on when we receive your complete application* ☐ First day of month after the event date
☐ **3. Court order or guardianship** Required by a court order to provide an eligible child(ren) coverage, including a child support order, appointment of guardianship of a child or a child in foster care is placed with you	**Select an effective date:** ☐ Same as the event date ☐ Based on when we receive your complete application*
☐ **4. Death** Death of a family member enrolled under current coverage	**Select an effective date:** ☐ First day of the month after we receive your complete application ☐ Based on when we receive your complete application*
☐ **5. Immigration** Immigration status changed ☐ **6. Domestic violence** I attest that I have been a victim of domestic violence that qualifies me for a special enrollment period. (The special enrollment period is available for 60 days following your request) ☐ **7. Spousal abandonment** I attest that I have been unable to locate my spouse after reasonable diligence. (The special enrollment period is available for 60 days following your request) **8. Other qualifying event** ☐ Material error on exchange ☐ Unintentional enrollment or non-enrollment in an exchange plan because of material error ☐ Violation by plan of material contract provision ☐ Newly ineligible for premium tax credit/subsidies ☐ Medicaid/FAMIS eligibility determination delay ☐ If you can't find your situation, contact your agent/broker or call us. We can only enroll based on events defined by state and/or federal law	Based on when we receive your complete application*

* If the coverage date is based on when we receive your complete application then if we receive it:

- Between the 1st and 15th day of the month, coverage is effective the 1st day of the following month.
- Between the 16th and the last day of the month, coverage is effective the 1st day of the second following month.

You must apply for coverage within 60 days before or 60 days after your qualifying event for the following events.

Qualifying events	Coverage effective date
9. Loss of coverage: Lost or will lose Minimum Essential Coverage: ☐ Involuntary loss of coverage (for any reason except non-payment of premium or fraud) ☐ A legal separation or divorce ☐ Moved to a new service area. Minimum Essential Coverage must have been in effect for one or more days of the 60 days prior to the move.	First day of the month after we receive your complete application
10. Permanent move ☐ Moved to U.S. from a foreign country or a U.S. territory ☐ Permanent move to a new service area (within the U.S.). Minimum Essential Coverage must have been in effect for one or more days of the 60 days prior to the move. ☐ **11. Non-calendar renewal** Current policy does not renew on a calendar year basis (renews on a date other than January 1) ☐ **12. Jail or prison** Released from jail or prison (incarceration)	Based on when we receive your complete application.*

* If the coverage date is based on when we receive your complete application then if we receive it:

- Between the 1st and 15th day of the month, coverage is effective the 1st day of the following month.
- Between the 16th and the last day of the month, coverage is effective the 1st day of the second following month.

Almost there! We need a bit more info.

We need supporting documentation for your qualifying event, such as a letter or official form from the source (employer, state or federal agency, for example) confirming the qualifying event occurred, the date the event happened, and the names of all applicants affected. If you're applying because you've lost your coverage, we need to know the reason why coverage was lost, and it must be included in the supporting documentation. In all instances, we might need additional documentation to confirm eligibility.

Give us or your agent a call if you have any questions.

Payment Methods for Individual Applications

Anthem And Its Affiliate HealthKeepers, Inc.

Applicant/Member name	Primary applicant's Social Security number

Anthem Blue Cross and Blue Shield (Anthem) and/or HealthKeepers, Inc. (HealthKeepers) will accept monthly payments on behalf of applicants/members **if the payment is made by the following persons or entities:** The Ryan White HIV/AIDS Program; other federal and state government programs that provide monthly payments and cost-sharing support for specific individuals; Indian tribes, tribal organizations and urban Indian organizations; or a relative or legal guardian on behalf of an applicant/member.

Unless required by law, Anthem and/or HealthKeepers does not accept monthly payments from third parties that are not listed above. Examples of third parties from whom Anthem and/or HealthKeepers will not accept monthly payments include, but are not limited to, insurance brokers and/or agents, doctors, hospitals, not-for-profit organizations (including religious organizations) that have or whose primary donors have a financial interest in the benefits of the contract/policy, commercial entities with a direct or indirect financial interest in the benefits of the contract/policy and employers that offer coverage under an employer health plan. Note: As allowed by law, Anthem and/or HealthKeepers reserves the right to decline monthly payments from third parties.

I authorize Anthem and/or HealthKeepers to debit the bank account listed or charge the credit/debit card listed for my first monthly payment on or after the day that my coverage is approved. By signing this form, I understand that the amount of the first payment may change from what I was told because my coverage has not been approved yet. In addition if I select Option 1 or Option 2 below, I understand that my future payments may vary as a result of changes(s) I make once enrolled, including but not limited to, adding and deleting dependents, moving my residence, changing coverage and/or changes made by Anthem and/or HealthKeepers of which I am notified according to my plan/policy. In addition, I understand if changes I make are close to the auto withdrawal date, Anthem and/or HealthKeepers may not be able to notify me before the withdrawal is made. **I agree to pay any service charge that Anthem and/or HealthKeepers may bill me because the debit/charge was not honored.** I understand if my monthly payment increases based on a certain percentage, Anthem and/or HealthKeepers will stop my automatic payments and send notification to me. I will have the option to reset the automatic monthly payments.

Please choose how you want to pay your monthly payments for all of your plans. Put a check in the box for either Option 1, Option 2 or Option 3.

☐ **Option 1 Bank Account Authorization: Have your first and future monthly payments automatically deducted from your bank account.**

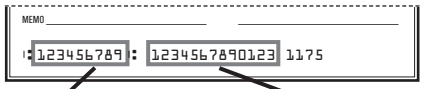
All of your monthly payments will be taken out of the **bank account** you check below.

Checking account: ☐ Business ☐ Personal

Savings account: ☐ Business ☐ Personal

Enter the requested debit date from your bank account ___ (1st to 6th of each month). If no date is requested your monthly payments will be debited on the first of each month.

Write the routing and account numbers that are on your check here: →



9-digit bank routing number	Bank account number

I authorize Anthem and/or HealthKeepers to automatically debit the **bank account** listed above each month to make my monthly payments. I agree that **Anthem and/or HealthKeepers' rights with each debit are the same as if the debit was a check that I signed.** I understand monthly payments will be made on the day I've indicated or within 3 business days thereafter. I authorize Anthem and/or HealthKeepers to automatically debit my account (and to make corrections to previous debits). This authority stays in effect until I let Anthem and/or HealthKeepers know that I no longer want them to debit my account by giving them a 30-day advance written notice. I understand that if my bank does not allow Anthem and/or HealthKeepers to debit my account for any reason, I will automatically be removed from automatic monthly payments and will be billed by mail. I understand if my monthly payment increases based on a certain percentage, Anthem and/or HealthKeepers will stop my automatic payments and send notification to me. I will have the option to reset the automatic monthly payments.

Authorized signature (as it appears on bank's records)	Printed bank account holder's name (as it appears on account)	Date (MM/DD/YY)
X		

☐ **Option 2 Credit/Debit Card Authorization: Have your first and future monthly payments automatically charged to your credit/debit card.**

Complete the information below

Enter the requested charge date for your credit/debit card ___ (1st to 6th of each month).

I authorize Anthem and/or HealthKeepers to automatically charge my **credit/debit card** listed below each month to make my monthly payments. I understand monthly payments will be made on the day I've indicated or within 3 business days thereafter. I authorize Anthem and/or HealthKeepers to charge my credit/debit card until I let them know that I no longer want them to charge my credit/debit card by giving them a 30-day advance written notice. I agree that Anthem and/or HealthKeepers, in honoring the monthly payments charged to my credit/debit card, is not responsible for any fees charged by my bank. I understand if that if any Anthem and/or HealthKeepers credit/debit transaction is not honored, I will automatically be removed from automatic monthly payments and will be billed by mail. I understand if my monthly payment increases based on a certain percentage, Anthem and/or HealthKeepers will stop my automatic payments and send notification to me. I will have the option to reset the automatic monthly payments.

Anthem and/or HealthKeepers accepts ☐ **Visa or** ☐ **Mastercard (Note to applicant: Please check one.)**

Card number	Expiration date ___ (MM/YY)

Billing address for this credit/debit card	City	Zip code

Authorized signature (as it appears on card)	Printed card holder's name (as it appears on card)	Date (MM/DD/YY)
X		

See page two for *Option 3 First Monthly Payment Only: Send us your first monthly payment now and receive a bill each month for your future monthly payments.*

Payment Methods for Individual Applications

Anthem®
And Its Affiliate HealthKeepers, Inc.

Applicant/Member name	Primary applicant's Social Security number

☐ **Option 3 First Monthly Payment Only: Send us your first monthly payment now and receive a bill each month for your future monthly payments.**

Choose one of the ways below that you would like to pay only your first monthly payment.

☐ Check (enclose your paper check with application) ☐ Electronic check (fill out section A below) ☐ Credit/Debit card (fill out section B below)

A. **Electronic check:** Instead of sending us a paper check, you can use an electronic check that allows Anthem and/or HealthKeepers to take the money right from your bank account to make your first payment on the day that your coverage is approved. You will not get the check back from your bank. (We will not keep this information on file or use it for any future payments.) Please fill out this information.

Printed account holder name	Routing number	Account Number	Amount of first payment
			$

B. **Credit/Debit card:** I allow Anthem and/or HealthKeepers to charge the credit or debit card I listed below one time for my first monthly payment. This payment will cover the first monthly payment for all of the plans I have with Anthem and/or HealthKeepers.

Anthem and/or HealthKeepers accepts ☐ Visa or ☐ Mastercard (Note to applicant: Please check one.)

Card number	Expiration date (MM/YY)

Billing address for this credit/debit card	City	Zip code

I authorize Anthem and/or HealthKeepers to debit/charge the bank account or credit/debit card listed above **to make my first monthly payment only.**

I agree that Anthem and/or HealthKeepers will not have to pay any fees that my bank may charge because my electronic check or credit/debit card was rejected even if I can no longer continue coverage. I understand that **this is a one-time payment and that I am responsible for making sure Anthem and/or HealthKeepers receives my future monthly payments after this first payment.**

Authorized signature (as it appears on bank account/card)	Printed bank account/card holder's name (as it appears on account/card)	Date (MM/DD/YY)
X		

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (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
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Vietnamese
Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة.
(711 :TDD/TTY)

Armenian
Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Farsi
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید. (TTY/TDD: 711)

French
Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

Japanese
この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Haitian
Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Italian
Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Polish
Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Punjabi
ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Navajo
Bee ná ahóót'i' t'áá ni nizaad k'ehjí niká a'doowoł t'áá jiik'e. Naaltsoos bee atah nílínígíí bee néého'dólzingo nanitínígíí béésh bee hane'í bikáá' áaji' hodíílnih. Naaltsoos bee atah nílínígíí bee néého'dólzingo nanitínígíí béésh bee hane'í bikáá' áaji' hodíílnih. (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.