

# Employee Enrollment Application For 1-50 Employee Small Groups<sup>1</sup> Connecticut



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 in black ink only.

## Section A: Application Type — Select one.

<input type="checkbox"/> New enrollment	<input type="checkbox"/> COBRA -	<input type="checkbox"/> Medicare	Qualifying event date: ____/____/____ (MM/DD/YYYY)
<input type="checkbox"/> Open enrollment (not applicable for Life and Disability products)	<b>Select qualifying event</b>	<input type="checkbox"/> Reduction in hours	
<input type="checkbox"/> Rehire - Rehire date ____/____/____ (MM/DD/YYYY)	<input type="checkbox"/> Left employment	<input type="checkbox"/> Divorce or legal separation	
	<input type="checkbox"/> Loss of dependent child status	<input type="checkbox"/> Death	
	<input type="checkbox"/> Covered employee's Medicare entitlement		

Court-ordered health care coverage?  Yes  No If yes, attach legal documentation.

## Section B: Employee and Dependent Information — All fields required. Attach a separate sheet if necessary.

Employee last name	First name	M.I.	Social Security no. <sup>2</sup> (required)	
Home address - Street and PO Box if applicable				
City		County		State ZIP code
Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner		Primary phone no.		Secondary phone no.
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MM/DD/YYYY)	Relationship to applicant <b>Self</b>	
Primary Care Physician (PCP) name		PCP ID no.	Existing Patient <input type="checkbox"/> Yes <input type="checkbox"/> No	
Employee email address			Income reported by: <input type="checkbox"/> W-2 <input type="checkbox"/> 1099 <input type="checkbox"/> Other: _____	
Employer name			Group no. (if known)	
Employer street address				
City			State	ZIP code
Employment status <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Disabled <input type="checkbox"/> Retired	Date of hire (MM/DD/YYYY)	Date of full-time employment (MM/DD/YYYY)	Date waiting period begins (MM/DD/YYYY)	No. of hours worked per week

Spouse/Domestic Partner last name	First name	M.I.	Social Security no. <sup>2</sup> (required)	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MM/DD/YYYY)	Relationship to applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	
Primary Care Physician (PCP) name		PCP ID no.	Existing Patient <input type="checkbox"/> Yes <input type="checkbox"/> No	

<sup>1</sup> A small group must have at least one eligible employee, in addition to the business owner. A spouse cannot be the only eligible employee.  
<sup>2</sup> Anthem Blue Cross and Blue Shield (Anthem) is required by the Internal Revenue Service to collect this information.

Life and Disability products underwritten by Anthem Life Insurance Company. Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans, Inc. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

**Section B: Employee and Dependent Information — Continued. All fields required. Attach a separate sheet if necessary.**

Dependent last name		First name		M.I.	Social Security no. <sup>1</sup> (required)
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MM/DD/YYYY)	Relationship to applicant <input type="checkbox"/> Child <input type="checkbox"/> Other If other, what is relationship? _____		
Primary Care Physician (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: _____					
Dependent last name		First name		M.I.	Social Security no. <sup>1</sup> (required)
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MM/DD/YYYY)	Relationship to applicant <input type="checkbox"/> Child <input type="checkbox"/> Other If other, what is relationship? _____		
Primary Care Physician (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: _____					
Dependent last name		First name		M.I.	Social Security no. <sup>1</sup> (required)
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MM/DD/YYYY)	Relationship to applicant <input type="checkbox"/> Child <input type="checkbox"/> Other If other, what is relationship? _____		
Primary Care Physician (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: _____					

<sup>1</sup> Anthem Blue Cross and Blue Shield (Anthem) is required by the Internal Revenue Service to collect this information.

**Section C: Type of Coverage**

**1. Medical Coverage — Select one plan option. Dental coverage for children under age 21 is already included in all our medical plans (also known as Pediatric Essential Health Benefits).**

PPO Plans	Anthem Platinum	Anthem Gold	Anthem Silver	Anthem Bronze
Century Preferred	<input type="checkbox"/> (2V1A) 10/0%/2500	<input type="checkbox"/> (2V1W)1000/20%/6000 <input type="checkbox"/> (2V0Z) 1500/20%/3000 <input type="checkbox"/> (2V2C) 2000/0%/4000 <input type="checkbox"/> (2V1F) 2500/0%/4500 <input type="checkbox"/> (2V36) 1350/10%/3675 w/HSA <input type="checkbox"/> (2V3J) 4250/20%/7350 w/HRA <input type="checkbox"/> (2V28) Tiered 1500/0%/5000	<input type="checkbox"/> (2V12) 3500/30%/5500 <input type="checkbox"/> (2V2Q) 3750/25%/7350 <input type="checkbox"/> (2V2L) 4500/0%/6000 <input type="checkbox"/> (2V2G) 5000/25%/7350 <input type="checkbox"/> (2V32) 3000/20%/5500 w/HSA <input type="checkbox"/> (2V1S) 3000/0%/6500 w/HSA	<input type="checkbox"/> (2V2U) 5000/30%/6650 w/HSA <input type="checkbox"/> (2V1K) 5500/20%/6650 w/HSA <input type="checkbox"/> (2V1N) 6650/0%/6650 w/HSA
EPO Plans	Anthem Platinum	Anthem Gold	Anthem Silver	Anthem Bronze
Century Preferred	<input type="checkbox"/> (2V3A) 10/0%/2500	<input type="checkbox"/> (2V3E)1000/20%/6000		
HMO Plans	Anthem Platinum	Anthem Gold	Anthem Silver	Anthem Bronze
BlueCare	<input type="checkbox"/> (2V2Y) 25/10%/3500 <input type="checkbox"/> (2V16) 10/0%/2500	<input type="checkbox"/> (2V20) Tiered 20/0%/6600		

**Member medical coverage — select one:**  
 Employee only    Employee + Spouse/Domestic Partner    Employee + child(ren)    Family

**2. Dental Coverage - Please ask your employer which dental options are available before checking your selection.**

**Anthem Dental Family and Anthem Dental Family Enhanced plans include certified pediatric dental essential health benefits. All other plans including Anthem Dental Prime and Anthem Dental Complete with product families including Value, Classic, Enhanced, and Voluntary do not include certified pediatric dental essential health benefits.**

**Member dental coverage - select one:**  
 Employee only    Employee + Spouse/Domestic Partner    Employee + child(ren)    Family    No coverage  
 If waiving coverage for employee and/or any eligible family members, you must complete Section E.

**Contract code** - Please indicate the contract code for the dental plan selected. Your employer will advise you of your plan options and contract codes.  
 Contract code: \_\_\_\_\_

**3. Vision Coverage - Select one plan option.**

**Member vision coverage - select one:**  
 Employee only    Employee + Spouse/Domestic Partner    Employee + child(ren)    Family    No coverage  
 If waiving coverage for employee and/or any eligible family members, you must complete Section E.

**Contract code** - Please indicate the contract code for the vision plan selected. Your employer will advise you of your plan options and contract codes.  
 Contract code: \_\_\_\_\_

**4. Life and Disability Coverage - A minimum of two employees must enroll.**

<input type="checkbox"/> Basic Life & AD&D <input type="checkbox"/> Basic Dependent Life <input type="checkbox"/> Optional Supplemental/Voluntary Life and AD&D      \$ _____ (employee amount) <input type="checkbox"/> Optional Supplemental/Voluntary Dependent Life Spouse      \$ _____ (spouse amount) <input type="checkbox"/> Optional Supplemental/Voluntary Dependent Life Child      \$ _____ (child amount)	<input type="checkbox"/> Short Term Disability <input type="checkbox"/> Long Term Disability <input type="checkbox"/> Voluntary Short Term Disability <input type="checkbox"/> Voluntary Long Term Disability
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Current annual income: \$ \_\_\_\_\_  
 Occupation: \_\_\_\_\_      Life and Disability class no. \_\_\_\_\_

**Primary Beneficiary - Attach a separate sheet if necessary.**

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
Address				Percentage to be paid to beneficiary	
Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
Address				Percentage to be paid to beneficiary	
Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
Address				Percentage to be paid to beneficiary	

**Contingent Beneficiary**

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
Address				Percentage to be paid to beneficiary	
Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
Address				Percentage to be paid to beneficiary	

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

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

Spouse/Domestic Partner Signature <b>X</b>	Spouse/Domestic Partner name	Date (MM/DD/YYYY)
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**Section D: Prior and Other Group Coverage - Attach a separate sheet if necessary.**

Are you or anyone applying for coverage currently eligible for Medicare?  Yes  No If yes, give name: \_\_\_\_\_

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

On the day your coverage begins, will you or a family member be covered by Medicare?  Yes  No

On the day your coverage begins, will you or a family member be covered by other health coverage?  Yes  No

On the day your coverage begins, will you or a family member be covered by other dental coverage?  Yes  No

If yes to any of these questions, please provide the following. If any coverage will remain in force once you enroll with Anthem, leave the End date blank.

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.	Dates (if applicable)
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <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"/> Health <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"/> Health <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"/> Health <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"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia				Start: End:

**Section E: Waiver/Declining Coverage**

- Medical coverage declined for - check all that apply:  Myself  Spouse/Domestic Partner  Dependent(s)  
 Dental coverage declined for - check all that apply:  Myself  Spouse/Domestic Partner  Dependent(s)  
 Vision coverage declined for - check all that apply:  Myself  Spouse/Domestic Partner  Dependent(s)  
 \*Life/AD&D coverage declined for:  Myself  
 Spouse, Domestic Partner and Dependent coverage not available if life coverage is waived/declined  
 Dependent Life coverage declined for:  Spouse/Domestic Partner and Dependents  
 Short Term Disability coverage declined for:  Myself  
 Long Term Disability coverage declined for:  Myself  
 Optional Supplemental/Voluntary coverage declined for:  Myself  
 Optional Supplemental/Voluntary Dependent Life coverage declined for:  Spouse/Domestic Partner and Dependents  
 Voluntary Short Term Disability coverage declined for:  Myself  
 Voluntary Long Term Disability coverage declined for:  Myself

- Reason for declining coverage - check all that apply:
- Covered by spouse's/domestic partner's group coverage  
 Enrolled in other insurance - Please provide company name and plan: \_\_\_\_\_  
 Enrolled in individual coverage  
 Spouse/Domestic Partner covered by employer's group medical Coverage  
 Medicare/Medicaid/VA  
 Other - please explain: \_\_\_\_\_  
 No coverage

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

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

Signature of applicant <b>X</b>	Printed name	Today's Date (MM/DD/YYYY)
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**Section F: Terms, Conditions and Authorizations**

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 Blue Cross and Blue Shield (Anthem)/Anthem Life 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 30 days.
- Any other class of persons identified by the Employer, provided that written approval of their eligibility is obtained from the Company(ies); 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:**

- Employee's spouse, or children age 26 or younger, which includes a newborn, natural child, or a child placed with the employee for adoption, a stepchild or any other child for whom the employee has legal guardianship or court ordered custody. The age limit for enrolling a child is age 26. Coverage for children will end on the renewal date of the group when the child reaches age 26.
- The age limit of 26 does not apply for the initial enrollment or maintaining enrollment of an unmarried child who cannot support himself or herself by reason of mental or physical handicap, mental illness, or physical incapacity 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 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 it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. I understand all benefits are subject to conditions stated in the Group Contract and coverage document.

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

I have read or have had read to me the completed application, and I understand that intentionally false and/or intentionally incomplete responses or statements may result in rescission of coverage and/or non-payment of claims for myself or my eligible dependents. I understand a copy of this application is provided to me as part of my Subscriber Agreement or health benefit plan document as applicable and is incorporated by reference therein. I certify that my statements in this form are true and complete to the best of my knowledge and belief.

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

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.

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

**Coverage Option**

If your employer/group offers HMO coverage which does not permit you to receive the full range of covered services from the provider of your choice, 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 the provider of your choice ("point-of-service" plan). This point-of-service plan may be offered by the HMO, Anthem or by another carrier.

For insurance entities, the term "medical loss ratio"(MLR) refers to the ratio of incurred claims to earned premium for a prior calendar year. The MLR is calculated for managed care (HMO) and PPO/Indemnity plans, one for state law purposes and the other as determined under federal law. For 2013, Anthem's Medical Loss Ratio for state law purposes was 81.6% for HMO plans and 84.2% for PPO/Indemnity plans. For 2013, Anthem's MLR for federal law purposes was 85.9% for small group plans and 89.4% for large group plans. Please refer to anthem.com for the most current MLR information.

**Life and/or Disability Authorization Section –Read carefully before signing.**

1. I authorize the release of any medical records or information concerning claims, conditions or treatment of myself and for any dependents listed herein, by any provider of health services, pharmacy related service organization, medical or medically-related facility, or the MIB, Inc., to Anthem Life Insurance Company (Anthem Life), its affiliates, and any administrators, reinsurers, agents, or other entity providing services on behalf of Anthem Life. This information will be used for purposes which include but are not limited to: processing this application for enrollment; group risk classification; detecting or preventing fraud or misrepresentation; internal and external audits; administration of claims; and quality improvement programs. Anthem Life will advise such entities that such information must be kept confidential to the extent required by applicable law, and should not be used for any unlawful purpose. This information includes any records or knowledge about medical history, including sensitive services such as mental health, psychiatric, substance abuse, reproductive health, information relating to HIV virus or AIDS, sexually transmitted or other communicable diseases contained in such records, including but not limited to, all records of office visits, examinations, treatment, evaluation, diagnostic and laboratory testing, reports, consultations, hospital records, prescription history, records for treatment of substance abuse, psychiatric counseling, notes, correspondence, insurance and billing information for treatment or services rendered by any provider. I understand that Anthem Life may collect personal information about me from outside sources, and that both personal and privileged information may be collected and disclosed to third parties without my further authorization, and may no longer be protected by Federal privacy laws. I also understand that I have a right to see and correct personal information that Anthem Life collects about me, and that I may receive a more detailed description of my rights under this law by writing to Anthem Life.
2. Payment of proceeds shall be made in accordance with the terms of the group contract. Unless otherwise provided herein, if one or more life insurance beneficiaries are named, the proceeds due shall be paid in equal shares to the named beneficiaries surviving the insured. Beneficiaries may be changed by the insured employee's written notice to his or her employer.
3. These coverages will become effective on the date established by the provisions of the group contract and certificates issued thereunder.
4. I give this authorization for myself and on behalf of my eligible dependents if covered by the Plan. I am acting as their agent and representative. This authorization, for purposes of processing this enrollment form, is valid for a period of 24-30 months from the date signed unless revoked by me in writing, which I may do at any time by contacting Anthem. A photocopy is as valid as the original.

Employee Signature

X

Date (MM/DD/YYYY)

<b>Sign here</b>	Applicant signature <b>X</b>	Date (MM/DD/YYYY)
	Spouse/Domestic Partner signature <b>X</b>	Date (MM/DD/YYYY)

**Special Enrollment Rights for Medical Coverage Only.**

If you declined enrollment for yourself or your dependent(s) (including a spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependent(s) in this plan if you or your dependent(s) lose eligibility for the other health insurance or group health plan coverage (or if the employer stops contribution towards your coverage or your dependent's other coverage). However, you must request enrollment within 31 days after coverage ends (or after the employer stops contribution toward the other coverage). In addition, if you have a dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependent(s) provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. You also understand that you and your dependents may enroll under two additional circumstances:

- Either your or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- You or your dependent becomes eligible for a subsidy (state premium assistance program).

In these cases, you may be able to enroll yourself and your dependents provided that you request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

# Get help in your language

## Language Assistance Services



Curious to know what all this says? We would be too. Here's the English version:  
If you need assistance to understand this document in an alternate language, you may request it at no additional cost by calling the Member Services number (855-738-6644). (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 Member Services telephone number on the back of your ID card.

### Spanish

Si necesita ayuda para entender este documento en otro idioma, puede solicitarla sin costo adicional llamando al número de Servicios para Miembros (855-738-6644). (TTY/TDD: 711)

### Albanian

Nëse ju nevojitet ndihmë për ta kuptuar këtë dokument në një gjuhë tjetër, mund ta kërkonit pa kosto shtesë duke telefonuar në numrin e shërbimeve për anëtarët (855-738-6644). (TTY/TDD: 711)

### Arabic

إذا احتجت إلى المساعدة لفهم هذا المستند بلغة أخرى، فيمكنك طلب المساعدة دون تكلفة إضافية من خلال الاتصال برقم خدمات الأعضاء (855-738-6644). (TTY/TDD: 711)

### Chinese

如果您需要協助以便以另一種語言理解本文件，您可以撥打成員服務號碼(855-738-6644)請求免費協助。(TTY/TDD: 711)

### French

Si vous avez besoin d'aide pour comprendre ce document dans une autre langue, vous pouvez en faire la demande gratuitement en appelant les Services destinés aux membres au numéro suivant : 855-738-6644. (TTY/TDD: 711)

### Greek

Αν χρειαστείτε βοήθεια για να κατανοήσετε το παρόν έγγραφο σε άλλη γλώσσα, μπορείτε να τη ζητήσετε χωρίς πρόσθετο κόστος καλώντας τον αριθμό του Τμήματος Υπηρεσιών Μέλους (855-738-6644). (TTY/TDD: 711)

### Haitian

Si ou bezwen èd pou konprann dokiman sa a nan yon lòt lang, ou kapab rele nimewo Manm Sèvis la pou mande asistans gratis nan nimewo (855-738-6644). (TTY/TDD: 711)



## Hindi

अगर आपको यह दस्तावेज़ वैकल्पिक भाषा में समझने के लिए सहायता की ज़रूरत है, तो आप सदस्य सेवाएँ नंबर (855-738-6644) पर कॉल करके अतिरिक्त लागत के बिना इसके लिए अनुरोध कर सकते हैं। (TTY/TDD: 711)

## Italian

Se ha bisogno di assistenza per la comprensione del presente documento in un'altra lingua, può richiederla senza alcun costo aggiuntivo chiamando il numero dedicato ai Servizi per i membri (855-738-6644). (TTY/TDD: 711)

## Korean

다른 언어로 본 문서를 이해하기 위해 도움이 필요하실 경우, 추가 비용 없이 회원 서비스 번호(855-738-6644)로 전화를 걸어 도움을 요청할 수 있습니다. (TTY/TDD: 711)

## Polish

Jeśli potrzebujesz pomocy w zrozumieniu niniejszego dokumentu w innym języku, możesz ją uzyskać bez ponoszenia dodatkowych kosztów, dzwoniąc do Działu Obsługi Klienta pod numer (855-738-6644). (TTY/TDD: 711)

## Portuguese-Europe

Se necessitar de ajuda para compreender este documento noutra língua, poderá solicitá-la gratuitamente ligando para o número dos Serviços para Membros (855-738-6644). (TTY/TDD: 711)

## Russian

Если вам нужна помощь, чтобы понять содержание настоящего документа на другом языке, вы можете бесплатно запросить ее, позвонив в отдел обслуживания участников (855-738-6644). (TTY/TDD: 711)

## Tagalog

Kung kailangan ninyo ng tulong upang maunawaan ang dokumentong ito sa ibang wika, maaari ninyo itong hilingin nang walang karagdagang bayad sa pamamagitan ng pagtawag sa Member Services sa numerong (855-738-6644). (TTY/TDD: 711)

## Vietnamese

Nếu quý vị cần hỗ trợ để hiểu được tài liệu này bằng một ngôn ngữ thay thế, quý vị có thể yêu cầu mà không tốn thêm chi phí bằng cách gọi số của Dịch Vụ Thành Viên (855-738-6644). (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](tel: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>.

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