

Employee Enrollment Application

EmployeeElect for 1-50 Employee Small Groups

California



Health care plans offered by Anthem Blue Cross. Insurance plans offered by Anthem Blue Cross Life and Health Insurance Company.

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.

Note: Social Security Numbers are required under Centers for Medicare & Medicaid (CMS) regulations.

Submit application to: Small Group Services
 Anthem Blue Cross
 PO Box 9062
 Oxnard, CA 93031-9062
 anthem.com/ca

Please complete in blue or black ink only.

Section A: Employee Information						
Last name		First name		M.I.	Social Security no.	
Home address – Street and PO Box if applicable			City		State _ _	ZIP code _ _ _ _
County		Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner	Primary phone no. _ _ _ _ _ _ _		Secondary phone no. _ _ _ _ _ _ _	
Employee email address						
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		Hire date (MM/DD/YYYY) _ _ _ _ _ _ _		First date of full-time employment (MM/DD/YYYY) _ _ _ _ _ _ _		No. of hours worked per week _ _ _
Language choice (optional): <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Tagalog <input type="checkbox"/> Other – please specify: _____						
Do you read and write English? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, the translator must sign and submit a Statement of Accountability						
Section B: Application Type						
Select one						
<input type="checkbox"/> New enrollment		<input type="checkbox"/> COBRA – Select qualifying event <input type="checkbox"/> Left employment <input type="checkbox"/> Loss of dependent child status <input type="checkbox"/> Covered employee's Medicare entitlement		<input type="checkbox"/> Cal-COBRA Cal-COBRA applicants must submit first month's premium. <input type="checkbox"/> Reduction in hours <input type="checkbox"/> Divorce or legal separation <input type="checkbox"/> Death		
Note: For Cal-COBRA/Cobra applicants						
Effective date _ _ _ _ _ _ _			Qualifying event date _ _ _ _ _ _ _			

Section C: Type of Coverage – Select from only the coverages offered by your employer

1. Medical Coverage – select one option **Medical plans offered by Anthem Blue Cross**

PPO Plans	Anthem Premier	Anthem Preferred	Anthem Essential	Anthem Core
Statewide PPO Network (Prudent Buyer)		<input type="checkbox"/> DirectAccess – gwfa* <input type="checkbox"/> DirectAccess – gyfa* <input type="checkbox"/> DirectAccess – gzfa* <input type="checkbox"/> DirectAccess w/HRA – gfra* <input type="checkbox"/> DirectAccess w/HRA – gkkb* <input type="checkbox"/> DirectAccess w/HRA – gsob*	<input type="checkbox"/> DirectAccess – gbwa* <input type="checkbox"/> DirectAccess Plus – gbpa* <input type="checkbox"/> DirectAccess Plus – gbqa* <input type="checkbox"/> DirectAccess Plus – gtob* <input type="checkbox"/> DirectAccess Plus – guob* <input type="checkbox"/> DirectAccess w/HSA – gzra*	<input type="checkbox"/> DirectAccess – gfua* <input type="checkbox"/> DirectAccess – gkua* <input type="checkbox"/> DirectAccess – gtdf* <input type="checkbox"/> DirectAccess Plus – gsdf* <input type="checkbox"/> DirectAccess Plus w/Dental – gsdf <input type="checkbox"/> DirectAccess w/HSA – gjua* <input type="checkbox"/> DirectAccess w/HSA – gmua* <input type="checkbox"/> DirectAccess w/HSA – gpua*
Select PPO Network	<input type="checkbox"/> DirectAccess Plus – gabf*	<input type="checkbox"/> DirectAccess – gwfa* <input type="checkbox"/> DirectAccess – gyfa* <input type="checkbox"/> DirectAccess – gzfa* <input type="checkbox"/> DirectAccess Plus – gbbf* <input type="checkbox"/> DirectAccess Plus – gjca* <input type="checkbox"/> DirectAccess Plus – gmca* <input type="checkbox"/> DirectAccess Plus – gnca* <input type="checkbox"/> DirectAccess w/HRA – gfra* <input type="checkbox"/> DirectAccess w/HRA – gkkb* <input type="checkbox"/> DirectAccess w/HRA – gsob*	<input type="checkbox"/> DirectAccess – gbwa* <input type="checkbox"/> DirectAccess – gcbf* <input type="checkbox"/> DirectAccess Plus – gbpa* <input type="checkbox"/> DirectAccess Plus – gbqa* <input type="checkbox"/> DirectAccess Plus – gtob* <input type="checkbox"/> DirectAccess Plus – guob* <input type="checkbox"/> DirectAccess w/HSA – gzra*	<input type="checkbox"/> DirectAccess – gdbf* <input type="checkbox"/> DirectAccess – gfua* <input type="checkbox"/> DirectAccess – gkua* <input type="checkbox"/> DirectAccess – gtdf* <input type="checkbox"/> DirectAccess Plus – gsdf* <input type="checkbox"/> DirectAccess Plus w/Dental – gsdf <input type="checkbox"/> DirectAccess w/HSA – gjua* <input type="checkbox"/> DirectAccess w/HSA – gmua* <input type="checkbox"/> DirectAccess w/HSA – gpua*

Other: _____ None

HMO Plans	Anthem Premier	Anthem Preferred	Anthem Essential	Anthem Core
Traditional HMO Network (CaliforniaCare)		<input type="checkbox"/> Guided Access – gfca* <input type="checkbox"/> Guided Access – gxba* <input type="checkbox"/> Guided Access – gzba*	<input type="checkbox"/> Guided Access Plus – gboa* <input type="checkbox"/> Guided Access Plus w/Dental – gboa	
Select HMO Network	<input type="checkbox"/> Guided Access Plus – gjaa* <input type="checkbox"/> Guided Access Plus – gwaf*	<input type="checkbox"/> Guided Access – gfca* <input type="checkbox"/> Guided Access – gxba* <input type="checkbox"/> Guided Access – gzba* <input type="checkbox"/> Guided Access Plus – gpa* <input type="checkbox"/> Guided Access Plus – gsaa* <input type="checkbox"/> Guided Access Plus – gxaf* <input type="checkbox"/> Guided Access Plus – gzna*	<input type="checkbox"/> Guided Access – gyaf* <input type="checkbox"/> Guided Access Plus – gboa* <input type="checkbox"/> Guided Access Plus w/Dental – gboa	
Priority Select HMO Network	<input type="checkbox"/> Guided Access Plus – gjaa* <input type="checkbox"/> Guided Access Plus – gwaf*	<input type="checkbox"/> Guided Access – gfca* <input type="checkbox"/> Guided Access – gxba* <input type="checkbox"/> Guided Access – gzba* <input type="checkbox"/> Guided Access Plus – gpa* <input type="checkbox"/> Guided Access Plus – gsaa* <input type="checkbox"/> Guided Access Plus – gxaf* <input type="checkbox"/> Guided Access Plus – gzna*	<input type="checkbox"/> Guided Access – gyaf* <input type="checkbox"/> Guided Access Plus – gboa* <input type="checkbox"/> Guided Access Plus w/Dental – gboa	

Other: _____ None

Please indicate the contract code for the medical plan selected: Contract code: _____

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

Please Note:*All health benefit plans are required to provide coverage for the 10 Essential Health Benefits (EHBs), including dental pediatric EHBs. This plan does not include dental pediatric EHBs. If you select this plan, you will also be automatically enrolled in Anthem Dental Pediatric, a separate dental plan providing the required EHB pediatric benefits. The additional cost of this dental pediatric coverage will be added to your bill.

Social Security no. _____

2. Dental Coverage – select one option

<p>Offered by Anthem Blue Cross Life and Health Insurance Company</p> <p style="text-align: center;">Employer Sponsored</p> <p> <input type="checkbox"/> Dental Blue Silver 100-80* <input type="checkbox"/> Dental Blue Silver Plus 100-80* <input type="checkbox"/> Dental Blue Gold 100-80* <input type="checkbox"/> Dental Blue Gold Plus 100-80* <input type="checkbox"/> Dental Blue Platinum 100-80* <input type="checkbox"/> Dental Blue Platinum Plus 100-80* <input type="checkbox"/> High Option PPO* <input type="checkbox"/> Standard Option PPO* <input type="checkbox"/> Basic Option PPO* </p> <p style="text-align: center;">Voluntary Dental Coverage</p> <p><input type="checkbox"/> Voluntary Dental PPO*</p>	<p>Offered by Anthem Blue Cross</p> <p style="text-align: center;">Dental Net DHMO – Employer Sponsored</p> <p> <input type="checkbox"/> Dental Net 2000A* <input type="checkbox"/> Dental Net 2000B* <input type="checkbox"/> Dental Net 2000C* </p> <p style="text-align: center;">Dental Net Voluntary DHMO Coverage</p> <p> <input type="checkbox"/> Dental Net Voluntary 2000A* <input type="checkbox"/> Dental Net Voluntary 2000B* <input type="checkbox"/> Dental Net Voluntary 2000C* </p>
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*These optional dental plans do not include the required essential health benefits. When medical coverage is selected, these optional dental plans are provided in addition to Anthem Dental Pediatric, (a separate dental plan providing the required EHB pediatric benefits).

Other: _____ None **Please indicate the contract code for the dental plan selected:** Contract code: _____

Member dental coverage – select one: Employee only Employee + Spouse/Domestic Partner Employee + child(ren) Family

3. Vision Coverage – select one option **Offered by Anthem Blue Cross Life and Health Insurance Company**

<p><input type="checkbox"/> Blue View Vision <input type="checkbox"/> Blue View Vision Plus</p>	<p>Voluntary Vision Coverage: <input type="checkbox"/> Voluntary Blue View Vision <input type="checkbox"/> Voluntary Blue View Vision Plus</p>
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Other: _____ None **Please indicate the contract code for the vision plan selected:** Contract code: _____

Member vision coverage – select one: Employee only Employee + Spouse/Domestic Partner Employee + child(ren) Family

Social Security no.
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Section D: Coverage Information – All fields required. Attach a separate sheet if necessary.
 Please access the Provider Directory at anthem.com to determine if your physician is a participating provider.
 For HMO plans: provide 3- or 6-digit Primary Care Physician no.

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). In the case of your child, the age limit of 26 does not apply when the child is and continues to be (1) incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition and (2) chiefly dependent upon the subscriber for support and maintenance. The employee will be required to submit certification by a physician of the child's condition. List all dependents beginning with the eldest.

Employee last name	First name	M.I.	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 Self		PCP name			PCP ID no.

Spouse/Domestic Partner last name	First name	M.I.	Social Security 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 <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner		PCP name			PCP ID no.	

Does this dependent have a different address? Yes No
 If yes, please enter and include county: _____

Dependent last name	First name	M.I.	Social Security 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 <input type="checkbox"/> Child <input type="checkbox"/> Other If other, what is relationship? _____		PCP name			PCP ID no.	

Does this dependent have a different address? Yes No
 If yes, please enter and include county: _____

Dependent last name	First name	M.I.	Social Security 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 <input type="checkbox"/> Child <input type="checkbox"/> Other If other, what is relationship? _____		PCP name			PCP ID no.	

Does this dependent have a different address? Yes No
 If yes, please enter and include county: _____

Dependent last name	First name	M.I.	Social Security 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 <input type="checkbox"/> Child <input type="checkbox"/> Other If other, what is relationship? _____		PCP name			PCP ID no.	

Does this dependent have a different address? Yes No
 If yes, please enter and include county: _____

Social Security no. _____

Section E: 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	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 _____
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Medicare Part D ID no.	Medicare Part D Carrier	Part D effective date
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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

If yes to any of these questions, 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.	Dates (if applicable)
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental				Start: _____ End: _____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental				Start: _____ End: _____

Section F: 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 coverage declined for:** Myself

Reason for declining coverage – check all that apply:

- Covered by spouse'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

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 waive coverage. BY WAIVING 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 UP TO TWELVE (12) MONTHS TO BE ENROLLED IN THIS GROUP'S MEDICAL AND/OR GROUP LIFE INSURANCE PLAN UNLESS I QUALIFY FOR A SPECIAL OPEN ENROLLMENT.

Special Open Enrollment

If you declined enrollment for yourself or your dependent(s) (including a spouse/domestic partner), you may be able to enroll yourself or your dependent(s) in this health benefit plan or change health benefit plans as a result of certain triggering events, including: (1) you or your dependent loses minimum essential coverage; (2) you gain or become a dependent; (3) you are mandated to be covered as a dependent pursuant to a valid state or federal court order; (4) you have been released from incarceration; (5) your health coverage issuer substantially violated a material provision of the health coverage contract; (6) you gain access to new health benefit plans as a result of a permanent move; (7) you were receiving services from a contracting provider under another health benefit plan, for one of the conditions described in Section 1373.96(c) of the Health and Safety Code and that provider is no longer participating in the health benefit plan; (8) you are a member of the reserve forces of the United States military or a member of the California National Guard, and returning from active duty service; or (9) you demonstrate to the department that you did not enroll in a health benefit plan during the immediately preceding enrollment period because you were misinformed that you were covered under minimum essential coverage. You must request special enrollment within 60 days from the date of the triggering event to be able to enroll yourself or your dependent(s) in this health benefit plan or change health benefit plans as a result of a qualifying triggering event.

*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. Please examine your options carefully before waiving this coverage.

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

Signature of applicant X	Printed name	Date (MM/DD/YYYY)
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Section G: 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 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 60 days.

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/domestic partner, 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 child for whom the employee or annuitant has assumed a parent-child relationship as indicated by intentional assumption of parental status, or 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 last day of the month in which the children reach age 26.
- The age limit of 26 for enrolling a child does not apply for the initial enrollment or maintaining enrollment while the child is and continues to be (1) incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition and (2) chiefly dependent upon the subscriber for support and maintenance. The employee will be required to submit certification by a physician of the child'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 realize any false statement or misrepresentation in the application may result in loss of coverage.

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.

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.

Read carefully – Signature required

REQUIREMENT FOR BINDING ARBITRATION

ALL DISPUTES 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 BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AGREE TO BE BOUND BY THIS ARBITRATION PROVISION AND ACKNOWLEDGE THAT THE RIGHT TO A JURY TRIAL OR TO PARTICIPATE IN A CLASS ACTION IS WAIVED FOR BOTH DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND MEDICAL MALPRACTICE CLAIMS.

By providing your "wet or electronic" signature below, you acknowledge that such signature is valid and binding.

Sign here	Applicant signature X	Date (MM/DD/YYYY) _____
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Anthem Blue Cross Language Assistance Notice

IMPORTANT: An interpreter can be provided for you to communicate with your doctor or health plan at no cost. To get an interpreter or to ask about written information in your language, please contact your group administrator.

IMPORTANTE: Se le puede brindar sin costo los servicios de un intérprete para que pueda comunicarse con su médico o plan de salud. Para obtener un intérprete o para solicitar información escrita en su idioma, comuníquese con el administrador de su grupo. (Spanish)

重要提示: 您與您的醫生或保健計畫交談時，可獲得免費口譯服務。如欲請翻譯員提供口譯，或欲查詢中文書面資料，請聯絡您的團體行政人員。(Cantonese or Mandarin)

중요: 의사 또는 건강보험사와의 의사소통을 위하여 통역사를 무료로 이용하실 수 있습니다. 통역이나 한국어로 번역된 정보를 원하시면 그룹 담당자에게 요청하시기 바랍니다. (Korean)

MAHALAGA: Mai-alok ang tagapagsalin sa iyo nang libre upang makipag-usap ka sa iyong doktor o planong pangkalusugan. Upang kumuha ng tagapagsalin o magtanong tungkol sa nakasulat na impormasyon sa iyong lengguahe, paki-usap ang tagapangasiwa ng iyong pangkat. (Tagalog)

CHÚ Ý QUAN TRỌNG: Quý vị có thể được thông dịch viên giúp đỡ miễn phí khi quý vị cần tiếp xúc với bác sĩ hoặc nhân viên trong chương trình bảo hiểm sức khỏe của quý vị. Để được thông dịch viên giúp đỡ hoặc được cấp thông tin, văn bản chuyên ngữ sang ngôn ngữ của quý vị, xin quý vị vui lòng liên lạc ban quản trị chương trình bảo hiểm. (Vietnamese)

Anthem Blue Cross Life and Health Insurance Company Notice of Language Assistance

IMPORTANT: An interpreter can be provided for you to communicate with your doctor or health plan at no cost. To get an interpreter or ask about written information in your language, please call the phone number listed on the back of your ID card or contact your group administrator.

IMPORTANTE: Se le puede brindar sin costo los servicios de un intérprete para que pueda comunicarse con su médico o plan de salud. Para obtener un intérprete o para solicitar información en su idioma, llame al número que figura en el reverso de su tarjeta de identificación o póngase en contacto con el administrador de su grupo. (Spanish)

重要提示: 您與您的醫生或保健計畫交談時，可獲得免費口譯服務。如欲請翻譯員提供口譯，或欲查詢中文書面資料，請撥打您識別證背面的電話號碼，或聯絡您的團體行政人員。(Chinese)

Anthem Blue Cross Life and Health Insurance Company Notice of Language Assistance

CHÚ Ý QUAN TRỌNG: Quý vị có thể được thông dịch viên giúp đỡ miễn phí khi quý vị cần tiếp xúc với bác sĩ hoặc nhân viên trong chương trình bảo hiểm sức khỏe của quý vị. Để được thông dịch viên giúp đỡ hoặc được cấp thông tin, văn bản chuyên ngữ sang ngôn ngữ của quý vị, xin quý vị vui lòng gọi số điện thoại ghi phía sau thẻ hội viên của quý vị hoặc liên lạc ban quản trị chương trình bảo hiểm. (Vietnamese)

MAHALAGA: Mai-alok ang tagapagsalin sa iyo nang libre upang makipag-usap ka sa iyong doktor o planong pangkalusugan. Upang kumuha ng tagapagsalin o magtanong tungkol sa nakasulat na impormasyon sa iyong lengguage, paki-tawagan ang numero ng telepono na nakalista sa likod ng iyong ID card o paki-usap ang tagapangasiwa ng iyong pangkat. (Tagalog)

중요: 의사 또는 건강보험사와의 의사소통을 위하여 통역사를 무료로 이용하실 수 있습니다. 통역이나 한국어로 번역된 정보를 원하시면 가입자님의 ID 카드 뒷면에 있는 전화번호로 연락하시거나 그룹 담당자에게 요청하시기 바랍니다. (Korean)

ԿԱՐԵՎՈՐ: Ձեր բժշկի կամ առողջապահական ծրագրի հետ հաղորդակցվելու համար՝ Ձեզ անվճար թարգմանիչ կարող է մատակարարվել: Թարգմանիչ ստանալու կամ Ձեր լեզվով գրավոր տեղեկությունների մասին հարցնելու համար՝ խնդրվում է զանգահարել Ձեր ինքնուրույն քարտի ետևի մասում գրված հեռախոսի համարով կամ կապվել Ձեր խմբային կառավարչի հետ: (Armenian)

ПОМНИТЕ: Для общения с вашим врачом или представителем плана медицинского страхования вам могут предоставить бесплатные услуги переводчика. Для того, чтобы получить услуги переводчика или попросить о предоставлении информации в письменном виде на вашем языке, пожалуйста, позвоните по номеру, который указан на оборотной стороне вашей идентификационной карты (ID card), или свяжитесь с администратором вашей медицинской группы. (Russian)

重要事項: 医師、および、ヘルスプラン担当者との意思疎通には、通訳者による通訳サービスを無料で受けることが出来ます。通訳者サービス、または、あなたが話す言語で書かれた文書による情報を要請するには、あなたのIDカードの裏側に記載された電話番号に電話をするか、または、あなたの属するグループのアドバイザーに連絡をとってください。 (Japanese)

ਜ਼ਰੂਰੀ ਸੂਚਨਾ: ਤੁਹਾਡੇ ਡਾਕਟਰ ਨਾਲ ਜਾਂ ਹੈਲਥ ਪਲਾਨ ਬਾਰੇ ਗੱਲਬਾਤ ਕਰਨ ਲਈ ਤੁਹਾਨੂੰ ਦੁਬਾਸੀਏ (ਅਨੁਵਾਦਕ) ਦੀ ਸੇਵਾ ਮੁਫਤ ਦਿੱਤੀ ਜਾ ਸਕਦੀ ਹੈ। ਦੁਬਾਸੀਏ ਲੈਣ ਲਈ ਜਾਂ ਲਿਖਤ ਜਾਣਕਾਰੀ ਪੰਜਾਬੀ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੇ ਆਈ.ਡੀ. ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ ਜਾਂ ਆਪਣੇ ਗਰੁੱਪ ਪ੍ਰਬੰਧਕ ਨੂੰ ਸੰਪਰਕ ਕਰੋ। (Punjabi)

សារៈសំខាន់ : យើងអាចផ្តល់អ្នកបកប្រែជូនអ្នកដោយឥតគិតថ្លៃ សំរាប់ប្រាស្រ័យទាក់ទងជាមួយនឹងគ្រូពេទ្យ ឬគំរោងសុខភាពរបស់អ្នក ។ ដើម្បីទទួលបានអ្នកបកប្រែ ឬសាកសួរអំពីព័ត៌មានដែលសរសេរជាភាសាខ្មែរ សូមមូលស័ព្ទទៅលេខដែលមានកត់នៅលើខ្នងអត្តសញ្ញាណប័ណ្ណរបស់អ្នក ឬទាក់ទងអ្នកគ្រប់គ្រងក្រុមរបស់អ្នក ។ (Khmer)

هام: يمكننا توفير مترجم فوري لك للتواصل مع الطبيب الخاص بك أو بخصوص خطتك الصحية بدون مقابل. للحصول على مترجم فوري أو لطلب معلومات كتابية بلغتك، رجاء الاتصال على رقم الهاتف الموجود على ظهر بطاقة العضوية أو اتصل بمسؤول المجموعة. (Arabic)

TSEEM CEEB: Yeej nrhiav tau ib tug neeg pab txhais lus uas yuav pab koj nrog koj tus kws kho mob los sis pawg kho mob tham pub dawb rau koj. Yog xav tau ib tug neeg txhais lus los sis xav tau cov ntawv hauv koj yam lus, thov hu mus rau tus naj npawb xov tooj nram qab koj daim ID los sis hu mus rau tus neeg saib xyuas koj pawg hauj lwm. (Hmong)