

**Employee Enrollment Application  
For 51+ employee groups  
Indiana**



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 electronically or in blue or black ink only.

Employer name	Group no.	Subsection
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**Section 1: Employee information**

Last name		First name		M.I.	Social Security no.* (required)	
Birthdate (MM/DD/YYYY)		Home address				
City			County		State	ZIP code
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner			Primary phone no.	
Employee email address						
Employment status <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Disabled <input type="checkbox"/> Retired				Hire date (MM/DD/YYYY)		No. of hours worked per week
Primary Care Physician (PCP) name				PCP ID no.		Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

**Section 2: Reason for application – Select one**

<input type="checkbox"/> New enrollment <input type="checkbox"/> Annual open enrollment (not applicable to life and disability) <input type="checkbox"/> New hire <input type="checkbox"/> Rehire – Rehire date: _____ (MM/DD/YYYY) <input type="checkbox"/> Marriage – Date of marriage: _____ (MM/DD/YYYY) <input type="checkbox"/> Birth of child <input type="checkbox"/> Add dependent (Fill in section 4) <input type="checkbox"/> Loss of eligibility for other coverage – Date previous coverage ended: _____ (MM/DD/YYYY) <input type="checkbox"/> COBRA – Select qualifying event <input type="checkbox"/> Left employment <input type="checkbox"/> Reduction in hours <input type="checkbox"/> Death <input type="checkbox"/> Medicare <input type="checkbox"/> Loss of dependent child status <input type="checkbox"/> Divorce or legal separation <input type="checkbox"/> Covered employee's Medicare entitlement Qualifying event date: _____ (MM/DD/YYYY) <input type="checkbox"/> Waiver (To decline ALL coverage skip to section 8.)	
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\*Anthem Blue Cross and Blue Shield (Anthem) is required by the Internal Revenue Service to collect this information.

**Section 3: Type of coverage**

<b>Medical coverage</b>		
<b>Large Group 51-99 options</b>		
<input type="checkbox"/> Blue Access (PPO)	<input type="checkbox"/> HealthSync (HMO)	<input type="checkbox"/> HealthSync POS HSA
<input type="checkbox"/> Blue Access PPO HRA	<input type="checkbox"/> HealthSync (POS)	
<input type="checkbox"/> Blue Access PPO HSA	<input type="checkbox"/> HealthSync HMO HSA	
<b>Large Group 100+ options</b>		
<input type="checkbox"/> Anthem Essential (PPO)	<input type="checkbox"/> Blue Access PPO HSA	<input type="checkbox"/> HealthSync (HMO)
<input type="checkbox"/> Blue Access (PPO)	<input type="checkbox"/> Blue Access PPO HRA	<input type="checkbox"/> HealthSync (POS)
<input type="checkbox"/> Blue Preferred (HMO)	<input type="checkbox"/> Blue Access PPO HRA (with Copay)	<input type="checkbox"/> HealthSync HMO HSA
<input type="checkbox"/> Blue Preferred (POS)	<input type="checkbox"/> Blue Access PPO Deductible First HRA	<input type="checkbox"/> HealthSync POS HSA
	<input type="checkbox"/> Blue Access PPO HIA Plus	
<b>Member medical coverage – select one:</b>		
<input type="checkbox"/> Employee only <input type="checkbox"/> Employee + Spouse/Domestic Partner <input type="checkbox"/> Employee + child(ren) <input type="checkbox"/> Family <input type="checkbox"/> No coverage		
<b>Flexible Spending Account (FSA) coverage – More than one plan may be selected, depending on employer offerings.</b>		
<input type="checkbox"/> Healthcare FSA (excluded if you have an HSA plan)	<input type="checkbox"/> Commuter Parking	
<input type="checkbox"/> Limited-Purpose FSA (for dental and vision services)	<input type="checkbox"/> Commuter Transit	
<input type="checkbox"/> Dependent Care FSA	<input type="checkbox"/> No FSA coverage at this time	
<b>Dental coverage</b>		
<input type="checkbox"/> Prime Essential Choice <input type="checkbox"/> Prime Consumer Choice <input type="checkbox"/> Complete Essential Choice <input type="checkbox"/> Complete Consumer Choice		
<input type="checkbox"/> Other: _____		
<b>Member dental coverage – select one:</b>		
<input type="checkbox"/> Employee only <input type="checkbox"/> Employee + Spouse/Domestic Partner <input type="checkbox"/> Employee + child(ren) <input type="checkbox"/> Family <input type="checkbox"/> No coverage		
<b>Vision coverage</b>		
<input type="checkbox"/> Vision		
<b>Member vision coverage – select one:</b>		
<input type="checkbox"/> Employee only <input type="checkbox"/> Employee + Spouse/Domestic Partner <input type="checkbox"/> Employee + child(ren) <input type="checkbox"/> Family <input type="checkbox"/> No coverage		
<b>Life and disability coverage</b>		
If you select life and/or disability coverage over the guaranteed issue amount or are a late entrant an Evidence of Insurability form may be sent to you to complete.		
<input type="checkbox"/> Basic Life <input type="checkbox"/> Basic Life and Accidental Death and Dismemberment <input type="checkbox"/> Basic Dependent Life <input type="checkbox"/> Optional Supplemental/Voluntary Life and Accidental Death and Dismemberment. . . . . \$ _____ (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"/> Voluntary Accidental Death and Dismemberment . . . . . \$ _____ (employee amount) <input type="checkbox"/> Voluntary Accidental Death and Dismemberment Family Plan (Spouse and Child coverage) <input type="checkbox"/> Voluntary Accidental Death and Dismemberment Spouse Only (no Child coverage) <input type="checkbox"/> Voluntary Accidental Death and Dismemberment Child Only (no Spouse coverage) <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		
Current annual income – For employer/Anthem use \$ _____	Occupation	Life and disability class no. – For employer/Anthem use

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

Social Security no. * (required)
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**Life and disability coverage – Continued**

**Primary beneficiary**

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

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

**Contingent beneficiary – If no primary beneficiary survives, the proceeds will be paid to the contingent beneficiary(ies) listed.**

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

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no. * (required)	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.

**Spousal consent for community property states only (Note: The insurance company is not responsible for the validity of a spouse'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 if your spouse will not be named as a primary beneficiary for 50% or more of your benefit amount. Please have your spouse read and sign the following. I am aware that my spouse, 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
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\*Anthem is required by the Internal Revenue Service to collect this information.

Social Security no. * (required)
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**Section 4: Coverage information – All fields required. Attach a separate sheet if necessary.**

Dependent information must be completed for all additional dependents (if any) to be covered under this coverage. An eligible dependent may be your spouse or domestic partner, your children, or your spouse or domestic partner's children (to the end of the calendar month in which they turn age 26 unless they qualify as a disabled person). List all dependents beginning with the eldest.

**Please read the Genetic Information Non-discrimination Act (GINA) information on page 3 of the application, under Section 7, Significant Terms, Conditions and Authorizations, prior to answering the questions in Section 4.**

Spouse/Domestic Partner last name		First name		M.I.	Social Security no. * (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		
PCP name			PCP ID no.	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Dependent last name		First name		M.I.	Social Security no. * (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"/> Biological child of applicant/spouse/domestic partner <input type="checkbox"/> Other If other, what is relationship? _____		
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. * (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"/> Biological child of applicant/spouse/domestic partner <input type="checkbox"/> Other If other, what is relationship? _____		
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. * (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"/> Biological child of applicant/spouse/domestic partner <input type="checkbox"/> Other If other, what is relationship? _____		
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: _____					

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

Social Security no. \* (required)

**Section 5: Prior and other group coverage**

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

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

Are you or a family member previously or currently covered by a Medicare, medical and/or dental plan?  Yes  No  
 If yes, please provide the following:

Name of person covered (Last name, first, M.I.)	Type (check one)	Coverage (check all that apply)	Carrier name	Carrier phone no.	Policy ID no.	Policyholder name	Dates (if applicable) (MM/DD/YY)
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Medical <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"/> Medical <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"/> Medical <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"/> Medical <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"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia					Start: _____ End: _____

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

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

Please read this section carefully before signing the application.

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

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

- |   |   |
|---|---|
| <ol style="list-style-type: none"> <li>1. I understand that I may not assign any payment under my Anthem program.</li> <li>2. I agree to have money taken from my wages/pension, if necessary, to cover the premium cost for the coverage applied for.</li> <li>3. I am asking for the coverage I chose on this form. If I made choices that are not available to me, I agree that my choices may be changed to those on the employer's application.</li> </ol> | <ol style="list-style-type: none"> <li>4. I agree that I will let my employer know right away of any changes that would make me or any dependent(s) ineligible for this coverage.</li> <li>5. By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself.</li> </ol> |
|---|---|

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

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

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

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

**Thank you for choosing Anthem Blue Cross and Blue Shield.**

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

Read section 6 carefully before signing.

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

Employee signature	Date (MM/DD/YYYY)
<b>X</b>	

**Section 8: Waiver/Declining coverage**

<b>Medical coverage</b>			
<b>Medical coverage declined for – check all that apply:</b> Reason for declining coverage – check all that apply:	<input type="checkbox"/> Myself <input type="checkbox"/> Spouse/domestic partner <input type="checkbox"/> Dependent(s) <input type="checkbox"/> Covered by spouse's/domestic partner's group coverage <input type="checkbox"/> Enrolled in other insurance – Please provide company name and plan: _____  <input type="checkbox"/> Enrolled in individual coverage <input type="checkbox"/> Spouse covered by employer's group medical coverage <input type="checkbox"/> Medicare/Medicaid/VA <input type="checkbox"/> Other – please explain: _____ <input type="checkbox"/> No coverage		
<b>Dental coverage</b>			
<b>Dental coverage declined for – check all that apply:</b> Reason for declining coverage – check all that apply:	<input type="checkbox"/> Myself <input type="checkbox"/> Spouse/domestic partner <input type="checkbox"/> Dependent(s) <input type="checkbox"/> Covered by spouse's/domestic partner's group coverage <input type="checkbox"/> Enrolled in other insurance – Please provide company name and plan: _____  <input type="checkbox"/> Enrolled in individual coverage <input type="checkbox"/> Spouse covered by employer's group medical coverage <input type="checkbox"/> Medicare/Medicaid/VA <input type="checkbox"/> Other – please explain: _____ <input type="checkbox"/> No coverage		
<b>Vision coverage</b>			
<b>Vision coverage declined for – check all that apply:</b> Reason for declining coverage – check all that apply:	<input type="checkbox"/> Myself <input type="checkbox"/> Spouse/domestic partner <input type="checkbox"/> Dependent(s) <input type="checkbox"/> Covered by spouse's/domestic partner's group coverage <input type="checkbox"/> Enrolled in other insurance – Please provide company name and plan: _____  <input type="checkbox"/> Enrolled in individual coverage <input type="checkbox"/> Spouse covered by employer's group medical coverage <input type="checkbox"/> Medicare/Medicaid/VA <input type="checkbox"/> Other – please explain: _____ <input type="checkbox"/> No coverage		
<b>Life and disability coverage</b>			
<b>*Life/AD&amp;D coverage declined for:</b> Spouse, Domestic Partner and dependent coverage not available if life coverage is waived/declined. <b>Dependent Life coverage declined for:</b> <b>Optional Supplemental/Voluntary coverage declined for:</b> <b>Optional Supplemental/Voluntary Dependent Life coverage declined for:</b> <b>Voluntary Short Term Disability coverage declined for:</b> <b>Voluntary Long Term Disability coverage declined for:</b> <b>Reason for declining coverage – check all that apply:</b>	<input type="checkbox"/> Myself <input type="checkbox"/> Spouse/domestic partner and dependents <input type="checkbox"/> Myself <input type="checkbox"/> Spouse/domestic partner and dependents <input type="checkbox"/> Myself <input type="checkbox"/> Myself <input type="checkbox"/> Life/AD&D declined for religious reasons <input type="checkbox"/> Do not elect to enroll in Dependent Life <input type="checkbox"/> Do not elect to enroll in Optional Supplemental/Voluntary coverage <input type="checkbox"/> Do not elect to enroll in Optional Supplemental/Voluntary Dependent Life coverage <input type="checkbox"/> Do not elect to enroll in Voluntary Short Term Disability <input type="checkbox"/> Do not elect to enroll in Voluntary Long Term Disability		
*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.			
<b>Sign here <span style="color: red;">only</span> if you are declining coverage.</b>			
Signature of applicant  <span style="color: red; font-weight: bold; font-size: 1.2em;">X</span>	Printed name	Social Security no.	Date (MM/DD/YYYY)

# 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 (855-886-6152). (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 (855-886-6152). (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 (855-886-6152). (TTY/TDD: 711)

## Burmese

ဤစာရွက်စာတမ်းကို နားလည် သဘောပေါက်နိုင်ရန် အခြားဘာသာစကား တစ်မျိုးမျိုးဖြင့် သင်လိုအပ်ပါက အကြောင်းတွေ ထပ်မံပေးအပ်ရာ မလိုပဲ အဖွဲ့ဝင်အတွက် ဝန်ဆောင်မှုများ ဌာန ဖုန်းနံပါတ် (855-886-6152) သို့ ခေါ်ဆိုကာ တောင်းခံနိုင်ပါသည်။

(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(855-886-6152)請求免費協助。(TTY/TDD: 711)

## Dutch

Als u hulp nodig heeft om dit document te begrijpen in een andere taal, mag u daar zonder aanvullende kosten om vragen door te bellen met het ledenservicenummer (855-886-6152). (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 : 855-886-6152. (TTY/TDD: 711)

## German

Falls Sie Hilfe in einer anderen Sprache benötigen, um dieses Dokument zu verstehen, können Sie diese kostenlos anfordern, indem Sie die Servicenummer für Mitglieder anrufen (855-886-6152). (TTY/TDD: 711)

## Hindi

अगर आपको यह दस्तावेज़ वैकल्पिक भाषा में समझने के लिए सहायता की ज़रूरत है, तो आप सदस्य सेवाएँ नंबर (855-886-6152) पर कॉल करके अतिरिक्त लागत के बिना इसके लिए अनुरोध कर सकते हैं। (TTY/TDD: 711)



## Japanese

この書面を他の言語で理解するための支援が必要な場合には、メンバーサービス番号（855-886-6152）に電話して支援を求めることができます。追加費用はかかりません。（TTY/TDD: 711）

## Korean

다른 언어로 본 문서를 이해하기 위해 도움이 필요하실 경우, 추가 비용 없이 회원 서비스 번호(855-886-6152)로 전화를 걸어 도움을 요청할 수 있습니다. (TTY/TDD: 711)

## Pennsylvania Dutch

Wann du Hilfe brauchschtsch um selle Document zu verschtehe in en annere Schprooch, du kannschtsch fer sell frooge um nix zu bezaahle. Ruff Member Services Nummer (855-886-6152) aa. (TTY/TDD: 711)

## Punjabi

ਜੇ ਤੁਹਾਨੂੰ ਕਿਸੇ ਬਦਲਵੀਂ ਭਾਸ਼ਾ ਵਿੱਚ ਇਸ ਦਸਤਾਵੇਜ਼ ਨੂੰ ਸਮਝਣ ਲਈ ਮਦਦ ਚਾਹੀਦੀ ਹੈ, ਤਾਂ ਤੁਸੀਂ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ (855-886-6152) ਤੇ ਕਾਲ ਕਰਕੇ ਕਿਸੇ ਵਾਧੂ ਲਾਗਤ ਦੇ ਬਿਨਾਂ ਇਸ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। (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 (855-886-6152). (TTY/TDD: 711)

## Tagalog

Kung kailangan ninyo ng tulong upang maunawaan ang dokumentong ito sa ibang wika, maaari ninyo itong hilingin nang walang karagdang bayad sa pamamagitan ng pagtawag sa Member Services sa numerong (855-886-6152). (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 (855-886-6152). (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>.

Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc. Independent licensee 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.