blue california

Health Plan & Life Insurance Employee Enrollment Application

Blue Shield plans for 101+ employees

Blue Shield of California and
Blue Shield of California Life & Health Insurance Company (Blue Shield Life)

Please note: Failure to complete this enrollment application legibly and completely may result in a delay in the enrollment process.

Reason for application:

☐ New hire	☐ Loss of coverage date _____	☐ Late enrollment
☐ Re-hire date _____	☐ Open enrollment	☐ Other qualifying event type_____
		Date above event occurred _____

Section 1 – Important enrollment guidelines for Specialty Benefits coverage

Dental, vision, and life insurance coverage - An employee may enroll in a dental, vision, or life plan without enrolling in a health plan. In order for a dependent to enroll in a dental or vision plan, the employee must be enrolled in the same dental or vision plan.

Life insurance enrollment is subject to the following rules:

1. All Basic Term Life insurance amounts for employees who enroll when first eligible for benefits are fully Guarantee Issued (no Evidence of Insurability required). Evidence of Insurability is required for late enrollees.
2. For Supplemental Life, Evidence of Insurability is required for all amounts over the Guarantee Issue.
3. An employee must be enrolled in Supplemental Life/AD&D coverage for their spouse/domestic partner or dependent children to be eligible for Supplemental Life coverage. Spouse/domestic partner and/or dependent children do not have to be covered under the Basic Dependent Life coverage to be eligible for Supplemental Life coverage.

Section 2 – Plan(s) Select and fill in plan name(s), if applicable.

Medical benefits without ABHP (account-based health plan) options:

☐ Active Choice®* _____ ☐ Active Choice® Plus _____ ☐ Active Choice® Classic _____ ☐ Access+ HMO® _____
☐ Access+ HMO® SaveNet℠ _____ ☐ Local Access+ HMO® _____ ☐ Trio HMO _____ ☐ Trio HMO Savings _____
☐ Added Advantage POS℠ _____ ☐ Full PPO _____ ☐ Full PPO Savings† _____ ☐ Full EPO _____
☐ Tandem PPO _____ ☐ Tandem PPO Savings† _____ ☐ Tandem EPO _____ ☐ Blue Shield 65 Plus℠ (HMO) _____

Medical benefits with ABHP (account-based health plan) options:

Active Choice®: ☐ HRA ☐ HIA ☐ FSA
Active Choice® Plus: ☐ HRA ☐ HIA ☐ FSA
Active Choice® Classic: ☐ HRA ☐ HIA ☐ FSA
Access+ HMO®: ☐ HRA ☐ HIA ☐ FSA
Access+ HMO® SaveNet℠: ☐ HRA ☐ HIA ☐ FSA
Local Access+ HMO®: ☐ HRA ☐ HIA ☐ FSA
Trio HMO: ☐ HRA ☐ HIA ☐ FSA ☐ LPFSA‡

Full PPO: ☐ HRA ☐ HIA ☐ FSA
Full PPO Savings†: ☐ HRA ☐ HIA ☐ FSA ☐ HSA ☐ LPFSA‡
Full EPO: ☐ HRA ☐ HIA ☐ FSA
Tandem PPO: ☐ HRA ☐ HIA ☐ FSA
Tandem PPO Savings†: ☐ HRA ☐ HIA ☐ FSA ☐ HSA ☐ LPFSA‡
Tandem EPO: ☐ HRA ☐ HIA ☐ FSA
Blue Shield 65 Plus℠ (HMO): ☐ HRA ☐ HIA ☐ FSA

Specialty Benefits: ☐ Basic group term life/AD&D insurance* _____ ☐ Dependent basic life insurance*_____
☐ Supplemental Life insurance*_____ ☐ Supplemental AD&D insurance*_____ ☐ Dental PPO _____
☐ Dental HMO _____ ☐ Vision* _____ ☐ Other _____

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

† Full PPO Savings plans, Tandem PPO Savings, and Trio HMO Savings are HSA-eligible high-deductible health plans.

‡ Must be paired with an HSA plan only.

Note: Blue Shield does not offer tax advice, nor do we offer HSAs, HRAs, HIAs, FSAs, or LPFSAs.

Internal use only. Do not write in this section and skip to Section 3.

Department code	Group ID	Subgroup ID	Class ID	Effective date _____

Section 3 – Employee information

Social Security number	**Employer (group) name**	
Last name	**First name**	MI

Employment status: ☐ Full time ☐ Part time ☐ Retiree	**Date of hire:** _____	Job title/classification

Section 3 – Employee information (continued)

Home address – (street, city, state, ZIP code)	Basic group term life/AD&D insurance amount:
	Dependent life amount: (all eligible dependents will be covered)
Mailing address (if different from home address)	Supplemental Life insurance amount:
	Supplemental AD&D insurance amount:

Cell phone number	Landline phone number	**Email address (Required for electronic communications)**

I consent to Blue Shield and their covered entities contacting me about health and wellness education or promotional information to serve me better. Communications can be by phone or text using auto-dialer or prerecorded message. ☐ Yes ☐ No

BSC follows TCPA guidelines and will always provide you with an option to Opt-Out at any time. https://www.blueshieldca.com/terms.

Communication preference: ☐ Electronic ☐ Paper **Go paperless!** Please watch for an email with a link which will allow you to register your account, customize your communication preferences, and access your digital ID card and benefit information.

Date of birth _____ **Gender** ☐ Male ☐ Female **Marital status** ☐ Single ☐ Married ☐ Domestic partner

Language preference: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Persian ☐ Other _____

Are you enrolling your spouse/domestic partner and/or child dependents ☐ Yes ☐ No If "yes," complete Section 4 of application.

Please tell us about yourself. How would you describe your race or ethnicity? These questions are optional and are only used to help ensure all members have the same access to the highest quality of care.

1. Are you of Hispanic or Latino origin?	2. If yes, please select one:	3. Which race(s) do you identify with? (select one)	
☐ Yes ☐ No ☐ Unknown ☐ Declined	☐ Cuban ☐ Guatemalan ☐ Mexican, Mexican American, Chicano ☐ Puerto Rican ☐ Salvadoran ☐ 2 or more Ethnicities ☐ Other Hispanic, Latino, Spanish: _____	☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African American ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Hmong ☐ Japanese	☐ Korean ☐ Laotian ☐ Native Hawaiian ☐ Samoan ☐ Vietnamese ☐ White ☐ 2 or more Races ☐ Other ☐ Unknown ☐ Declined

HMO provider information: Blue Shield of California directory website: **blueshieldca.com/fap/app/search.html**

Name of primary care physician (PCP):		Provider number:
IPA/medical group name:	IPA/medical group number:	Existing patient? ☐ Yes ☐ No
Name of dental provider	Dental provider number:	Existing patient? ☐ Yes ☐ No

Section 4 – Dependent spouse/domestic partner/children information

If you, your spouse/domestic partner, or your dependents are refusing coverage, please complete and sign the Refusal of Coverage form.

Dependent's address, if different from employee's address – Please indicate which dependent(s) this applies to:

Are all your dependents of the same Race and Ethnicity as the subscriber? ☐ Yes ☐ No
If you answered "No", please include the race and ethnicity for each of your dependents.

Enrolling spouse/domestic partner information	Enroll in (please check all that apply)	HMO and Added Advantage POS only – name of primary care physician	Dental HMO only – dental provider
What race or ethnicity does this member identify with:			
☐ Spouse ☐ Domestic partner ☐ Male ☐ Female First MI Last **Social Security number** Date of birth (mm/dd/yyyy)	☐ Medical ☐ Dental ☐ Vision ☐ Supplemental Life $_____ ☐ Supplemental AD&D $_____	Doctor's name First Last Provider number IPA/medical group name IPA/medical group number Existing patient? ☐ Yes ☐ No	Dental provider name First Last Dental provider number Existing patient? ☐ Yes ☐ No
Communication preference ☐ Electronic ☐ Paper	**Email address (Required for electronic communications)**		

Enrolling dependent child(ren) information	Enroll in (please check all that apply)	HMO and Added Advantage POS only – name of primary care physician	Dental HMO only – dental provider
What race or ethnicity does this member identify with:			
☐ Male ☐ Female First MI Last **Social Security number** Date of birth (mm/dd/yyyy) Disabled? ☐ Yes ☐ No	☐ Medical ☐ Dental ☐ Vision ☐ Supplemental Life $_____ ☐ Supplemental AD&D $_____	Doctor's name First Last Provider number IPA/medical group name IPA/medical group number Existing patient? ☐ Yes ☐ No	Dental provider name First Last Dental provider number Existing patient? ☐ Yes ☐ No
Communication preference ☐ Electronic ☐ Paper	**Email address (Required for electronic communications)**		

What race or ethnicity does this member identify with:			
☐ Male ☐ Female First MI Last **Social Security number** Date of birth (mm/dd/yyyy) Disabled? ☐ Yes ☐ No	☐ Medical ☐ Dental ☐ Vision ☐ Supplemental Life $_____ ☐ Supplemental AD&D $_____	Doctor's name First Last Provider number IPA/medical group name IPA/medical group number Existing patient? ☐ Yes ☐ No	Dental provider name First Last Dental provider number Existing patient? ☐ Yes ☐ No
Communication preference ☐ Electronic ☐ Paper	**Email address (Required for electronic communications)**		

Section 4 – Dependent spouse/domestic partner/children information (continued)

What race or ethnicity does this member identify with:

☐ Male ☐ Female First MI Last **Social Security number** Date of birth (mm/dd/yyyy) Disabled? ☐ Yes ☐ No	☐ Medical ☐ Dental ☐ Vision ☐ Supplemental Life $_____ ☐ Supplemental AD&D $_____	Doctor's name First Last Provider number IPA/medical group name IPA/medical group number Existing patient? ☐ Yes ☐ No	Dental provider name First Last Dental provider number Existing patient? ☐ Yes ☐ No
Communication preference ☐ Electronic ☐ Paper	**Email address (Required for electronic communications)**		

Section 5 – Life insurance beneficiary

Primary beneficiary – Blue Shield Life will pay the proceeds to the primary beneficiary. If more than one person is named as primary beneficiary, the proceeds will be distributed equally to those who survive the insured, unless otherwise specified in the % of benefits field.

First name	MI	Last name	
Social Security number	Relationship	% of benefits	Date of birth
Address			
City		State	ZIP code
First name	MI	Last name	
Social Security number	Relationship	% of benefits	Date of birth
Address			
City		State	ZIP code

Contingent beneficiary – Proceeds will be paid to a contingent beneficiary only if no primary beneficiary survives the insured.

First name	MI	Last name	
Social Security number	Relationship	% of benefits	Date of birth
Address			
City		State	ZIP code

If beneficiary is a trust or corporation, please provide name and date of trust agreement and state of incorporation.

Name of trust/corporation	Date of trust	State of incorporation

COMMUNITY PROPERTY LAWS – If you are married or in a domestic partnership, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin), and name someone other than your spouse/domestic partner as beneficiary, it is possible that payment of benefits will be delayed or disputed unless your spouse/domestic partner also signs the beneficiary designation.
I agree to the above-stated beneficiary designation(s).

Print spouse/domestic partner name:_____

Spouse/domestic partner signature:_____ Date:_____

Section 6 – Medicare information

1. Are you or any of your dependents currently covered by Medicare? ☐ Yes ☐ No
   If "yes," please attach a copy of your Medicare card(s) and/or select the type of coverage below:
   Part A: ☐ Effective date: _____ (mm/dd/yyyy)
   Part B: ☐ Effective date: _____ (mm/dd/yyyy)
2. Is Medicare eligibility due to end-stage renal disease (ESRD)? ☐ Yes ☐ No
   If "yes," please answer the following questions:
   a) What was the first date of dialysis treatment, and what type of dialysis are you receiving?
   Date _____
   Type: ☐ Hemo ☐ Self-dialysis (peritoneal)
   b) If you have had a kidney transplant, what was the date of the transplant: _____ (mm/dd/yyyy)

Section 7 – Authorization

The following authorization section is to be signed by **all** employees applying for coverage with Blue Shield of California or Blue Shield of California Life & Health Insurance Company ("Blue Shield Life").

This enrollment cannot be processed without your signed authorization.

I agree: All information on this form is correct and true to the best of my knowledge and belief. I understand that it is the basis on which coverage may be issued under the plan. I understand that if I have committed fraud or made an intentional misrepresentation of any material fact in conjunction with this application Blue Shield of California/Blue Shield Life may pursue one of the following remedies within the first 24 months of coverage: my coverage may be canceled, or following 30-day notice, rescinded. I understand that coverage does not become effective until this and my employer's application have been approved by Blue Shield of California/Blue Shield Life.

Signature of employee_____ Date _____

Print employee name _____

I further authorize my employer to deduct from my earnings the contribution (if any) required toward the cost of this plan.

Signature of employee _____ Date _____

Print employee name _____

Disclosure of personal and health information

At Blue Shield of California/Blue Shield Life, we understand the importance of keeping your personal information private, and we take our obligation to do so very seriously. We are required by law to maintain the privacy and security of your personal information in whatever format it is held – paper, electronic, or oral. This statement applies to personal information that Blue Shield obtains, creates, and/or maintains about you and your covered dependents.

In the course of administering your Blue Shield coverage, we collect, use, and disclose information about you and your covered dependents, and we create records about you, your medical treatment, and the services we provide to you. The information in these records is called protected health information ("PHI") and includes individually identifiable personal information such as your name, address, telephone number, and Social Security number, as well as your health information, such as healthcare diagnosis or claim information.

We obtain PHI about you and/or your covered dependents from you, at your direction, and/or with your permission. We also obtain your PHI from other sources as permitted by law, including, for example, from your healthcare provider, insurer, insurance support organization, health information exchange, health plan, or insurance agent. We use and disclose your PHI to administer your Blue Shield coverage and as otherwise permitted or required by law. In doing so, we may disclose your PHI to others including, for example, a healthcare provider, insurer, insurance support organization, health insurance exchange, health plan, or your insurance agent.

Blue Shield maintains a Notice of Privacy Practices ("Notice") that describes your privacy rights, our obligations to protect your privacy, and how we use your PHI with and without your specific authorization. When we use or disclose your PHI, we are bound by the terms of the Notice, which applies to all records that we create, obtain, and/or maintain that contain your PHI. You will receive our Notice when you enroll for Blue Shield insurance coverage. You may also obtain a copy of our Notice by calling the customer service number on your Blue Shield member ID card or by visiting our website at: **blueshieldca.com/bsca/about-blue-shield/privacy/confidentiality.sp**.

I further authorize my employer to deduct from my earnings the contribution (if any) required toward the cost of this plan.

Signature of employee _____ **Date** _____

Print employee name _____

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Agent/Broker Attestation

Attestation of Agent/Broker assisting in the submission of this application: (1) to the best of my knowledge, the information on the application is complete and accurate; and (2) I have explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation.

Signature of Agent/Broker_____ Date _____

If an Agent/Broker willfully states as true any material fact he or she knows to be false, that person shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to ten thousand dollars ($10,000). Any public prosecutor may bring a civil action to impose that civil penalty. These penalties shall be paid to the Insurance Fund.

Blue Shield of California Life & Health Insurance Company

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

Blue Shield of California Life & Health Insurance Company complies with applicable state laws and federal civil rights laws, and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. Blue Shield of California Life & Health Insurance Company does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Blue Shield Life:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats, and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield Life Civil Rights Coordinator.

If you believe that Blue Shield Life has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance with:

Blue Shield of California Life & Health Insurance Company Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711)
Fax: (844) 696-6070
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You may also contact the California Department of Insurance if you believe that Blue Shield of California Life & Health Insurance Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. You can file a grievance with:

California Department of Insurance
Consumer Communications Bureau
300 S. Spring Street, South Tower
Los Angeles, CA 90013

Phone: 1-800-927-HELP (4357) or TDD 1-800-482-4833

Complaint forms are available at **www.insurance.ca.gov/01-consumers/101-help**

If you believe that you have not been provided these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201

(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

Notice of the Availability of Language Assistance Services

Blue Shield of California Life & Health Insurance Company

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-866-346-7198. For more help call the CA Dept. of Insurance at 1-800-927-4357. English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-866-346-7198. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

免費語言服務。您可獲得口譯員服務。可以用中文把文件唸給您聽，有些文件有中文的版本，也可以把這些文件寄給您。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打 1-866-346-7198 與我們聯絡。欲取得其他協助，請致電 1-800-927-4357 與加州保險部聯絡。Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch. Quý vị có thể được người khác đọc giúp các tài liệu và nhận một số tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-866-346-7198. Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-866-346-7198번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-866-346-7198. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-866-346-7198 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-866-346-7198. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance), по телефону 1-800-927-4357. Russian

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、ＩＤカード記載の番号または1-866-346-7198までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Japanese

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند.برای دریافت کمک،با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره 1-866-346-7198 تماس بگیرید.برای دریافت کمک بیشتر، به CA Dept. of Insurance(اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تلفن کنید.Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-866-346-7198 'ਤੇ ' ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

សេវាកម្មភាសាឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-866-346-7198 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول علي مترجم و قراءة الوثائق لك باللغة العربية. للحصول علي المساعدة، اتصل بنا علي الرقم المبين علي بطاقة عضويتك أو علي الرقم 1-866-346-7198. للحصول علي المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا علي الرقم 1-800-927-4357. Arabic

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-866-346-7198. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

บริการทางภาษาอย่างไม่เสียค่าใช้จ่าย คุณสามารถรับบริการจากล่าม รวมถึงให้เจ้าหน้าที่อ่านเอกสารให้คุณฟัง หรือส่งเอกสารบางส่วนในภาษาของคุณไปหาคุณได้ หากต้องการความช่วยเหลือ กรุณาโทรศัพท์ตามหมายเลขที่ระบุอยู่ด้านหลังบัตรประจำตัวของคุณ หรือ ที่หมายเลข 1-866-346-7198 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรมาที่ กรมการประกันภัยแห่งมลรัฐแคลิฟอร์เนียที่หมายเลข 1-800-927-4357 Thai

निःशुल्क भाषा सेवाएँ। आप एक दुभाषिया की सेवा प्राप्त कर सकते हैं। आप दस्तावेजों को पढ़वा के सुन सकते हैं और कुछ को अपनी भाषा में स्वयं को भिजवा सकते हैं। सहायता के लिए, अपने ID कार्ड पर दिए गए नंबर पर, या 1-866-346-7198 पर हमें फ़ोन करें। अधिक सहायता के लिए कैलीफोर्निया बीमा विभाग (CA Dept. of Insurance) को 1-800-927-4357 पर फ़ोन करें। Hindi

Doo bááh ílínígó saad bee yát'i' bee aná'áwo'. Díí shá ata'halne'dooígí hóló̱o̱doo nínízingo éí bíighah. Naaltsoos naanin——áhájeehígí shich'į' yíidooltah éí doodagó ła' shich'į' ádoolníił nínízingo bíighah. Shíká a'doowoł nínízingo nihich'į' béésh bee hodíilnih dóó námboo éí díí ninaaltsoos dootł'ízhígí bee néího'dílzinígí bine'déé' bikáá' éí doodagó éí (866)346-7198jį' hodíilnih. Hózhó shíká anáá'doowoł nínízingo éí díí béeso ách'a̱ah naa'nil bił haz'á̱ą́jį' 1-800-927-4357jį' hodíilnih. Navajo

ບໍລິການແປພາສາໂດຍບໍ່ເສຍຄ່າ. ທ່ານສາມາດຂໍເອົາຜູ້ແປພາສາໄດ້. ທ່ານສາມາດຂໍໃຫ້ອ່ານເອກະສານໃຫ້ທ່ານຟັງ ແລະ ສົ່ງເອກະ-ສານບາງຢ່າງທີ່ເປັນພາສາຂອງທ່ານ. ສໍາລັບຄວາມຊ່ວຍເຫຼືອ, ໃຫ້ໂທຫາພວກເຮົາຕາມເບີໂທລະສັບທີ່ມີໃນບັດປະຈໍາຕົວຂອງທ່ານ ຫຼື ໂທຫາເບີ1-866-346-7198. ສໍາລັບຄວາມຊ່ວຍເຫຼືອເພີ່ມເຕີມໂທຫາ ພະແນກ ປະກັນໄພຂອງລັດຄາລິຟໍເນຍໄດ້ທີ່ເບີ1-800-927-4357. Laotian