Small Business Subscriber Change Request
Blue Shield of California and Blue Shield of California Life & Health Insurance Company

July 1, 2021

All change requests must be received within 31 days of the effective date of the change. This form is used to request changes in personal information, add/cancel dependent coverage, or change plans during open enrollment. For employees requesting a new primary care physician (HMO plans), visit **blueshieldca.com** or call Blue Shield at the number on the back of your Blue Shield member ID card.

Which changes are you making? (select all that apply)

☐ Subscriber address	☐ Date of birth	☐ Dependent address change	☐ Date of hire
☐ Phone/Email address change	☐ Social Security Number	☐ Dependent addition coverage	☐ Waiving coverage
☐ Subscriber name change	☐ Dependent name change	☐ Effective date update	☐ Plan change

Subscriber information – All information requested in this section is required for all changes.

Enrolled employee (subscriber) name	Blue Shield subscriber ID number	
Social Security number (required per CMS)	Employment status ☐ Full time (30 hrs) ☐ Part time (20-29 hrs) ☐ COBRA/Cal-COBRA beneficiary	
Group/employer name	Blue Shield Group ID (from ID card)	Requested effective date

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) Reset	
☐ 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

Member information update

Address change

Please complete this section to update your address. Include both your full previous and full new address. HMO plans: If you have moved outside your primary care physician's service area, you will need to change primary care physician. Visit **blueshieldca.com**, or call Blue Shield at the number on your ID card for more information.

Old address	City	State	ZIP code	County
New address	City	State	ZIP code	County

Dependent name (if address change is applicable for dependent only):

Phone/email address change

Please complete this section to update your phone or email address information with Blue Shield.

Old phone number	☐ Work ☐ Home	Old email address
New phone number	☐ Work ☐ Home	New email address

Subscriber name	Subscriber ID number	Employer name

Employee name change – documentation may be required

Note: A copy of court order, marriage license, driver's license, or ID card are examples of required documentation.

Old name	New name

Reason for change: ☐ Marriage ☐ Divorce ☐ Other (please specify):	Documentation attached? ☐ Yes ☐ No

Date of birth correction – documentation required

Note: A copy of the driver's license, ID card, or birth certificate are examples of required documentation.

Member's name	Date of birth	Documentation attached? ☐ Yes ☐ No

Social Security number correction/change – documentation required

A copy of the Social Security card, letter of verification from the Social Security Office, and a written statement explaining the reason for the change are examples of required documentation.

Old Social Security number	New Social Security number	Documentation attached? ☐ Yes ☐ No

Member eligibility changes

Dependent addition of coverage

Please complete this section to add a spouse, domestic partner, or dependent child to the employee's coverage. Please copy and attach additional pages as needed if adding multiple dependents. The request must be received within the time frame allowed per the qualifying event, or during the group's open enrollment period. Documentation is required to verify the date of the qualifying event, including for loss of coverage, adoption, or court-ordered coverage. A completed **Refusal of Coverage (C19927)** is required for any dependent that is refusing coverage under the plan. **Note:** Social Security number is required per CMS.

Dependent 1

Relationship to employee	**Reason for addition**	**Event date**
☐ Dependent child ☐ Spouse/domestic partner ☐ Dependent child: legal guardianship	☐ Newborn ☐ Adoption* ☐ Court order* ☐ Marriage ☐ Domestic partnership ☐ Loss of coverage† ☐ Open enrollment	
	* Court order required. † Documentation required.	

Social Security number	Date of birth	Gender: ☐ Male ☐ Female

Which Race does this dependent identify with?	Which Ethnicity does this dependent identify with?

First name	**MI**	**Last name**	**Suffix**

Address (if different from employee)	City	State	ZIP code

Was the dependent covered under another health insurance plan within the past 12 months? ☐ Yes ☐ No If yes, please specify carrier and plan name, start and end dates of coverage: Carrier and plan name: to

HMO provider name	HMO provider number	IPA/MG name	Current patient? ☐ Yes ☐ No

Dental HMO provider name	Dental HMO provider number	Current patient? ☐ Yes ☐ No

Enrolling in same products selected by subscriber? ☐ Yes ☐ No	If no, please attach completed Refusal of Coverage form.

Subscriber name	Subscriber ID number	Employer name

Dependent 2

Relationship to employee	**Reason for addition**		**Event date**
☐ Dependent child ☐ Spouse/domestic partner ☐ Dependent child: legal guardianship	☐ Newborn ☐ Adoption* ☐ Court order* ☐ Marriage	☐ Domestic partnership ☐ Loss of coverage† ☐ Open enrollment	
	* Court order required. † Documentation required.		

Social Security number	Date of birth	Gender: ☐ Male ☐ Female
Which Race does this dependent identify with?	Which Ethnicity does this dependent identify with?	

First name	**MI**	**Last name**	**Suffix**

Address (if different from employee)	City	State	ZIP code

Was the dependent covered under another health insurance plan within the past 12 months? ☐ Yes ☐ No If yes, please specify carrier and plan name, start and end dates of coverage: Carrier and plan name: to

HMO provider name	HMO provider number	IPA/MG name	Current patient? ☐ Yes ☐ No

Dental HMO provider name	Dental HMO provider number	Current patient? ☐ Yes ☐ No

Enrolling in same products selected by subscriber? ☐ Yes ☐ No | If no, please attach completed Refusal of Coverage form.

Dependent cancellation of coverage

Please complete this section to cancel all Blue Shield coverage for a dependent spouse, domestic partner, or child due to loss of eligibility. If any dependents being cancelled remain eligible for coverage, or if coverage is being partially cancelled (not all plans), a completed Refusal of Coverage form is required for those plans being declined/cancelled.

Relationship to employee	**Reason for cancellation**		**Event date**
☐ Dependent child ☐ Spouse/domestic partner	☐ Divorce ☐ Death ☐ Military deployment	☐ Other insurance coverage ☐ Termination of domestic partnership	

Social Security number	Date of birth	Gender: ☐ Male ☐ Female

First name	MI	Last name	Suffix

Address (if different from employee)	City	State	ZIP code

Cancel coverage for all Blue Shield plans? ☐ Yes ☐ No If no, please attach completed Refusal of Coverage form.

Relationship to employee	**Reason for cancellation**		**Event date**
☐ Dependent child ☐ Spouse/domestic partner	☐ Divorce ☐ Death ☐ Military deployment	☐ Other insurance coverage ☐ Termination of domestic partnership	

Social Security number	Date of birth	Gender: ☐ Male ☐ Female

First name	MI	Last name	Suffix

Address (if different from employee)	City	State	ZIP code

Cancel coverage for all Blue Shield plans? ☐ Yes ☐ No If no, please attach completed Refusal of Coverage form.

Relationship to employee	**Reason for cancellation**		**Event date**
☐ Dependent child ☐ Spouse/domestic partner	☐ Divorce ☐ Death ☐ Military deployment	☐ Other insurance coverage ☐ Termination of domestic partnership	

Social Security number	Date of birth	Gender: ☐ Male ☐ Female

First name	MI	Last name	Suffix

Address (if different from employee)	City	State	ZIP code

Cancel coverage for all Blue Shield plans? ☐ Yes ☐ No If no, please attach completed Refusal of Coverage form.

Subscriber name	Subscriber ID number	Employer name

Plan changes

Plan change request

Please indicate the requested changes to coverage through an annual or special open enrollment period by completing all sections below for medical plan and specialty plan options.

Medical benefit plans: Please check with your employer to determine the benefit plans available to you.

☐ **No change to medical benefits.**

Blue Shield of California Off-Exchange Package Plans

PPO plans – Full PPO Network

- ☐ Platinum Full PPO 0/0 OffEx
- ☐ Platinum Full PPO 0/10 OffEx
- ☐ Platinum Full PPO 250/10 OffEx
- ☐ Platinum Full PPO 250/15 OffEx
- ☐ Gold Full PPO 0/25 OffEx
- ☐ Gold Full PPO 500/30 OffEx
- ☐ Gold Full PPO 750/30 OffEx
- ☐ Gold Full PPO 1200/35 OffEx
- ☐ Silver Full PPO 1950/50 OffEx
- ☐ Silver Full PPO 2225/50 OffEx*
- ☐ Silver Full PPO 2400/55 OffEx
- ☐ Bronze Full PPO 6250/70 OffEx
- ☐ Bronze Full PPO 6850/65 OffEx
- ☐ Bronze Full PPO 7500/50 OffEx

HSA-compatible HDHP plans – Full PPO Network

- ☐ Gold Full PPO Savings 1750/15% OffEx
- ☐ Silver Full PPO Savings 2100/25% OffEx
- ☐ Silver Full PPO Savings 2600/35% OffEx
- ☐ Bronze Full PPO Savings 5700/40% OffEx
- ☐ Bronze Full PPO Savings 7000 OffEx

HSA-compatible HDHP plans – Tandem PPO Network

- ☐ Gold Tandem PPO Savings 1750/15% OffEx
- ☐ Silver Tandem PPO Savings 2100/25% OffEx
- ☐ Silver Tandem PPO Savings 2600/35% OffEx
- ☐ Bronze Tandem PPO Savings 5700/40% OffEx
- ☐ Bronze Tandem PPO Savings 7000 OffEx

Tandem PPO plans – Tandem PPO Network

- ☐ Platinum Tandem PPO 0/0 OffEx
- ☐ Platinum Tandem PPO 0/10 OffEx
- ☐ Platinum Tandem PPO 250/10 OffEx
- ☐ Platinum Tandem PPO 250/15 OffEx
- ☐ Gold Tandem PPO 0/25 OffEx
- ☐ Gold Tandem PPO 500/30 OffEx
- ☐ Gold Tandem PPO 750/30 OffEx
- ☐ Gold Tandem PPO 1200/35 OffEx
- ☐ Silver Tandem PPO 1950/50 OffEx
- ☐ Silver Tandem PPO 2225/50 OffEx*
- ☐ Silver Tandem PPO 2400/55 OffEx
- ☐ Bronze Tandem PPO 6250/70 OffEx
- ☐ Bronze Tandem PPO 6850/65 OffEx
- ☐ Bronze Tandem PPO 7500/50 OffEx

Access+ HMO plans – Access+ HMO Network

- ☐ Platinum Access+ HMO® 0/20 OffEx
- ☐ Platinum Access+ HMO® 0/25 OffEx
- ☐ Platinum Access+ HMO® 0/30 OffEx
- ☐ Gold Access+ HMO® 0/30 OffEx
- ☐ Gold Access+ HMO® 500/35 OffEx
- ☐ Gold Access+ HMO® 1000/35 OffEx
- ☐ Gold Access+ HMO® 1500/35 OffEx
- ☐ Silver Access+ HMO® 2350/65 OffEx

Local Access+ HMO plans – Local Access+ HMO Network

- ☐ Platinum Local Access+ HMO® 0/20 OffEx
- ☐ Platinum Local Access+ HMO® 0/25 OffEx
- ☐ Platinum Local Access+ HMO® 0/30 OffEx
- ☐ Gold Local Access+ HMO® 0/30 OffEx
- ☐ Gold Local Access+ HMO® 500/35 OffEx
- ☐ Gold Local Access+ HMO® 1000/35 OffEx
- ☐ Gold Local Access+ HMO® 1500/35 OffEx
- ☐ Silver Local Access+ HMO® 2350/65 OffEx

Trio HMO plans – Trio ACO HMO Network

- ☐ Platinum Trio HMO 0/20 OffEx
- ☐ Platinum Trio HMO 0/25 OffEx
- ☐ Platinum Trio HMO 0/30 OffEx
- ☐ Gold Trio HMO 0/30 OffEx
- ☐ Gold Trio HMO 500/35 OffEx
- ☐ Gold Trio HMO 1000/35 OffEx
- ☐ Gold Trio HMO 1500/35 OffEx
- ☐ Silver Trio HMO 2350/65 OffEx

Blue Shield of California Mirror Package Plans

- ☐ Blue Shield Trio Platinum 90 HMO 0/20 + Child Dental
- ☐ Blue Shield Platinum 90 PPO 0/15 + Child Dental
- ☐ Blue Shield Gold 80 PPO 350/25 + Child Dental
- ☐ Blue Shield Trio Gold 80 HMO 250/35 + Child Dental
- ☐ Blue Shield Trio Silver 70 HMO 2250/55 + Child Dental
- ☐ Blue Shield Silver 70 PPO 2250/50 + Child Dental
- ☐ Blue Shield Bronze 60 PPO 6300/65 + Child Dental

* The Silver Full PPO 2225/50 OffEx and Silver Tandem PPO 2225/50 OffEx offer enhanced coverage for members diagnosed with diabetes, asthma, COPD, and CAD.

Subscriber name	Subscriber ID number	Employer name

Specialty benefit plans – dental,* vision,* and life insurance* plan selection

* Only benefits your employer group offers are available for selection. Any benefits selected that are not offered by your employer group will be omitted from your enrollment.

Section SB1 – Dental benefits

Dental HMO plans

☐ DHMO Basic	☐ DHMO Standard	☐ DHMO Plus	☐ DHMO Deluxe	☐ DHMO Voluntary

Dental PPO plans

- ☐ Smile℠ Value 50/1500/No Ortho/MAC/NR
- ☐ Smile℠ 50/1500/No Ortho/MAC/NR
- ☐ Smile℠ Plus 50/1500/Ortho/MAC/NR
- ☐ Smile℠ Basic 75/1000/No Ortho/MAC/NR
- ☐ Smile℠ Basic 50/1000/No Ortho/MAC
- ☐ Smile℠ Basic 50/1000/Ortho/U85
- ☐ Smile℠ Plus 50/1500/No Ortho/MAC
- ☐ Smile℠ Plus 50/1500/No Ortho/MAC/WP*
- ☐ Smile℠ Deluxe 50/1500/Ortho/MAC/NR
- ☐ Smile℠ Deluxe 2000 50/2000/No Ortho/MAC/NR
- ☐ Smile℠ Deluxe Plus 2000 50/2000/Ortho/MAC/NR
- ☐ Smile℠ Deluxe Gold 50/1500/Ortho/U85/NR
- ☐ Smile℠ Plus Gold 50/1500/Ortho/U85/NR
- ☐ Smile℠ Plus Gold 50/1500/Ortho/U80
- ☐ Smile℠ Plus Gold 50/1500/No Ortho/U80
- ☐ Smile℠ Plus Gold 50/1500/Ortho/U80/ADV
- ☐ Smile℠ Plus Gold 50/1500/Ortho/U90/ADV
- ☐ Smile℠ Plus Gold 50/1500/No Ortho/U90/ADV
- ☐ Smile℠ Plus Gold 50/2500/Ortho/U90/ADV
- ☐ Smile℠ Plus Gold 50/2500/No Ortho/U90/ADV
- ☐ Ultimate Dental Plus PPO for Small Business 50/2000/Ortho/MAC/NR
- ☐ Ultimate Dental PPO for Small Business 50/2000/No Ortho/MAC/NR
- ☐ Ultimate Dental PPO for Small Business 50/2000/No Ortho/U80
- ☐ Ultimate Dental PPO for Small Business 50/2000/Lifetime Ortho/U90
- ☐ Ultimate Dental PPO for Small Business 50/2000/No Ortho/U90

Voluntary Dental PPO Plans*

- ☐ Smile℠ Basic Voluntary 75/1000/No Ortho/MAC/NR
- ☐ Smile℠ Basic Voluntary 50/1000/No Ortho/MAC
- ☐ Smile℠ Basic Voluntary 50/1500/Ortho/U80
- ☐ Smile℠ Basic Voluntary 50/1000/No Ortho/U80 (No Wait)†

Dental In-Network Only (INO) plans† (only available for groups enrolled in these plans prior to 12/31/2018)

- ☐ Smile℠ INO Dental Plan 50/1500/Endo-Perio 80%/Ortho
- ☐ Smile℠ INO Dental Plan 50/1500/Endo-Perio 80%/No Ortho
- ☐ Smile℠ INO Dental Voluntary Plan 50/1500/Endo-Perio 50%/Ortho*
- ☐ Smile℠ INO Dental Voluntary Plan 50/1500/Endo-Perio 50%/No Ortho*
- ☐ Smile℠ INO Dental Plan 50/2500/Endo-Perio 80%/Ortho
- ☐ Smile℠ INO Dental Plan 50/2500/Endo-Perio 80%/No Ortho
- ☐ Smile℠ INO Dental Voluntary Plan 50/2500/Endo-Perio 50%/Ortho*
- ☐ Smile℠ INO Dental Voluntary Plan 50/2500/Endo-Perio 50%/No Ortho*

Dental PPO plans (only available for groups enrolled in these plans prior to 12/31/2018)

- ☐ Ultimate Dental PPO for Small Business 50/2000/MAC
- ☐ Ultimate Dental Plus PPO for Small Business 50/2000/MAC
- ☐ Smile℠ Deluxe 2000 50/2000/No Ortho/MAC
- ☐ Smile℠ Deluxe Plus 2000 50/2000/Ortho/MAC
- ☐ Smile℠ Deluxe 50/1500/Ortho/MAC
- ☐ Smile℠ Deluxe Gold 50/1500/Ortho/U85
- ☐ Smile℠ 50/1500/No Ortho/MAC
- ☐ Smile℠ Plus 50/1500/Ortho/MAC
- ☐ Smile℠ Value 50/1500/No Ortho/MAC
- ☐ Smile℠ Plus Gold 50/1500/Ortho/U85
- ☐ Smile℠ Basic 75/1000/No Ortho/MAC
- ☐ Smile℠ Basic Voluntary 75/1000/No Ortho/MAC

* Voluntary dental plans require a minimum of one (1) enrolling, eligible employee.

† This Voluntary plan does not include Waiting Periods and submission of proof of any prior coverage is not required.

ADV stands for Advantage. ADV plans incentivize members to use in-network providers. NR stands for No Rollover.

Section SB2 – Vision coverage

Vision coverage*

Ultimate Vision for Small Business (12-12-12)	Preferred Vision for Small Business (12-12-24)	Basic Vision for Small Business (12-24-24)
☐ Ultimate Vision Plus 0/0/150/120	☐ Preferred Vision Plus 0/0/150/120	☐ Basic Vision Plus 0/0/150/120
☐ Ultimate Vision 0/0/150	☐ Preferred Vision 0/0/150	☐ Basic Vision 0/0/150
☐ Ultimate Vision Plus 10/25/150/120	☐ Preferred Vision Plus 10/25/150/120	☐ Basic Vision Plus 10/25/150/120
☐ Ultimate Vision 10/25/150	☐ Preferred Vision 10/25/150	☐ Basic Vision 10/25/150
☐ Ultimate Vision 0/0/120	☐ Preferred Vision 0/0/120	☐ Basic Vision 0/0/120
☐ Ultimate Vision 10/25/120	☐ Preferred Vision 10/25/120	☐ Basic Vision 10/25/120
☐ Ultimate Vision Voluntary 10/25/150[1]	☐ Preferred Vision Voluntary 10/25/120[1]	☐ Basic Vision Voluntary 10/25/120[1]

☐ Other (please specify) _____

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

1 Voluntary vision plans require a minimum of one (1) enrolling, eligible employee.

Subscriber name	Subscriber ID number	Employer name

Section SB3 – Life/AD&D insurance

Group term life insurance*

Employee information

Full-time employment date	Average hours worked per week	Rehire date	Class/occupation	Earnings $ _____ (excluding overtime, bonuses, etc.) ☐ Hour ☐ Week ☐ Month ☐ Year

Designation of beneficiary

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 stated beneficiary designation(s).

Spouse/domestic partner signature _____ Date _____

Spouse/domestic partner name (please print)

Primary beneficiary – Blue Shield Life will pay the life insurance benefits to the primary beneficiary/beneficiaries identified. An employee may designate more than one primary beneficiary. Please show percentages for each primary beneficiary in the "% of benefits" column to total 100% of benefits. If the percentage is not defined, the benefits will be distributed equally to those primary beneficiaries who survive the employee. To designate more than two primary beneficiaries, please provide on a separate sheet of paper, which is signed and dated by the employee, and attach to this form.

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

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

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

Employee and dependent benefit amounts

Please contact your benefits administrator for more information regarding your group life insurance coverage. Coverage granted to individuals listed in this enrollment form shall be subject to all provisions and limitations stated in the Blue Shield of California Life & Health Insurance Company group life insurance policy.

Employee Basic Life and AD&D Insurance amount: $ _____	Amount of coverage requested for dependent(s): $ _____
Number of eligible dependents: _____	Basic Dependent Life Insurance: ☐ Yes ☐ No

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

If transferring to medical HMO and/or dental HMO plan(s), provide primary care physician/dental provider information below.*
Please complete this section for the subscriber and all of their dependents if they have a preferred provider. If no provider is received, a provider will be assigned for each member enrolled.

Last name	MI	First name	Sex ☐ Male ☐ Female	Date of birth
HMO provider name	HMO provider number	Independent Practice Association/medical group		Current patient? ☐ Yes ☐ No
Dental HMO provider name	Dental HMO provider number			Current patient? ☐ Yes ☐ No
Last name	MI	First name	Sex ☐ Male ☐ Female	Date of birth
HMO provider name	HMO provider number	Independent Practice Association/medical group		Current patient? ☐ Yes ☐ No
Dental HMO provider name	Dental HMO provider number			Current patient? ☐ Yes ☐ No

Subscriber name	Subscriber ID number	Employer name

Last name	MI	First name	Sex ☐ Male ☐ Female	Date of birth
HMO provider name	HMO provider number	Independent Practice Association/medical group		Current patient? ☐ Yes ☐ No
Dental HMO provider name	Dental HMO provider number			Current patient? ☐ Yes ☐ No
Last name	MI	First name	Sex ☐ Male ☐ Female	Date of birth
HMO provider name	HMO provider number	Independent Practice Association/medical group		Current patient? ☐ Yes ☐ No
Dental HMO provider name	Dental HMO provider number			Current patient? ☐ Yes ☐ No

* Please note: If Blue Shield is unable to assign the primary care physician and/or dental HMO provider you requested, Blue Shield will designate a provider at random. HMO primary care physicians can be changed by visiting **blueshieldca.com** after enrollment.

Acknowledgement and signature

I acknowledge and agree: All information I have provided on this form is accurate and complete to the best of my knowledge and belief. I understand that this form, along with any prior enrollment form, the *Evidence of Coverage/Certificate of Insurance* and Health Service Agreement/Policy, and any endorsements and attachments thereto, collectively constitutes the entire agreement for coverage.

Signature of employee _____ **Date** _____

Print employee name _____

If faxing this form, keep this document for your files.

Blue Shield of California protects the privacy of your personal information, including your individually identifiable health information. We will not disclose your personal information without your authorization, except as permitted or required by law. To obtain a copy of Blue Shield's Notice of Privacy Practices, call the customer service number on your Blue Shield member ID card or visit our website at **blueshieldca.com/bsca/documents/about-blue-shield/privacy**.

PLEASE BE SURE TO RETURN ALL PAGES OF THIS FORM. Missing information or pages may delay processing.
Complete your Subscriber Change Request form at blueshieldca.com.

Blue Shield of California

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

Blue Shield of California 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 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 of California:

- 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 of California Civil Rights Coordinator.

If you believe that Blue Shield of California 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
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 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

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For help at no cost, please call right away at the Member/Customer Service telephone number on the back of your Blue Shield ID card, or (866) 346-7198.

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda sin cargo, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Blue Shield o al (866) 346-7198. (Spanish)

重要通知：您能讀懂這封信嗎？如果不能，我們可以請人幫您閱讀。這封信也可以 用您所講的語言書寫。如需免费幫助，請立即撥打登列在您的Blue Shield ID卡背面上的 會員/客戶服務部的電話，或者撥打電話 (866) 346-7198。(Chinese)

QUAN TRỌNG: Quý vị có thể đọc lá thư này không? Nếu không, chúng tôi có thể nhờ người giúp quý vị đọc thư. Quý vị cũng có thể nhận lá thư này được viết bằng ngôn ngữ của quý vị. Để được hỗ trợ miễn phí, vui lòng gọi ngay đến Ban Dịch vụ Hội viên/Khách hàng theo số ở mặt sau thẻ ID Blue Shield của quý vị hoặc theo số (866) 346-7198. (Vietnamese)

MAHALAGA: Nababasa mo ba ang sulat na ito? Kung hindi, maari kaming kumuha ng isang tao upang matulungan ka upang mabasa ito. Maari ka ring makakuha ng sulat na ito na nakasulat sa iyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa numerong telepono ng Miyembro/Customer Service sa likod ng iyong Blue Shield ID kard, o (866) 346-7198. (Tagalog)

Baa' ákohwiindzindooígí: Díí naaltsoosísh yíiníłta'go bíiníghah? Doo bíiníghahgóó éí, naaltsoos nich'į' yiidóołtahígíí ła' nihee hóló. Díí naaltsoos ałdó' t'áá Diné k'ehjí ádoolníił nínízingo bíighah. Doo bąąh ílínígó shíká' adoowoł nínízingó nihich'į' béésh bee hodíilnih dóó námboo éí díí Blue Shield bee néího'dílzinígí bine'déé' bikáá' éí doodagó éí (866) 346-7198 jį' hodíilnih. (Navajo)

중요: 이 서신을 읽을 수 있으세요? 읽으실 수 경우, 도움을 드릴 수 있는 사람이 있습니다. 또한 다른 언어로 작성된 이 서신을 받으실 수도 있습니다. 무료로 도움을 받으시려면 Blue Shield ID 카드 뒷면의 회원/고객 서비스 전화번호 또는 (866) 346-7198로 지금 전환하세요. (Korean)

ԿԱՐԵՎՈՐ Է. Կարողանում ե՞ք կարդալ այս նամակը: Եթե ոչ, ապա մենք կօգնենք ձեզ: Դուք պետք է նաև կարողանաք ստանալ այս նամակը ձեր լեզվով: Ծառայությունն անվճար է: Խնդրում ենք անմիջապես զանգահարել Հաճախորդների սպասարկման բաժնի հեռախոսահամարով, որը նշված է ձեր Blue Shield ID քարտի ետևի մասում, կամ (866) 346-7198 համարով: (Armenian)

ВАЖНО: Не можете прочесть данное письмо? Мы поможем вам, если необходимо. Вы также можете получить это письмо написанное на вашем родном языке. Позвоните в Службу клиентской/членской поддержки прямо сейчас по телефону, указанному сзади идентификационной карты Blue Shield, или по телефону (866) 346-7198, и вам помогут совершенно бесплатно. (Russian)

重要：お客様は、この手紙を読むことができますか？ もし読むことができない場合、弊社が、お客様をサポートする人物を手配いたします。 また、お客様の母国語で書かれた手紙をお送りすることも可能です。 無料のサポートを希望される場合は、Blue Shield IDカードの裏面に記載されている会員/お客様サービスの電話番号、または、(866) 346-7198にお電話をおかけください。 (Japanese)

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر پاسختان منفی است، می‌توانیم کسی را برای کمک به شما در اختیارتان قرار دهیم. حتی می‌توانید نسخه مکتوب این نامه را به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، لطفاً بدون فوت وقت از طریق شماره تلفنی که در پشت کارت شناسی Blue Shield تان درج شده است و یا از طریق شماره تلفن 346-7198 (866) با خدمات اعضا/مشتری تماس بگیرید. (Persian)

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ ਤਾਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿਚ ਮਦਦ ਲਈ ਅਸੀਂ ਕਿਸੇ ਵਿਅਕਤੀ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਵਿਚ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਤੁਹਾਡੇ Blue Shield ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਮੈਂਬਰ/ਕਸਟਮਰ ਸਰਵਿਸ ਟੈਲੀਫ਼ੋਨ ਨੰਬਰ ਤੇ, ਜਾਂ (866) 346-7198 ਤੇ ਕਾੱਲ ਕਰੋ। (Punjabi)

ប្រការសំខាន់៖ តើអ្នកអាចលិខិតនេះ បានដែរឬទេ? បើមិនអាចទេ យើងអាចឲ្យគេជួយអ្នកក្នុងការអានលិខិតនេះ។ អ្នកក៏អាចទទួលបានលិខិតនេះជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅកាន់លេខទូរស័ព្ទសេវាសមាជិក/អតិថិជនដែលមាននៅលើខ្នងប័ណ្ណសម្គាល់ Blue Shield របស់អ្នក ឬតាមរយៈលេខ (866) 346-7198។ (Khmer)

المهم :هل تستطيع قراءة هذا الخطاب؟ أن لم تستطع قراءته، يمكننا إحضار شخص ما ليساعدك في قراءته. قد تحتاج أيضاً إلى الحصول على هذا الخطاب مكتوباً بلغتك. للحصول على المساعدة بدون تكلفة، يرجى الاتصال الآن على رقم هاتف خدمة العملاء/أحد الأعضاء المدون على الجانب الخلفي من بطاقة الهوية Blue Shield أو على الرقم 346-7198 (866).(Arabic)

TSEEM CEEB: Koj pos tuaj yeem nyeem tau tsab ntawv no? Yog hais tias nyeem tsis tau, peb tuaj yeem nrhiav ib tug neeg los pab nyeem nws rau koj. Tej zaum koj kuj yuav tau txais muab tsab ntawv no sau ua koj hom lus. Rau kev pab txhais dawb, thov hu kiag rau tus xov tooj Kev Pab Cuam Tub Koom Xeeb/Tub Lag Luam uas nyob rau sab nraum nrob qaum ntawm koj daim npav Blue Shield ID, los yog hu rau tus xov tooj (866) 346-7198. (Hmong)

สำคัญ: คุณอ่านจดหมายฉบับนี้ได้หรือไม่ หากไม่ได้ โปรดขอความช่วยจากผู้อ่านได้ คุณอาจได้รับจดหมายฉบับนี้เป็นภาษาของคุณ หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดติดต่อฝ่ายบริการลูกค้า/สมาชิกทางเบอร์โทรศัพท์ในบัตรประจำตัว Blue Shield ของคุณ หรือโทร (866) 346-7198 (Thai)

महत्वपूर्ण: क्या आप इस पत्र को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी मदद के लिए किसी व्यक्ति का प्रबंध कर सकते हैं। आप इस पत्र को अपनी भाषा में भी प्राप्त कर सकते हैं। नि:शुल्क मदद प्राप्त करने के लिए अपने Blue Shield ID कार्ड के पीछे दिए गये मेंबर/कस्टमर सर्विस टेलीफोन नंबर, या (866) 346-7198 पर कॉल करें। (Hindi)

ສິ່ງສຳຄັນ: ທ່ານສາມາດອ່ານຈົດໝາຍນີ້ໄດ້ບໍ? ຖ້າອ່ານບໍ່ໄດ້, ພວກເຮົາສາມາດໃຫ້ບາງຄົນຊ່ວຍອ່ານໃຫ້ທ່ານຟັງໄດ້. ທ່ານຍັງສາມາດຂໍໃຫ້ແປຈົດໝາຍນີ້ເປັນພາສາຂອງທ່ານໄດ້.ສຳລັບຄວາມຊ່ວຍເຫຼືອແບບບໍ່ເສຍຄ່າ, ກະລຸນາ ໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກ/ລູກຄ້າໃນທັນທີເບີໂທລະສັບຢູ່ດ້ານຫຼັງບັດສະມາຊິກ Blue Shield ຂອງທ່ານ, ຫຼືໂທໄປຫາເບີ(866) 346-7198. (Laotian)

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'a̱a̱h naa'nil bił haz'á̱a̱jį' 1-800-927-4357jį' hodíilnih. Navajo

ບໍລິການແປພາສາໂດຍບໍ່ເສຍຄ່າ. ທ່ານສາມາດຂໍເອົາຜູ້ແປພາສາໄດ້. ທ່ານສາມາດຂໍໃຫ້ອ່ານເອກະສານໃຫ້ທ່ານຟັງ ແລະ ສົ່ງເອກະສານບາງຢ່າງທີ່ເປັນພາສາຂອງທ່ານ. ສໍາລັບຄວາມຊ່ວຍເຫຼືອ, ໃຫ້ໂທຫາພວກເຮົາຕາມເບີໂທລະສັບທີ່ມີໃນບັດປະຈໍາຕົວຂອງທ່ານ ຫຼື ໂທຫາເບີ1-866-346-7198. ສໍາລັບຄວາມຊ່ວຍເຫຼືອເພີ່ມເຕີມໂທຫາ ພະແນກ ປະກັນໄພຂອງ ລັດຄາລິຟໍເນຍໄດ້ທີ່ເບີ1-800-927-4357. Laotian