Employee Change Form
EmployeeElect for 1–50 Employee Small Groups
California

Instructions:

If you are cancelling coverage for a dependent or changing a name, please provide a reason in the designated sections. Complete electronically, or in blue or black ink and return to your employer. Please use extra sheets of paper if necessary.

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

Reset Form | Save and Print

Section A: General Information

Employer name			Group no.
Employee last name	Employee first name	M.I.	Employee Social Security no.* (required)

Language choice (optional): ☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Vietnamese ☐ Tagalog ☐ Other – please specify: _____

Do you read and write English? ☐ Yes ☐ No If no, the translator must sign and submit a Statement of Accountability.

Section B: Employee Information – Required

Reason for change – Required. Check all that apply.

☐ Address change ☐ Add spouse/Domestic Partner or dependent ☐ Enrollment in Medicare (Fill in Section E) ☐ Cancel coverage
☐ Name change ☐ Cancel spouse/Domestic Partner or dependent ☐ COBRA
☐ Benefit change ☐ Change Primary Care Physician (PCP) ☐ Cal-COBRA ☐ Other: _____

☐ Add
☐ Change
☐ Cancel (Complete Section F)

Event reason – Required. Check all that apply.
☐ Open enrollment (not applicable for Life) ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage
☐ Other insurance ☐ Death ☐ Divorce ☐ Other – please explain: _____

Event date – Required _____ (MM/DD/YYYY)

Home address – Street and PO Box if applicable	City	State	ZIP code

Birthdate (MM/DD/YYYY)	Sex ☐ Male ☐ Female	Marital status ☐ Single ☐ Married ☐ Domestic Partner (DP)	Number of dependents

Phone no.	Email address	Occupation

PCP name (if selecting an HMO plan)	PCP ID no. (if selecting an HMO plan)	Existing patient? ☐ Yes ☐ No

Section C: Family Information – Spouse/Domestic Partner and dependents to be added/changed/cancelled. Attach a separate sheet if necessary.

☐ Add
☐ Change
☐ Cancel (Complete Section F)

Event reason – Required. Check all that apply.
☐ Open enrollment (not applicable for Life) ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage
☐ Other insurance ☐ Death ☐ Divorce ☐ Other – please explain: _____

Event date – Required _____ (MM/DD/YYYY)

Spouse/Domestic Partner last name	First name	M.I.	Social Security no.* (required)

Sex ☐ Male ☐ Female	Disabled? ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Spouse ☐ Domestic Partner

PCP name (if selecting an HMO plan)	PCP ID no. (if selecting an HMO plan)	Existing patient? ☐ Yes ☐ No

Does the Spouse/Domestic Partner have a different address? ☐ Yes ☐ No **If yes, please provide full address and ZIP code:**

Street address, if different	City	State	ZIP code

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

Life products underwritten by Anthem Blue Cross Life and Health Insurance Company. Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Employee name	Social Security no.

Section C: Family Information – Continued

☐ Add
☐ Change
☐ Cancel (Complete Section F)

Event reason – Required. Check all that apply.
☐ Open enrollment (not applicable for Life) ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage
☐ Other insurance ☐ Death ☐ Divorce ☐ Other – please explain: _____

Event date – Required _____ (MM/DD/YYYY)

Dependent last name	First name	M.I.	Social Security no.* (required)

Sex	Disabled	Birthdate (MM/DD/YYYY)	Relationship to applicant
☐ Male ☐ Female	☐ Yes ☐ No		☐ Child ☐ Other If other, what is relationship? _____

PCP name (if selecting an HMO plan)	PCP ID no. (if selecting an HMO plan)	Existing patient?
		☐ Yes ☐ No

Does this dependent have a different address? ☐ Yes ☐ No If yes, please provide full address and ZIP code:

Street address, if different	City	State	ZIP code

☐ Add
☐ Change
☐ Cancel (Complete Section F)

Event reason – Required. Check all that apply.
☐ Open enrollment (not applicable for Life) ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage
☐ Other insurance ☐ Death ☐ Divorce ☐ Other – please explain: _____

Event date – Required _____ (MM/DD/YYYY)

Dependent last name	First name	M.I.	Social Security no.* (required)

Sex	Disabled	Birthdate (MM/DD/YYYY)	Relationship to applicant
☐ Male ☐ Female	☐ Yes ☐ No		☐ Child ☐ Other If other, what is relationship? _____

PCP name (if selecting an HMO plan)	PCP ID no. (if selecting an HMO plan)	Existing patient?
		☐ Yes ☐ No

Does this dependent have a different address? ☐ Yes ☐ No If yes, please provide full address and ZIP code:

Street address, if different	City	State	ZIP code

☐ Add
☐ Change
☐ Cancel (Complete Section F)

Event reason – Required. Check all that apply.
☐ Open enrollment (not applicable for Life) ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage
☐ Other insurance ☐ Death ☐ Divorce ☐ Other – please explain: _____

Event date – Required _____ (MM/DD/YYYY)

Dependent last name	First name	M.I.	Social Security no.* (required)

Sex	Disabled	Birthdate (MM/DD/YYYY)	Relationship to applicant
☐ Male ☐ Female	☐ Yes ☐ No		☐ Child ☐ Other If other, what is relationship? _____

PCP name (if selecting an HMO plan)	PCP ID no. (if selecting an HMO plan)	Existing patient?
		☐ Yes ☐ No

Does this dependent have a different address? ☐ Yes ☐ No If yes, please provide full address and ZIP code:

Street address, if different	City	State	ZIP code

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

Employee name	Social Security no.

Section D: Plan/Type of Coverage

1. Medical Coverage

Please Note: All health plans include the required coverage for the dental pediatric essential health benefits.

Enter network name, product plan name and contract code selected:

Network name	Product plan name	Contract code, if known

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

2. Dental Coverage

Product plan name	For all Dental HMO plans, you must enter your Dental office no.: _____	Contract code, if known

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

Optional dental plans do not include coverage for dental pediatric essential health benefits.

3. Vision Coverage

Product plan name	Contract code, if known

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

4. Life Coverage — If offered by your employer. Life benefits are available for 2–50 Employee Small Groups. Offered by Anthem Blue Cross Life and Health Insurance Company.

☐ Life & AD&D
☐ Dependent Life

☐ Optional Supplemental Life — Select one:
☐ $15,000 ☐ $25,000 ☐ $50,000 ☐ $100,000

☐ Other: _____

Salary amount: $ _____ ☐ Hourly ☐ Monthly ☐ Annually Employee class: ☐ 1 ☐ 2

Primary Beneficiary — Attach a separate sheet if necessary

Last name	First name	M.I.	Relationship	Social Security no.	Percentage

Contingent Beneficiary — Attach a separate sheet if necessary

Last name	First name	M.I.	Relationship	Social Security no.	Percentage

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

NOTICE OF EXCHANGE OF INFORMATION: To proposed Insured and other persons proposed to be Insured, if any — information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report on this information to MIB, Inc., a non-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB may, upon request, supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of this information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734; and telephone number is 866-692-6901.

Spousal Consent For Community Property States Only (Note: The insurance company is not responsible for the validity of a spouse 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 signature	Spouse name	Date
X		

Employee name	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)
			☐ Age ☐ Disability ☐ ESRD: Onset date _____

Medicare Part D ID no.	Medicare Part D Carrier	Part D effective date

Is anyone applying for coverage covered by other health, dental, or vision 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.	Policy holder name	Dates (if applicable)
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Vision					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Vision					Start: End:

Section F: Waiver/Declining Coverage – Proof of coverage will be required

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/Domestic Partner's group coverage
- ☐ Enrolled in other Insurance –
  Please provide company name and plan: _____
- ☐ Enrolled in Individual coverage
- ☐ Spouse/Domestic Partner covered by employer's group medical Coverage
- ☐ Medicare/Medicaid/VA
- ☐ Other – please explain: _____
- ☐ No coverage

List names of dependents to be waived: _____

I acknowledge that the available coverage's 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, DENTAL, VISION, AND/OR GROUP LIFE COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL, DENTAL, VISION, AND/OR GROUP LIFE 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, DENTAL, VISION, 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	Printed name	Date (MM/DD/YYYY)
X		

Employee name	Social Security no.

Section G: Terms, Conditions and Authorizations

Please read this section carefully before signing the application.

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.

W-9 Certification Language

As part of the W-9 Certification required by the Internal Revenue Service (IRS), I certify that the Social Security number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me) and I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding and I am a U.S. citizen or other U.S. person.

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)

Employee name	Social Security no.

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 impurmasyon 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 chuyển 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)

Employee name	Social Security no.

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 chuyển 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 impurmasyon sa iyong lengguahe,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 ինքնության քարտի ետ§ի մասում գրված հեռախոսի համարով կամ կապվեք Ձեր խմբայինն 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 ਦੁਭਾਸ਼ੀਏ (ਅਨੁਵਾਦਕ) ਦੀ ਸੇਵਾ ਮੁਫਤ ਦਿੱਤੀ ਜਾ ਸਕਦੀ ਹੈ। ਦੁਭਾਸ਼ੀਆ 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 សំរាប់ក្រាស្រ័យទាក់ទងជាមួយនឹងគ្រូពេទ្យ ឬគំរោងសុខភាពរបស់អ្នក ។ ដើម្បីទទួលអ្នកបកប្រែ ឬសាកសួរអំពីព័ត៌មានដែលសរសេរជាភាសាខ្មែរ សូមទូរស័ព្ទទៅលេខដែលមានកត់នៅលើខ្នងអត្តសញ្ញាណប័ណ្ណរបស់អ្នក 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 los 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)