Individual Application

2027 Health Insurance Enrollment
Maryland Residents

CareFirst
Family of health care plans

CareFirst of Maryland, Inc. ▪ 6100 Merriweather Dr., Suite 300, Columbia, MD 21044
Group Hospitalization and Medical Services, Inc. ▪ **CareFirst BlueChoice, Inc.** ▪ 1440 G Street, NW, Washington, DC 20005
CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. are private, not-for-profit health service plans

INSTRUCTIONS

1. Please fill out all applicable spaces on this application. Print or type all information.
2. Sign and return this application in the postage-paid return envelope if provided, or mail to:
   Mailroom Administrator
   P.O. Box 14651, Lexington, KY 40512

Give careful attention to all questions in this application. Accurate, complete information is necessary before your application can be processed. ***If incomplete, the application will be returned and your coverage will be delayed.***

Please check if you are applying for new coverage or making changes to a current policy.

◯ New coverage ◯ Making changes

SECTION 1. PRIMARY APPLICANT INFORMATION *(the primary applicant will be the head of household)*

Last Name	First Name	Middle Initial (M.I.)	Social Security #
Residence Address (Number and Street, Apt #)	City	State	ZIP Code (9-digit, if known)
Billing Address, if different (Number and Street, Apt #)	City	State	ZIP Code (9-digit, if known)
Residence County / Date of Birth	Sex ◯ Male ◯ Female	Marital Status ◯ Single ◯ Married ◯ Domestic Partner	
Home Phone ( )	Work/Mobile Phone ( )		
Email Address (optional)	Spoken Language (optional)	Written Language (optional)	

SECTION 2. ENROLLING FAMILY MEMBER(S)

(complete only if you are enrolling a spouse, partner, dependent[s] or child dependent of a domestic partner to your plan)

	Last Name	First Name	M.I.	Relationship	Social Security #	Date of Birth	Sex
Spouse							◯ M ◯ F
Domestic Partner							◯ M ◯ F
Dependent or child dependent of a domestic partner 1							◯ M ◯ F
Dependent or child dependent of a domestic partner 2							◯ M ◯ F
Dependent or child dependent of a domestic partner 3							◯ M ◯ F
Dependent or child dependent of a domestic partner 4							◯ M ◯ F
Dependent or child dependent of a domestic partner 5							◯ M ◯ F

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst BlueChoice, Inc., The Dental Network and First Care, Inc. are independent licensees of the Blue Cross and Blue Shield Association. In the District of Columbia and Maryland, CareFirst MedPlus is the business name of First Care, Inc. In Virginia, CareFirst MedPlus is the business name of First Care, Inc. of Maryland (used in VA by: First Care, Inc.). BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

SECTION 2. ENROLLING FAMILY MEMBER(S)
(complete only if you are enrolling a spouse, partner, dependent[s] or child dependent of a domestic partner to your plan)

Dependent or child dependent of a domestic partner 6							○ M ○ F
Dependent or child dependent of a domestic partner 7							○ M ○ F

SECTION 3. PLAN SELECTION *(check one)*

Plan Name	In-network Deductible	Out-of-network Deductible
If you are applying for one of the following **Health Maintenance Organization (HMO)** plans underwritten by CareFirst BlueChoice, Inc., **please check here** ○		
○ BlueChoice HMO Young Adult 12000 Virtual Connect Plus	Individual: $12,000/Family: $24,000	N/A
BlueChoice HMO Young Adult is only available for individuals under age 30. Some exceptions may apply.		
○ BlueChoice HMO Value Bronze 11110	Individual: $11,110/Family: $22,220	N/A
○ BlueChoice HMO Bronze 6100 Virtual Connect Plus	Individual: $6,100/Family: $12,200	N/A
○ BlueChoice HMO HSA Bronze 6550 Virtual Connect Plus	Individual: $6,550/Family: $13,100	N/A
○ BlueChoice HMO Value Silver 4500	Individual: $4,500/Family: $9,000	N/A
○ BlueChoice HMO HSA Silver 3700 Virtual Connect Plus	Individual: $3,700/Family: $7,400	N/A
○ BlueChoice HMO Referral Silver 2500 Virtual Connect Plus	Individual: $2,500/Family: $5,000	N/A
○ BlueChoice HMO Gold 1750 Virtual Connect Plus	Individual: $1,750/Family: $3,500	N/A
○ BlueChoice HMO Value Gold 1300	Individual: $1,300/Family: $2,600	N/A
○ BlueChoice HMO Gold 0 Virtual Connect Plus	Individual: $0/Family: $0	N/A
If you are applying for one of the following **Preferred Provider Organization (PPO)** plans, benefits are either underwritten by: Group Hospitalization and Medical Services, Inc. (for residents of Montgomery or Prince George's Counties), **please check here** ○; **OR** CareFirst of Maryland, Inc. (for residents of Baltimore City or any other county in the state of Maryland, **excluding Montgomery or Prince George's Counties), please check here** ○		
○ BluePreferred PPO Value Bronze 11110	Individual: $11,110/Family: $22,220	Individual: $22,220/Family: $44,440
○ BluePreferred PPO Value Silver 4500	Individual: $4,500/Family: $9,000	Individual: $9,000/Family: $18,000
○ BluePreferred PPO HSA Silver 3700 Virtual Connect Plus	Individual: $3,700/Family: $7,400	Individual $7,400/Family $14,800
○ BluePreferred PPO Value Gold 1300	Individual: $1,300/Family: $2,600	Individual: $2,600/Family: $5,200

Important Deductible Information:

For all plans: Single party applicants: the Individual Deductible must be met before full benefits will begin. Multi-party applicants: if one member on the policy meets the Individual Deductible, full benefits will begin for that member. That member will not be able to contribute more than the Individual Deductible amount toward the Family Deductible. Once the Family Deductible has been met, full benefits will be available to all members on the policy.

Please Note: Coverage will begin immediately for in-network preventive benefits as they are not subject to a deductible. Other benefits, as specified in the member contract, also may be covered without having to meet a deductible first. In-network and out-of-network (if applicable) deductible expenses will not be applied to each other.

SECTION 4. PRIMARY CARE PHYSICIAN INFORMATION

If you selected a BlueChoice HMO plan in Section 3, please select a Primary Care Physician (PCP) from the CareFirst BlueChoice Directory available at **carefirst.com/doctor**. Indicate the PCP ID (PID) number for all enrolling applicants. Otherwise, skip to Section 5.

Applicant Name	PCP ID (PID)
Spouse/Domestic Partner	**PCP ID (PID)**
Eligible Dependent or Child Dependent of a Domestic Partner Name(s)	**PCP ID (PID)**

SECTION 5. COORDINATION OF BENEFITS

The purpose of this section is to coordinate benefits appropriately with other carriers. If you have other insurance, failure to complete this section may cause delays in processing any claims submitted.

1. Is anyone listed on this application enrolled in, covered by or eligible for Medicare? If yes, please provide the following: ○ Yes ○ No

Name of Family Member(s)	Medicare Number	Effective Date

2. Is anyone listed on this application covered by other health insurance, including other Blue Cross and Blue Shield coverage? If yes, please provide the following: ○ Yes ○ No

Name of Family Member(s)	Insurance Company	Policy Number and Type	Effective Date

3. Will your new CareFirst policy be replacing your existing policy? **Please note a YES response to this question is not sufficient as notification of policy termination.** ○ Yes ○ No

SECTION 6. LIMITED OPEN ENROLLMENT ELIGIBILITY	
Do you or your dependent(s) qualify for a Limited Open Enrollment Period? Please review the list of qualifying life events listed below (1–12). Be sure to review all the questions before making a selection. If one (1) of the events applies to you or your dependent(s), mark "Yes" next to it. Please note, you will be required to provide documentation as proof of your event. **If none of these events apply to you or your dependent(s), please check "NO" and proceed to Section 7.**	○ Yes ○ No
1. Within the last 60 days, have you or your dependent(s) married, or entered a domestic partnership? Had a birth, adoption, placement of adoption, or been granted court-appointed testamentary, child support order, or other court order of a child or qualified dependent? Had a child placed with you or your dependent(s) as a foster child by an accredited foster child agency? (Note: The foster child is not eligible for coverage.)	○ Yes ○ No
2. Within the last 60 days:	
Have you or your dependent(s) experienced an error in enrollment or non-enrollment by misrepresentation, misconduct, error, or inaction of an officer, employee, or agent of the Maryland Health Connection or the Department of Health and Human Services, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities?	○ Yes ○ No
Were you or your dependent(s) enrolled in a qualified health plan in which the plan substantially violated a material provision of its contract?	○ Yes ○ No
Have you or your dependent(s) become newly ineligible for subsidies?	○ Yes ○ No
Have you lost a dependent, or are no longer considered a dependent, due to a divorce, legal separation, or death of the enrollee or his or her dependent?	○ Yes ○ No
Have you or your dependent(s) been released from a prison term resulting from a criminal conviction?	○ Yes ○ No
3. Were you or your dependent(s) covered under a non-calendar year group health plan, qualified small employer health reimbursement arrangement (QSEHRA) or individual health insurance policy and are you or your dependent(s) within 60 days prior to or within 60 days after your policy renewal date?	○ Yes ○ No
4. Within the last 60 days have you or your dependent(s) terminated employment and refused COBRA coverage or have you or your dependent(s) completed the full term of your COBRA coverage?	○ Yes ○ No
Within the past 60 days, did you or your dependent(s) become aware of the fact that you or your dependent(s) should have received timely notice of an event that triggers eligibility for a special enrollment period and were you or your dependent(s) otherwise reasonably unaware that a triggering event for a special enrollment period occurred?	○ Yes ○ No
In the next 60 days or within the last 60 days, will you or your dependent(s) have your COBRA continuation coverage for which an employer is or was paying all or part of the premiums, or for which a government entity is or was providing subsidies, end or ended, because the employer completely will cease or ceased its contributions, or government subsidies completely will cease or ceased?	○ Yes ○ No
5. In the next 60 days or within the last 60 days: Will you or have you or your dependent(s) lost minimum essential coverage (excluding failure to pay premiums and rescissions) or your state-sponsored pregnancy or medically needy coverage through Medicaid or loss of access to health care services through coverage provided to a pregnant woman's unborn child?	○ Yes ○ No
6. In the next 60 days or within the last 60 days: Will you or your dependent(s) coverage through an employer-sponsored plan or has your or the applicant's dependent's coverage through an employer-sponsored plan been discontinued for one of the following reasons? ■ no longer provides minimum value **(plan covers less than 60 percent actuarial value)** OR ■ is considered unaffordable **(employee contribution to plan premium of self-only coverage exceeds 9.5 percent of employee's household income)**	○ Yes ○ No

SECTION 6. LIMITED OPEN ENROLLMENT ELIGIBILITY	
7. In the next 60 days or within the last 60 days: Will you or have you or your dependent(s) gained access to a new Qualified Health Plan as a result of a permanent move to or within Maryland, and for 1 or more days during the 60 days preceding the move, you or your dependent(s): ■ had other minimum essential coverage OR ■ were residing in a foreign country or in a United States territory Or for 1 or more days during the 60 days preceding the move or during the most recent open enrollment period or special enrollment period, you or your dependent(s): ■ lived in a service area where no Qualified Health Plan was available through the Exchange ■ had pregnancy related coverage or access to healthcare services through unborn child coverage ■ are an Indian as defined by section 4 of the Indian Health Care Improvement Act ■ had medically needed coverage	◯ Yes ◯ No
8. Please provide an answer if one or both events apply. Within the last 60 days: ■ Have you been the victim of domestic abuse or spousal abandonment or a dependent or unmarried victim within a household and are currently enrolled in other minimum essential coverage through the perpetrator of the abuse or abandonment? ■ Have you been a dependent of a victim of domestic abuse or spousal abandonment who is seeking to enroll in coverage at the same time as the victim, on the same application as the victim? The response to these questions about abuse or an individual's status as a victim of domestic violence will not be used to cancel, refuse to underwrite or renew, or refuse to issue a policy of health insurance or a health benefits plan; refuse to pay a claim, cancel, or otherwise terminate a policy of health insurance or a health benefits plan; increase rates for health insurance or a health benefits plan; or for policies of health benefits plans, add a surcharge, apply a rating factor, or use any other underwriting practice that adversely takes the information into account.	◯ Yes ◯ No
9. Did you or your dependent apply for **Qualified Health Plan coverage** through the Maryland Health Connection during the annual open enrollment period or due to a qualifying life event, and were told that you or your dependent potentially qualified for Medicaid or CHIP coverage BUT ■ were later determined ineligible for Medicaid or CHIP coverage after your applicable Qualified Health Plan enrollment period had ended or found ineligible more than 60 days after the qualifying event Or did you or your dependent apply for **Medicaid or CHIP coverage** through a state agency during the annual Qualified Health Plan open enrollment period BUT ■ were later determined ineligible for Medicaid or CHIP coverage after the Qualified Health Plan open enrollment period had ended	◯ Yes ◯ No
10. Within the last 90 days, have you or your dependent(s) had a pregnancy confirmed by a health care practitioner?	◯ Yes ◯ No
11. Within the last 60 days, have you or your dependent gained access to an individual coverage HRA (ICHRA) or have you been newly provided a qualified small employer health reimbursement arrangement (QSEHRA)?	◯ Yes ◯ No
12. Within the last 60 days, did you receive notice that you are not eligible for Medicare coverage, but you are over the age of 65?	◯ Yes ◯ No

SECTION 7. ELECTRONIC COMMUNICATION CONSENT

CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) want to help you manage your health care information and protect the environment by offering you the option of electronic communication.

Instead of paper delivery, you can receive electronic notices about your CareFirst health care coverage through email and/or text messaging by providing your email address and/or mobile phone number and consent below.

Electronic notices regarding your CareFirst health care coverage include, but are not limited to:

- Explanation of Benefits Alerts
- Reminders
- Notice of HIPAA Privacy Practices
- Certification of Creditable Coverage

You may also receive information on programs related to your existing products and services along with new products and services that may be of interest to you.

Please note: This consent for electronic communications applies to the Primary Applicant only. Spouse/Domestic Partners and dependents 18 years of age and older can consent to electronic communications through **carefirst.com/myaccount**. Members can also change email and consent information anytime by logging into **carefirst.com/myaccount** or by calling the customer service phone number on your member ID card. You can also request a paper copy of electronic notices at any time by calling the customer service phone number on your member ID card.

I understand that to access the information provided electronically through email, I must have the following:

- Internet access;
- An email account that allows me to send and receive emails; and
- Microsoft Explorer 11, or Microsoft Edge 13.0 (or higher) or Chrome 75(or higher), or Firefox 66.0 (or higher), Safari 12 (or Higher) and Adobe Acrobat Reader 2017(or higher).

I understand that to receive notices through text messaging,

- A text messaging plan with my mobile phone provider is required; and
- Standard text messaging rates will apply.

Primary Applicant Name	Email Address	Mobile Phone Number
	Alternate Email Address	Alternate Mobile Phone Number
By checking my preference below, I hereby agree to electronic delivery of notices, instead of paper delivery. ◯ Email only ◯ Mobile phone text messaging only ◯ Email and mobile phone text messaging		
Signature:		

CareFirst will not sell your email or phone number to any third party and will not share it with third parties except for CareFirst Business Associates that perform functions on CareFirst's behalf or to comply with the law.

SECTION 8. CONDITIONS OF ENROLLMENT *(please read this section carefully)*

IT IS UNDERSTOOD AND AGREED THAT:

A copy of this application will be provided to the Primary Applicant.

The Primary Applicant, or Parent or Guardian of the Primary Applicant, attests to being a resident of the State of Maryland, which is a requirement for coverage under this application.

To the best of my knowledge and belief, all statements made on this application are complete, true and correctly recorded. They are representations that are made to induce the issuance of, and form part of the consideration for, a CareFirst policy. CareFirst will provide 30 days' advance written notice of any rescission of coverage if it is determined that the Primary Applicant performed an act, practice, or omission that constitutes fraud or made an intentional misrepresentation of material fact. CareFirst will refund any premiums to the Primary Applicant. The Member is responsible for repayment of any claim payment made by CareFirst on the Member's behalf.

If you have any questions concerning the benefits and services that are provided by or excluded under this Agreement, please contact a membership services representative at 800-544-8703 before signing this application.

WARNING: ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

Signature of Primary Applicant	Date
Signature of Applicant 2 (Spouse or Domestic Partner—only applies to the portions of the application completed by the spouse or domestic partner)	Date
NOTE: Applications submitted solely on behalf of applicants under the age of 18, where payment of premium is made by the parent or legal guardian, must be signed by the parent or legal guardian.	
Parent or Legal Guardian's Signature	Date

SECTION 9. RACE, ETHNICITY, LANGUAGE *(this information is voluntary)*

CareFirst is asking its members to voluntarily provide their race, ethnicity and language attributes. The information provided, while voluntary, will assist us to improve quality of care and access to care thereby reducing health care disparities and promote better health outcomes. The information you provide will not have a negative impact on any services we provide you. The information is kept strictly confidential and will not be shared unless required by law to disclose it.

Race

White/Caucasian
Black or African American
American Indian or Alaska Native
Asian
Native Hawaiian or other Pacific Islander
Other—(To include Multi-Racial)
Decline to answer
Unknown—Could not be determined

Ethnicity

Hispanic/Latino/ Spanish origin

Preferred Spoken Language*

01 English
02 Albanian
03 Amharic
04 Arabic
05 Burmese
06 Cantonese
07 Chinese (simplified & traditional)
08 Creole (Haitian)
09 Farsi
10 French (European)
11 Greek
12 Gujarati
13 Hindi
14 Italian
15 Korean
16 Mandarin
17 Portuguese (Brazilian)
18 Russian
19 Serbian
20 Somali
21 Spanish (Latin America)
22 Tagalog (Filipino)
23 Urdu
24 Vietnamese
98 Other and unspecified languages
99 Unknown

	Last Name	First Name	Race	Ethnicity	Country of Origin	Preferred Spoken Language (*specify number from above)
Primary Applicant						
Spouse						
Domestic Partner						
Dependent or child dependent of a domestic partner 1						
Dependent or child dependent of a domestic partner 2						
Dependent or child dependent of a domestic partner 3						
Dependent or child dependent of a domestic partner 4						
Dependent or child dependent of a domestic partner 5						
Dependent or child dependent of a domestic partner 6						
Dependent or child dependent of a domestic partner 7						

SECTION 10. SEXUAL ORIENTATION, GENDER IDENTITY, PRONOUNS

CareFirst is asking its members to provide their sexual orientation, gender identity, and pronouns. The information provided will assist us to improve quality of care and access to care, thereby reducing health care disparities and promoting better health outcomes. The information you provide will not have a negative impact on any services we provide you.

Your privacy is important, and your information will be kept strictly confidential and will not be shared unless required by law to disclose it.

Sexual Orientatation	**Gender Identity**	**Pronouns**
Gay	Male	He/him/his
Lesbian	Female	She/her/hers
Heterosexual, Straight	Transgender male/Trans man	They/them/theirs
Pansexual	Transgender female/Trans woman	Other, please specify
Bisexual	Intersex	Choose not to disclose
Asexual	Nonbinary, gender non-conforming	
Queer	Two-spirit/Gender fluid/Gender queer	
Other, please specify	Other, please specify	
Not Sure	Not Sure	
Choose not to disclose	Choose not to disclose	

	Last Name	First Name	Sexual Orientation	Gender Identity	Pronouns
Primary Applicant					
Spouse					
Domestic Partner					
Dependent or child dependent of a domestic partner 1					
Dependent or child dependent of a domestic partner 2					
Dependent or child dependent of a domestic partner 3					
Dependent or child dependent of a domestic partner 4					
Dependent or child dependent of a domestic partner 5					
Dependent or child dependent of a domestic partner 6					
Dependent or child dependent of a domestic partner 7					

FOR OFFICE USE ONLY:

○ Re-sign and re-date below only if checked.

Signature of Primary Applicant	Date
Signature of Applicant 2 (Spouse or Domestic Partner—only applies to the portions of the application completed by the spouse or domestic partner)	Date
Parent or Legal Guardian's Signature	Date

For Broker Use Only:	**Name**	**NPN #**	**Tax ID #**	**CareFirst-Assigned ID #**
General Agency		[redacted]		
Writing Agent				[redacted]

Notice of Nondiscrimination and Availability of Language Assistance Services

(UPDATED 4/15/2025)

CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc., CareFirst Diversified Benefits and all of their corporate affiliates (CareFirst) comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. CareFirst does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

CareFirst:

- Provides free aid and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call 855-258-6518.

If you believe CareFirst has failed to provide these services, or discriminated in another way, on the basis of race, color, national origin, age, disability or sex, you can file a grievance with our CareFirst Civil Rights Coordinator by mail, fax or email. If you need help filing a grievance, our CareFirst Civil Rights Coordinator is available to help you.

To file a grievance regarding a violation of federal civil rights, please contact the Civil Rights Coordinator as indicated below. Please do not send payments, claims issues, or other documentation to this office.

Civil Rights Coordinator, Corporate Office of Civil Rights

Mailing Address	P.O. Box 14858 Lexington, KY 40512
Email Address	**civilrightscoordinator@carefirst.com**
Telephone Number	410-528-7820
Fax Number	410-505-2011

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, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

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

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Foreign Language Assistance

Attention (English): This notice contains information about your insurance coverage. It may contain key dates and you may need to take action by certain deadlines. You have the right to get this information and assistance in your language at no cost. Members should call the phone number on the back of their identification card. All others may call 1-855-258-6518 and wait through the dialogue until prompted to push 0. When an agent answers, state the language you need and you will be connected to an interpreter.

ማሳሰቢያ (Amharic)፦ ይህ ማሳወቂያ ስለ ኢንሹራንስ ሽፋንዎ መረጃ ይዟል። ቁልፍ ቀኖችን ሊይዝ ይችላል እና በተወሰኑ የግዜ ገደቦች እርምጃ መውሰድ ሊኖርብዎ ይችላል። ይህን መረጃ እና እገዛ ያለ ምንም ወጪ በቋንቋዎ የማግኘት መብት አለዎት። አባላት በአባላት መታወቂያ ካርዳቸው ጀርባ ወዳለው ስልክ ቁጥር መደወል አለባቸው። ሌሎች በሙሉ ወደ 855-258-6518 በመደወል 0ን እንዲጫኑ እስኪጠየቁ ድረስ ምልልሱን መጠበቅ ይችላሉ። አንድ ወኪል ሲመልስ፣ የሚፈልጉትን ቋንቋ ይግለጹ እና ከአስተርጓሚ ጋር ይገናኛሉ።

انتبه (Arabic): يحتوي هذا الإشعار على معلومات حول تغطيتك التأمينية. قد يحتوي على تواريخ رئيسية وقد تحتاج إلى اتخاذ إجراء بحلول مواعيد نهائية معينة. لديك الحق في الحصول على هذه المعلومات والمساعدة بلغتك دون أي تكلفة. يجب على الأعضاء الاتصال برقم الهاتف الموجود على ظهر بطاقة هوية العضوية الخاصة بهم. يمكن للآخرين الاتصال بالرقم 855-258-5618 والانتظار طوال الحوار حتى يُطلب منهم الضغط على الرقم 0. عندما يجيبك أحد الوكلاء، حدد اللغة التي تحتاجها وسيتم توصيلك بمترجم فوري.

মনোযোগ দিন (Bengali): এই বিজ্ঞপ্তিতে আপনার বীমা কভারেজ সম্পর্কে তথ্য রয়েছে। এতে গুরুত্বপূর্ণ তারিখগুলি থাকতে পারে এবং আপনাকে হয়ত নির্দিষ্ট সময়সীমার মধ্যে পদক্ষেপ নিতে হতে পারে। আপনার ভাষায় বিনামূল্যে এই তথ্য এবং সহায়তা পাওয়ার অধিকার আপনার আছে। সদস্যদের তাদের সদস্য পরিচয়পত্রের পিছনে দেওয়া ফোন নম্বরে কল করা উচিত। অন্যরা 855-258-6518 নম্বরে কল করতে পারেন এবং 0 চাপ দেওয়ার জন্য অনুরোধ না করা পর্যন্ত সংলাপের জন্য অপেক্ষা করতে পারেন। যখন একজন এজেন্ট উত্তর দেবেন, তখন আপনার প্রয়োজনীয় ভাষাটি বলুন এবং আপনাকে একজন দোভাষীর সাথে সংযুক্ত করা হবে।

注意（Chinese）：此通知包含有關您的保險範圍的資訊。它可能包含關鍵日期，您可能需要在特定截止日期之前採取行動。您有權免費以您的語言獲取此資訊和協助。會員應撥打會員證背面的電話號碼。其他所有人可以撥打 855-258-6518 並等待對話框，直到提示按 0。當代理商接聽時，請說明您需要的語言，然後您将會與翻譯人員聯繫。

توجه (Farsi): این اطلاعیه حاوی اطلاعاتی درباره پوشش بیمه‌ای شما است. ممکن است شامل تاریخ‌های مهم باشد و لازم باشد تا مهلت‌های مشخصی اقدام کنید. شما حق دارید این اطلاعات و کمک را به زبان خود و به‌صورت رایگان دریافت کنید. اعضا باید با شماره تلفن درج‌شده در پشت کارت شناسایی عضویت خود تماس بگیرند. سایر افراد می‌توانند با شماره *855-258-6518* تماس بگیرند و منتظر بمانند تا دستور داده شود که عدد 0 را فشار دهند. هنگامی که یک نماینده پاسخ داد، زبان مورد نیاز خود را اعلام کنید تا به یک مترجم متصل شوید.

Attention (French): Le présent avis contient des informations essentielles relatives à votre couverture d’assurance. Il peut inclure des échéances importantes nécessitant une action de votre part dans un délai déterminé. Vous avez le droit d’obtenir ces informations ainsi qu’une assistance dans votre langue, et ce, sans frais. Les assurés sont invités à contacter le numéro figurant au verso de leur carte d’adhérent. Toute autre personne peut appeler le 855-258-6518 et patienter jusqu’à l’invitation à composer le 0. Lorsque votre appel sera pris en charge, indiquez la langue souhaitée afin d’être mis en relation avec un interprète.

Achtung (German): Dieser Hinweis enthält Informationen zu Ihrem Versicherungsschutz. Darin sind möglicherweise wichtige Termine aufgeführt und Sie müssen möglicherweise bis zu bestimmten Fristen Maßnahmen ergreifen. Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Mitglieder sollten die Telefonnummer auf der Rückseite ihres Mitgliedsausweises anrufen. Alle anderen können 855-258-6518 anrufen und den Dialog abwarten, bis sie aufgefordert werden, die 0 zu drücken. Wenn ein Agent antwortet, geben Sie die gewünschte Sprache an und Sie werden mit einem Dolmetscher verbunden.

ध्यान दें (Hindi): इस नोटिस में आपके बीमा कवरेज के बारे में जानकारी है। इसमें महत्वपूर्ण तिथियां हो सकती हैं और आपको निश्चित समय सीमा तक कार्रवाई करनी पड़ सकती है। आपको यह जानकारी और सहायता अपनी भाषा में निःशुल्क प्राप्त करने का अधिकार है। सदस्यों को अपने सदस्य पहचान पत्र के पीछे दिए गए फ़ोन नंबर पर कॉल करना चाहिए। अन्य सभी लोग 855-258-6518 पर कॉल कर सकते हैं और 0 दबाने का संकेत मिलने तक संवाद की प्रतीक्षा कर सकते हैं। जब कोई एजेंट उत्तर दे, तो वह भाषा बताएं जिसकी आपको आवश्यकता है और आपको दुभाषिया से जोड़ा जाएगा।

Leruoanya (Igbo): ọkwà a nwere ozi bànyéré mkpuchi megide ihe mberede gị. Ọ nwere ike inwe ụbọchị ndi dị óké ḿkpà ma o nwekwara ike idị mkpa ka imee ihe tupu oge ụfọdụ agafee. Inwere ikike inweta ozi a ya na enyemaka na asụsụ gị n'akwụghị ụgwọ ọbụla. Ndi òtù ga akpọ ọnụọgụgụ ekwenti dị na àzụ́ ḱáàdị njirimara ndi òtù ha. Ndi ọ̀zọ́ nile nwere íke ịkpọ 855-258-6518 ma chere geruo mkpariṭa ụka ruo mgbe asi ha pịa 0. Mgbe onye ozi zara,kwuo asụsụ ichọrọ, a ga ejikota gi na onye ntughari asụsụ.

Attenzione (Italian): Questa informativa contiene informazioni sulla copertura assicurativa. Potrebbe contenere date importanti e potrebbe essere necessario intraprendere azioni entro determinate scadenze. È possibile ottenere queste informazioni e assistenza nella propria lingua gratuitamente. I membri sono pregati di chiamare il numero di telefono riportato sul retro del proprio tesserino di riconoscimento. Tutti gli altri possono chiamare il numero 855-258-6518 e rimanere in linea fino a quando non viene richiesto di premere 0. Quando un operatore risponde, è necessario indicare la lingua desiderata per essere messi in contatto con un interprete.

주의 (Korean): 이 고지에는 귀하의 보험 적용 범위에 대한 정보가 포함되어 있습니다. 여기에는 주요 날짜가 포함되어 있을 수 있으며, 특정 마감일까지 조치를 취해야 할 수도 있습니다. 귀하는 비용 없이 귀하의 언어로 이러한 정보와 지원을 받을 권리가 있습니다. 회원은 회원증 뒷면에 있는 전화번호로 전화하시기 바랍니다. 회원이 아닌 모든 분들은 855-258-6518 로 전화하여 안내 메시지가 끝날 때까지 기다렸다가 0 을 눌러주세요. 상담원이 통화에 응답했을 때, 필요한 언어를 말씀하시면 통역사와 연결됩니다.

Baa'ákonínízin (Navajo): Díí bee ił hane'í béeso nich'ą́ąh naa'nil bee nik'é'asti'í bódahólníihgo bee baa dahane'í biyi'. Dayoołkáłí dóó bee ida'ii'aahí háídíí shį́į́ t'áá bich'į'jį' ha'át'íishį́į́ ádadiiliiłígíí biyi'. Díí bee baa dahane'í dóó t'áá jiik'eh nizaad bee nika'e'eyeedgo bee ná'ahoot'i'. Bił hada'dít'éhí binaaltsoos nitł'izhí bee béédahóziní bąąh béésh bee hane'í námboo biká'ígíí yee dahalne' dooleeł. Nááná ła' 855-258-6518 yee dahalne' dóó yáłti'í biba' asdáago niléí ó bił adílchííd hodoo'niidjį'. Naalnishí haadzį́į'go, saad nínízinígíí bee bił hodíilnih dóó ata' yáłti'í bich'į' ni'doolnih.

ध्यान दिनुहोस् (Nepali): यस सूचनामा तपाईंको बीमा कभरेजका बारेमा जानकारी समावेश छ। यसमा प्रमुख मितिहरू हुन सक्छन् र तपाईंले निश्चित समयसीमा भित्र कारबाही गर्नुपर्ने हुन सक्छ। तपाईंलाई यो जानकारी र सहयोग तपाईंको भाषामा निःशुल्क प्राप्त गर्ने अधिकार छ। सदस्यहरूले आफ्नो सदस्य परिचयपत्रको पछाडि रहेको फोन नम्बरमा कल गर्नुपर्छ। अरू सबैले 855-258-6518 मा कल गर्न सक्छन् र ० पुश गर्न प्रेरित नभएसम्म संवादको प्रतीक्षा गर्न सक्छन्। एजेन्टले जवाफ दिँदा, तपाईंलाई चाहिने भाषा बताउनुहोस् र तपाईंलाई दोभाषेसँग जोडिने छ।

Atenção (Portuguese): Este aviso contém informações sobre a cobertura do seu seguro. Ele pode conter datas importantes e você pode precisar tomar medidas dentro de determinados prazos. Você tem o direito de obter essas informações e assistência em seu idioma, sem nenhum custo. Os associados deverão ligar para o número de telefone indicado no verso do seu cartão de identificação de associado. Todos os outros podem ligar para 855-258-6518 e aguardar a mensagem até que seja solicitado a pressionar 0. Quando um agente atender, indique o idioma que você precisa e você será conectado a um intérprete.

Внимание (Russian): В настоящем уведомлении содержится информация о вашем страховом покрытии. Оно может содержать ключевые даты, и вам может потребоваться предпринять действия к определенным срокам. Вы имеете право получить эту информацию и помощь на своем языке бесплатно. Членам профсоюза следует звонить по номеру телефону, указанному на обратной стороне их удостоверения личности. Все остальные могут звонить по номеру 855-258-6518 и дождаться диалога, пока не появится предложение нажать 0. Когда агент ответит, назовите нужный вам язык, и вас соединят с переводчиком.

Fa'alogo (Samoan): O lenei fa'aaliga o lo'o iai fa'amatalaga i vaega e kava e lau inisiua. E ono aofia ai aso taua ma atonu e te mana‘omia ai le faia o se gaioiga i nisi taimi fa‘agata. E iai lau aia tatau e maua ai nei fa'amatalaga ma fesoasoani i lau gagana e aunoa ma se totogi. E tatau i sui auai ona vili le numera o le telefoni i tua o le latou pepa faamaonia. O isi uma e mafai ona vala'au i le 855-258-6518 ma fa'atali i le talanoaga se'ia fa'atonuina e oomi le 0. A tali mai se so'o upu, fa'ailoa atu le gagana e te mana'omia ona fa'afeso'ota'i lea o oe i se tagata fa'aliliu.

Pažnja (Serbian): Ovo obaveštenje sadrži informacije o vašem osiguranju. Može sadržati ključne datume i možda ćete morati da preduzmete akciju do određenih rokova. Imate prava da dobijete ove informacije i pomoć na vašem jeziku besplatno. Trebalo bi da članovi nazovu telefonski broj na poleđini svoje članske legitimacije. Svi ostali mogu pozvati 855-258-6518 i sačekati automat dok ne dobiju obaveštenje da pritisnu taster "0". Kada se agent javi, navedite jezik koji vam je potreban i bićete povezani s prevodiocem

Atención (Spanish): Este aviso contiene información sobre su cobertura de seguro. Puede contener fechas clave y es posible que deba tomar medidas antes de determinadas fechas límite. Usted tiene derecho a obtener esta información y asistencia en su idioma sin coste alguno. Los afiliados deben llamar al número de teléfono que figura en el reverso de su tarjeta de identificación del afiliado. Todos los demás pueden llamar al 855-258-6518 y esperar el diálogo hasta que se les solicite presionar 0. Cuando un agente responda, indique el idioma que necesita y se conectará con un intérprete.

Atensyon (Tagalog): Ang abisong ito ay naglalaman ng impormasyon tungkol sa saklaw ng iyong insurance. Maaaring naglalaman ito ng mga mahahalagang petsa at maaaring kailanganin mong kumilos ayon sa ilang partikular na mga deadline. May karapatan kang makuha ang impormasyong ito at tulong sa iyong wika nang walang bayad. Ang mga miyembro ay dapat tumawag sa numero ng telepono sa likod ng kanilang member identification card. Ang lahat ng iba ay maaaring tumawag sa 855-258-6518 at maghintay hanggang sa masabihan na pindutin ang 0. Kapag sumagot ang isang ahente, sabihin ang wikang kailangan mo at ikaw ay ikokonek sa isang tagapagsalin.

توجہ (Urdu): اس نوٹس میں آپ کی انشورنس کوریج کے بارے میں معلومات شامل ہیں۔ اس میں کلیدی تاریخیں شامل ہو سکتی ہیں اور آپ کو کچھ آخری تاریخوں تک کارروائی کرنے کی ضرورت پڑ سکتی ہے۔ آپ کو یہ معلومات اور مدد اپنی زبان میں، بغیر کسی قیمت کے حاصل کرنے کا حق ہے۔ ممبران کو اپنے رکنیتی کارڈ کی پشت پر دئے گئے فون نمبر پر کال کرنی چاہیے۔ باقی تمام لوگ *855-258-6518* پر کال کر سکتے ہیں اور 0 دبانے کا اشارہ ملنے تک ڈائیلاگ پر انتظار کرنا چاہئیے۔ جب کوئی ایجنٹ جواب دیتا ہے تو اپنی مطلوبہ زبان بتائیں اور آپ کا رابطہ ایک مترجم سے کر دیا جائے گا۔

Lưu ý (Vietnamese): Thông báo này có chứa thông tin về phạm vi bảo hiểm của bạn. Nó có thể chứa các ngày quan trọng và bạn có thể cần phải hành động theo thời hạn nhất định. Bạn có quyền nhận thông tin và hỗ trợ này bằng ngôn ngữ của mình mà không mất phí. Các thành viên nên gọi đến số điện thoại ở mặt sau thẻ thành viên của mình. Những người khác có thể gọi đến số 855-258-6518 và chờ qua hội thoại cho đến khi được nhắc nhấn số 0. Khi có nhân viên trả lời, hãy nêu ngôn ngữ bạn cần và bạn sẽ được kết nối với phiên dịch viên.