Small Business Employee Enrollment Form
Blue Shield of California and
Blue Shield of California Life & Health Insurance Company

blue california

Effective October 1, 2020

Subscriber information – Please note: Missing information may delay processing.

Additional subscriber information is located in Section 2.

Subscriber's last name	First name	MI
Social Security number		

Reason for application – Please indicate the reason for your enrollment below:

☐ New group enrollment Group effective date: _____	☐ New hire Date of hire : _____	☐ Rehire Date of rehire: _____
☐ Open enrollment Renewal date: _____	☐ COBRA/Cal-COBRA enrollment	
☐ New spouse/dependent Date of marriage/birth/adoption: _____	☐ Other qualifying event (specify): _____ Qualifying event date: _____	

Section 1a – Health plan selection – Select one health plan from the package(s) offered by your employer.

Blue Shield of California Off-Exchange Package for Small Business

PPO plans – Full PPO Network
- ☐ Platinum Full PPO 0/0 OffEx
- ☐ Platinum Full PPO 0/10 OffEx
- ☐ Platinum Full PPO 250/15 OffEx
- ☐ Gold Full PPO 0/20 OffEx
- ☐ Gold Full PPO 500/30 OffEx
- ☐ Gold Full PPO 750/30 OffEx
- ☐ Gold Full PPO 1200/35 OffEx
- ☐ Silver Full PPO 1800/55 OffEx
- ☐ Silver Full PPO 2300/45 OffEx
- ☐ Bronze Full PPO 5000/70 OffEx
- ☐ Bronze Full PPO 6500/50 OffEx
- ☐ Bronze Full PPO 6850/65 OffEx

HSA-compatible HDHP plans – Full PPO Network
- ☐ Silver Full PPO Savings 2000/25% OffEx
- ☐ Silver Full PPO Savings 2500/35% OffEx
- ☐ Bronze Full PPO Savings 5300/40% OffEx
- ☐ Bronze Full PPO Savings 6900 OffEx

HSA-compatible HDHP plans – Tandem PPO Network
- ☐ Silver Tandem PPO Savings 2000/25% OffEx
- ☐ Silver Tandem PPO Savings 2500/35% OffEx
- ☐ Bronze Tandem PPO Savings 5300/40% OffEx
- ☐ Bronze Tandem PPO Savings 6900 OffEx

Tandem PPO plans – Tandem PPO Network
- ☐ Platinum Tandem PPO 0/0 OffEx
- ☐ Platinum Tandem PPO 0/10 OffEx
- ☐ Platinum Tandem PPO 250/15 OffEx
- ☐ Gold Tandem PPO 0/20 OffEx
- ☐ Gold Tandem PPO 500/30 OffEx
- ☐ Gold Tandem PPO 750/30 OffEx
- ☐ Gold Tandem PPO 1200/35 OffEx
- ☐ Silver Tandem PPO 1800/55 OffEx
- ☐ Silver Tandem PPO 2300/45 OffEx
- ☐ Bronze Tandem PPO 5000/70 OffEx
- ☐ Bronze Tandem PPO 6500/50 OffEx
- ☐ Bronze Tandem PPO 6850/65 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 for Small Business
- ☐ Blue Shield Trio Platinum 90 HMO 0/15 + Child Dental
- ☐ Blue Shield Platinum 90 PPO 0/15 + Child Dental
- ☐ Blue Shield Trio Gold 80 HMO 250/25 + Child Dental
- ☐ Blue Shield Gold 80 PPO 250/25 + Child Dental
- ☐ Blue Shield Trio Silver 70 HMO 2250/50 + Child Dental
- ☐ Blue Shield Silver 70 PPO 2250/50 + Child Dental
- ☐ Blue Shield Bronze 60 PPO 6300/65 + Child Dental

Subscriber's last name	First name	MI	Social Security number

Section 1b – Specialty benefits – 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.

Select specialty plan(s) from the package offered by your employer.

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 PPO for Small Business 50/2000/MAC/NR
- ☐ Ultimate Dental Plus PPO for Small Business 50/2000/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.

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

‡ This Voluntary plan does not include Waiting Periods 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's last name	First name	MI	Social Security number

Section SB3 – Life/AD&D insurance

Group term life insurance* (Note: Please fill out if group is offering Blue Shield Life and life is being requested).

Employee information

Full-time employment date	Average hours worked per week	Rehire date	Job 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	

Information on 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.

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

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

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Subscriber's last name	First name	MI	Social Security number

Section 2a – Subscriber information

Note: Social Security numbers are required per CMS.

Social Security number	Employer (group) name	Blue Shield Group ID

Last name	First name	MI

Home (physical) address (no P.O. Box addresses)	City	State	ZIP code
Mailing address (if different from home address)	City	State	ZIP code

Work phone number:	Home phone number:	Language preference: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Other _____

Email address (required)

By providing your email, you will automatically have access to **blueshieldca.com**, and be enrolled in paperless communications. You can change your preferences at any time through your online account.

Date of birth:

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Domestic partner

Do you have any eligible dependent children under the age of 26? ☐ Yes ☐ No How many?_____ How many are enrolling?_____

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?
   - ☐ Yes
   - ☐ No
   - ☐ Unknown
   - ☐ Declined

2. If yes, please select one:
   - ☐ Cuban
   - ☐ Guatemalan
   - ☐ Mexican, Mexican American, Chicano
   - ☐ Puerto Rican
   - ☐ Salvadoran
   - ☐ 2 or more Ethnicities
   - ☐ Other Hispanic, Latino, Spanish:

     _____

3. Which race(s) do you identify with? (select one
   - ☐ 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

If there are applicable dependents included on your application, are all dependents listed of the same race and ethnicity as the primary applicant? ☐ Yes ☐ No
If you answered "No", please include the race and ethnicity for each of your dependents in Part 4.

Section 2b – Employment information

Date of hire: _____
(Full time or part time as noted below. If orientation period is applied, the date of hire is the first day after completion of the orientation period.)

Job title:

Job classification:

Employment status: Mark one option

I am a full-time employee actively working 30 hours or more per week for this employer. ☐ Yes ☐ No

I am a part-time employee actively working between 20-29 hours per week for this employer. ☐ Yes ☐ No

I am an existing COBRA participant or enrolling due to a COBRA qualifying event. ☐ Yes ☐ No If yes, complete section 7 (required).

Section 3 – HMO primary care physician/dental HMO provider assignment

This section is only required if you selected an HMO plan. If you selected a PPO plan, please proceed to Section 4.

HMO plan primary care physician selection

Would you like for Blue Shield to designate a primary care physician for you and your dependents who is located near your home or work?

☐ Yes, I would like Blue Shield to designate a primary care physician and/or dental HMO provider for me and my dependents.

☐ No, I would like to request a specific primary care physician and/or dental HMO provider for myself and my dependents (please specify below).

* 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. HMO primary care physicians can be changed by visiting **blueshieldca.com** after enrollment.

HMO primary care physician name	Provider number	IPA/MG name	Existing patient? ☐ Yes ☐ No
Dental HMO provider name	**Provider number**	Dental group name	Existing patient? ☐ Yes ☐ No

Subscriber's last name	First name	MI	Social Security number

Section 4 – Dependent information

Please note: If the employee, spouse/domestic partner, or child dependent(s) are refusing coverage for any product offered by the group, the employee must complete and sign a Refusal of Personal Coverage form at the end of this application instead of completing the section below. Blue Shield will enroll dependents under all plans that the employee is also enrolled/enrolling in unless indicated otherwise.

Dependent type: ☐ Spouse ☐ Domestic partner	**Gender:** ☐ Male ☐ Female	**Social Security number (required)**	**Enrolling in all products selected by subscriber?** ☐ Yes ☐ No If no, Refusal of Coverage attached? ☐ Yes ☐ No

First name	MI	Last name	Suffix

Date of birth	Address (if different from employee)

If different from Subscriber, which Race and Ethnicity does this dependent identify with?

HMO primary care physician name	Provider number	IPA name	Existing patient? ☐ Yes ☐ No
Dental HMO provider name	Provider number	Dental group name	Existing patient? ☐ Yes ☐ No

Dependent type: ☐ Dependent child ☐ Other dependent child: legal guardianship	**Gender:** ☐ Male ☐ Female	**Social Security number (required)**	**Enrolling in all products selected by subscriber?** ☐ Yes ☐ No If no, Refusal of Coverage attached? ☐ Yes ☐ No

First name	MI	Last name	Suffix

Date of birth	Address (if different from employee)

If different from Subscriber, which Race and Ethnicity does this dependent identify with?

HMO primary care physician name	Provider number	IPA name	Existing patient? ☐ Yes ☐ No
Dental HMO provider name	Provider number	Dental group name	Existing patient? ☐ Yes ☐ No

Dependent type: ☐ Dependent child ☐ Other dependent child: legal guardianship	**Gender:** ☐ Male ☐ Female	**Social Security number (required)**	**Enrolling in all products selected by subscriber?** ☐ Yes ☐ No If no, Refusal of Coverage attached? ☐ Yes ☐ No

First name	MI	Last name	Suffix

Date of birth	Address (if different from employee)

If different from Subscriber, which Race and Ethnicity does this dependent identify with?

HMO primary care physician name	Provider number	IPA name	Existing patient? ☐ Yes ☐ No
Dental HMO provider name	Provider number	Dental group name	Existing patient? ☐ Yes ☐ No

Dependent type: ☐ Dependent child ☐ Other dependent child: legal guardianship	**Gender:** ☐ Male ☐ Female	**Social Security number (required)**	**Enrolling in all products selected by subscriber?** ☐ Yes ☐ No If no, Refusal of Coverage attached? ☐ Yes ☐ No

First name	MI	Last name	Suffix

Date of birth	Address (if different from employee)

If different from Subscriber, which Race and Ethnicity does this dependent identify with?

HMO primary care physician name	Provider number	IPA name	Existing patient? ☐ Yes ☐ No
Dental HMO provider name	Provider number	Dental group name	Existing patient? ☐ Yes ☐ No

Subscriber's last name	First name	MI	Social Security number

Dependent type:	Gender:	Social Security number (required)	Enrolling in all products selected by subscriber?
☐ Dependent child ☐ Other dependent child: legal guardianship	☐ Male ☐ Female		☐ Yes ☐ No If no, Refusal of Coverage attached? ☐ Yes ☐ No

First name	MI	Last name	Suffix

Date of birth	Address (if different from employee)

If different from Subscriber, which Race and Ethnicity does this dependent identify with?

HMO primary care physician name	Provider number	IPA name	Existing patient? ☐ Yes ☐ No
Dental HMO provider name	Provider number	Dental group name	Existing patient? ☐ Yes ☐ No

Dependent type:	Gender:	Social Security number (required)	Enrolling in all products selected by subscriber?
☐ Dependent child ☐ Other dependent child: legal guardianship	☐ Male ☐ Female		☐ Yes ☐ No If no, Refusal of Coverage attached? ☐ Yes ☐ No

First name	MI	Last name	Suffix

Date of birth	Address (if different from employee)

If different from Subscriber, which Race and Ethnicity does this dependent identify with?

HMO primary care physician name	Provider number	IPA name	Existing patient? ☐ Yes ☐ No
Dental HMO provider name	Provider number	Dental group name	Existing patient? ☐ Yes ☐ No

Dependent type:	Gender:	Social Security number (required)	Enrolling in all products selected by subscriber?
☐ Dependent child ☐ Other dependent child: legal guardianship	☐ Male ☐ Female		☐ Yes ☐ No If no, Refusal of Coverage attached? ☐ Yes ☐ No

First name	MI	Last name	Suffix

Date of birth	Address (if different from employee)

If different from Subscriber, which Race and Ethnicity does this dependent identify with?

HMO primary care physician name	Provider number	IPA name	Existing patient? ☐ Yes ☐ No
Dental HMO provider name	Provider number	Dental group name	Existing patient? ☐ Yes ☐ No

Dependent type:	Gender:	Social Security number (required)	Enrolling in all products selected by subscriber?
☐ Dependent child ☐ Other dependent child: legal guardianship	☐ Male ☐ Female		☐ Yes ☐ No If no, Refusal of Coverage attached? ☐ Yes ☐ No

First name	MI	Last name	Suffix

Date of birth	Address (if different from employee)

If different from Subscriber, which Race and Ethnicity does this dependent identify with?

HMO primary care physician name	Provider number	IPA name	Existing patient? ☐ Yes ☐ No
Dental HMO provider name	Provider number	Dental group name	Existing patient? ☐ Yes ☐ No

Subscriber's last name	First name	MI	Social Security number

Dependent type: ☐ Dependent child ☐ Other dependent child: legal guardianship	Gender: ☐ Male ☐ Female	Social Security number (required)	Enrolling in all products selected by subscriber? ☐ Yes ☐ No If no, Refusal of Coverage attached? ☐ Yes ☐ No

First name	MI	Last name	Suffix

Date of birth	Address (if different from employee)

If different from Subscriber, which Race and Ethnicity does this dependent identify with?

HMO primary care physician name	Provider number	IPA name	Existing patient? ☐ Yes ☐ No

Dental HMO provider name	Provider number	Dental group name	Existing patient? ☐ Yes ☐ No

Section 5 – Other health plan information – If enrolling due to a loss of coverage under a prior health plan and/or to receive credit toward any employer waiting period, documentation is required to verify the date of the qualifying event.

Does any person applying for coverage currently have health coverage or previously had health coverage at any time in the past six (6) months? ☐ Yes ☐ No

If yes, specify carrier:_____

Type of coverage: ☐ Group ☐ Individual ☐ Medicare ☐ Covered California/State Health Insurance Exchange ☐ Other (specify): _____

Policy/ID number_____ Date coverage began: _____ Date ended (if coverage is active, please leave blank): _____

Please list all subscriber and dependent member names currently or previously enrolled in the health coverage identified above:	Documentation attached? ☐ Yes ☐ No

Section 6 – Medicare information

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

Section 7 – COBRA/Cal-COBRA group continuation coverage

Please complete this section only if enrolling for COBRA or Cal-COBRA group continuation coverage. Those individuals already enrolled in COBRA or Cal-COBRA coverage from a prior carrier are eligible to continue that coverage with Blue Shield for the remaining duration of time allowed through COBRA and/or Cal-COBRA (as applicable). Proof of enrollment as a COBRA/Cal-COBRA participant is required.

Please provide the name of the employee through whom group coverage was obtained prior to the qualifying event, in order to be eligible for COBRA/Cal-COBRA continuation coverage.

Employee last name	Employee first name	MI

Employee's/subscriber's Blue Shield ID (if applicable)	Original qualifying event date

Qualifying event reason:

☐ Termination or reduction in hours (last day worked)
☐ Termination or reduction in hours due to disability
☐ Divorce or legal separation
☐ Entitlement to Medicare by covered employee
☐ Attainment of maximum age for a dependent child
☐ Death of covered employee
☐ Termination of domestic partnership

Subscriber's last name	First name	MI	Social Security number

Section 8 - Disclosure of personal and health information

At Blue Shield of California, we understand the importance of keeping your personal information private, and we take our obligation to do so very seriously. Blue Shield protects the privacy and security of the personal information that we maintain, use, and disclose for purposes of administering your Blue Shield coverage.

Blue Shield obtains personal information about you and/or your covered dependents, including health and/or financial information, from you, at your direction, and/or with your permission. We are also permitted by federal and state law to obtain your personal information from other sources, including, for example, from your healthcare provider, insurer, insurance support organization, health plan, or insurance agent. We use and disclose your personal information to administer your Blue Shield coverage and as otherwise permitted or required by law. In doing so, we may disclose your personal information to others including, for example, a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent. Blue Shield will not disclose your personal information without your authorization except as permitted or required by law.

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

Acknowledgement and signature

I acknowledge and agree: All information I have provided on this enrollment form is correct and true to the best of my knowledge and belief. I understand that it is the basis on which coverage may be issued under the plan. I understand that if I have committed fraud or made an intentional misrepresentation of any material fact in conjunction with this enrollment within 24 months of issuance, Blue Shield may pursue one of the following remedies: coverage may be cancelled, or the applicable premium may be adjusted, or, following notice, coverage may be rescinded. I further authorize my employer to deduct from my earnings the contribution (if any) required toward the cost of this plan.

I understand that coverage does not become effective until this and my employer's application have been approved by Blue Shield of California.

Signature of employee	Date

Print employee name

All pages of this form are necessary to process your enrollment.
Missing information may delay processing.
If submitting for an existing Blue Shield plan, go to blueshieldca.com.

Refusal of Coverage form

Complete this form if you, your spouse, domestic partner, or child dependent(s) are refusing this group health, dental, vision, and/or life insurance coverage offered through the employer. (The employer must retain a copy of this form to provide to Blue Shield upon request.) Please type or print. Use black ink. ***Note: The employee's Social Security number is required for all eligible employees.**

Employee name	**Social Security number**	**Date of birth**
Employer (Group) name	**Hire date**	**State of residence**
Marital status Married ☐ Yes ☐ No Domestic partnership ☐ Yes ☐ No	Job title	

Is the employee a full-time employee, working at least 30 hours per week for this employer? ☐ Yes ☐ No **Or**
Is the employee a part-time employee, working at least 20 hours per week for this employer? ☐ Yes ☐ No

Declining coverage for:

I decline health plan coverage for:
- ☐ Myself and all dependents.
- ☐ My spouse/domestic partner only
- ☐ My children only
- ☐ My spouse/domestic partner and children only
- ☐ The following dependents only:

_____

If dental plan offered, I decline dental plan coverage for:
- ☐ Myself and all dependents.
- ☐ My spouse/domestic partner
- ☐ My children
- ☐ My spouse/domestic partner and children
- ☐ The following dependents only:

_____

If vision plan offered, I decline vision plan coverage for:
- ☐ Myself and all dependents
- ☐ My spouse/domestic partner
- ☐ My children
- ☐ My spouse/domestic partner and children
- ☐ The following dependents only:

_____

If life insurance plan offered, I decline life plan coverage for:
- ☐ Myself

Reason employee is declining coverage

OTHER EMPLOYER HEALTH COVERAGE
- ☐ Enrolling as a dependent or an employee on this group health plan
- ☐ Covered by this employer's other health plan (through another carrier)
- ☐ Covered by another employer's health plan (e.g., through your spouse/domestic partner)
- ☐ Covered by TRICARE

OTHER NON-EMPLOYER HEALTH COVERAGE
- ☐ Covered by an individual health plan.
- ☐ Covered California or other State Health Exchange
- ☐ Medicare, Medi-Cal, Healthy Families Program
- ☐ Other _____

OTHER DENTAL COVERAGE
- ☐ Enrolling as a dependent or an employee on this group dental plan
- ☐ Covered by another employer's dental plan (e.g., through your spouse/domestic partner)
- ☐ Other _____

OTHER VISION COVERAGE
- ☐ Enrolling as a dependent or an employee on this group vision plan
- ☐ Covered by another employer's vision plan (e.g., through your spouse/domestic partner)
- ☐ Other _____

OTHER LIFE INSURANCE COVERAGE
- ☐ Covered by another employer's life insurance coverage (e.g., through your spouse/domestic partner)
- ☐ Other _____

I acknowledge that the coverage available to me has been explained to me by my employer and I know that I have every right to enroll in this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I now decline to enroll myself, my spouse/domestic partner, and/or my child dependent(s) in my employer's group health plan. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage.

If I am declining enrollment for myself or my dependents because of other health coverage or because the employer stops contributing toward this coverage, I acknowledge that I may be able to enroll myself and my dependents in this plan if I request enrollment within 60 days after my or my dependents' other coverage ends or after the employer stops contributing toward the other coverage.

In addition, if I acquire a new dependent as the result of marriage/domestic partnership, birth, adoption or placement for adoption, I acknowledge that I, and my dependents, may request enrollment in my employer's health plan by applying for that coverage within 60 days of the marriage/domestic partnership, birth, adoption, or placement for adoption. I also acknowledge that if I, or my dependents, become eligible for the Healthy Families or the Medi-Cal Premium Assistance programs, I or my dependents may request enrollment in my employer's health plan by applying for coverage within 60 days of the notice of eligibility for these premium assistance programs.

If I have indicated above that the reason for declining coverage for myself or my dependent(s) is coverage under another employer health benefit plan, I acknowledge that if I or my dependent(s) involuntarily lose coverage under the other employer health benefit plan, I must request enrollment for myself and/or my dependent(s) in my employer health benefit plan within 60 days. Otherwise, I understand I may not enroll myself and/or my dependents in my employer's health plan until the earlier of the end of my employer's next open enrollment period or 12 months.

Signature of employee **Date**

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