Anthem Blue Cross Enrollment Form

Please return the completed enrollment form to your employer.

Effective date (MM/DD/YY)	Group no.

Purpose: ☒ New enrollment ☐ Re-hire ☐ Part-time to full-time ☐ Open enrollment ☐ Family addition ☐ Change ☐ COBRA ☐ Cal-COBRA

Section 1: Type of coverage — Select from only the coverages offered by your employer.

Medical

Anthem Blue Cross plans:
- ☒ HMO[1]
- ☐ Preferred HMO [1]
- ☐ Advantage HMO[1]
- ☐ Priority Select HMO[1]
- ☐ Select HMO[1]
- ☐ Vivity HMO[1]
- ☐ Clear Value
- ☐ Elements Choice (EQ) HMO[1]
- ☐ Other: ______

Anthem Blue Cross Life and Health Insurance Company plans:
- ☐ PPO (Prudent Buyer)
- ☐ EPO (Prudent Buyer Exclusive)
- ☐ POS (Blue Cross Plus)[1]
- ☐ Elements Choice (EQ) PPO
- ☐ Medicare
- ☐ CareAdvocate PPO
- ☐ Select PPO
- ☐ BC PPO (non-California resident)
- ☐ BC Exclusive (non-California resident)
- ☐ BC CareAdvocate PPO
- ☐ Consumer Driven Health Plans: (select one of the following)
  - ☐ H.S.A.[2] ☐ H.R.A.
  - ☐ H.I.A. Plus
- ☐ Elements Choice (EQ) HSA (non-California resident)

1 Indicate Medical Group/IPA no. in the *Employee and family information* section 3.
2 Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your employer.

Flexible Spending Account (FSA) — More than one plan may be selected, depending on employer offerings.

☐ Healthcare FSA ☐ Limited-Purpose FSA (for members enrolled in HSA plans) ☐ Dependent Care FSA ☐ Commuter Transit ☐ Commuter Parking

Dental

Anthem Blue Cross plans:
- ☒ Dental Net HMO[3]
- ☐ Choice Dental (select one of the following)
  - ☐ Dental Net HMO[3]
  - ☐ PPO Dental
- ☐ Other: ______

Anthem Blue Cross Life and Health Insurance Company plans:
- ☐ Dental Consumer Choice
- ☐ Dental Essential Choice
- ☐ Dental Prime
- ☐ Dental Complete
- ☐ Dental Prime Voluntary
- ☐ Dental Complete Voluntary
- ☐ Dental Consumer Choice Voluntary
- ☐ Dental Essential Choice Voluntary
- ☐ Voluntary PPO Dental
- ☐ Dental Blue Complete Incentive
- ☐ Dental Choice EPO
- ☐ Dental Choice EPO Voluntary
- ☐ Dental Blue PPO
- ☐ PPO Dental
- ☐ National Dental Blue PPO
- ☐ National PPO Dental
- ☐ National Voluntary PPO Dental

3 Indicate Dental Office no. in *Employee and family information* section 3.

Vision ☒ Blue View Vision (offered by Anthem Blue Cross Life and Health Insurance Company)

Life insurance All the coverages listed may not be offered by your employer. To elect dependent coverage, the corresponding employee coverage must be selected. List all life insurance beneficiaries in the *Life insurance beneficiary designation information* section.

Annual salary $

Elected benefit	Benefit amount	Elected benefit	Benefit amount	Elected benefit	Benefit amount
☒ Basic Life (AD&D)	$	☐ Optional Life - Employee	$	☐ Optional AD&D - Employee	$
☐ Dependent Life - Spouse	$	☐ Optional Dependent Life - Spouse	$	☐ Optional AD&D - Spouse	$
☐ Dependent Life - Child	$	☐ Optional Dependent Life - Child	$	☐ Optional AD&D - Child	$
		☐ Short Term Disability	$	☐ Voluntary Short Term Disability	$
		☐ Long Term Disability	$	☐ Voluntary Long Term Disability	$

Language choice (optional) ☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Other – please specify: ______

Section 2: Applicant's personal information

Social Security no. required under CMS Regulations and by the IRS.

Last name	First name	M.I.	Marital status ☐ Single ☐ Married ☐ Domestic Partner (DP)	Social Security or ID no.[4] (required)
Mailing address		Apt. no.	No. of dependents including spouse	Spouse/DP Social Security or ID no.[4] (required)
City		State	ZIP code	Home phone no.

Hire date/Rehire date Part-time to Full-time date (MM/DD/YY)	Employer name	Job title	Class	Dept. no.	Email address

To be eligible as a Domestic Partner, the Subscriber and Domestic Partner must have properly filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to the California Family Code, or have properly filed an equivalent document in accordance with the laws of another jurisdiction recognizing the creation of domestic partnerships.
4 Anthem is required by the Internal Revenue Service to collect this information.

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. Medical and Dental coverage provided by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company. Vision, Life and Disability insurance plans offered by Anthem Blue Cross Life and Health Insurance Company. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc.

Social Security or ID no.[1] (required)

Section 3: Employee and family information – Please list yourself and all eligible family members to be enrolled. Attach additional sheets if necessary.

Sex	Last Name	First Name	M.I.	Birthdate (MM/DD/YY)	Social Security or ID no.[1] (required)	Full-time student (if applicable, for non-medical plans)	If children are age 26 or over you must check the appropriate boxes below IRS Qualified Dependent	**HMO & POS ONLY** IPA/Primary Care Physician code	Current MD?	Dental Net **ONLY** Office no.
☐ M ☐ F	Employee								☐ Yes ☐ No	
☐ M ☐ F	Spouse/DP								☐ Yes ☐ No	
☐ M ☐ F						☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	
☐ M ☐ F						☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	
☐ M ☐ F						☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	
☐ M ☐ F						☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	

Section 4: Declination – Please complete if any coverage is declined or refused by an eligible employee and/or their eligible dependents.

A. Medical coverage declined for:
☐ Myself ☐ Spouse/DP ☐ Child(ren)

B. Dental coverage declined for:
☐ Myself ☐ Spouse/DP ☐ Child(ren)

C. Vision coverage declined for:
☐ Myself ☐ Spouse/DP ☐ Child(ren)

D. Life insurance coverage declined for:
☐ Myself ☐ Spouse/DP ☐ Child(ren)

Reason for declining coverage – check one
- ☐ Covered by spouse's group coverage
  Insurer name and ID no.: ______
- ☐ Covered by Anthem Individual policy
- ☐ Spouse covered by employer's group medical coverage
  Insurer name: ______
- ☐ Enrolled in Tricare
- ☐ Enrolled in any other insurance plan
  Insurer name: ______
- ☐ Medicare
- ☐ Other (Explain): ______

I acknowledge that the available coverages 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 decline coverage. **BY DECLINING THIS GROUP MEDICAL COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL COVERAGE ELSEWHERE) I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UNTIL THE NEXT OPEN ENROLLMENT PERIOD TO BE ENROLLED IN THIS GROUP MEDICAL AND/OR GROUP LIFE INSURANCE PLAN.**

Signature if declining coverage for employee/dependent(s)
X

Date (MM/DD/YY)

Section 5: COBRA/Cal-COBRA coverage information – Complete only if enrolling in COBRA/Cal-COBRA.

Reason for COBRA/Cal-COBRA coverage

Federal COBRA qualifying event date (MM/DD/YY)	Federal COBRA coverage begin date (MM/DD/YY)	Federal COBRA coverage end date (MM/DD/YY)
Cal-COBRA qualifying event date (MM/DD/YY)	Cal-COBRA coverage begin date (MM/DD/YY)	Cal-COBRA coverage end date (MM/DD/YY)

Section 6: Other coverage for all enrolling employees and dependents – All questions must be answered.

A. Do any persons on this application intend to continue other group coverage if this application is accepted?........ ☐ Yes ☐ No
If yes, name of person(s): ______
Insurance company: ______ Policy no. ______ Phone no. ______

B. Does any person applying for coverage currently have **health** insurance coverage?........ ☐ Yes ☐ No
Has any person applying for coverage had health insurance coverage at any time in the past six months? .... ☐ Yes ☐ No
If yes, applicant/family member name(s): ______
Type of continuous coverage: ☐ Group ☐ Individual ☐ Other: ______
Insurance company: ______ Policy no. ______ Phone no. ______
Date coverage began: ______ Date ended: ______ (MM/DD/YY)

1 Anthem is required by the Internal Revenue Service to collect this information.

Social Security or ID no.[1] (required)

Section 6: Other coverage for all enrolling employees and dependents (Continued) — All questions must be answered.

C. Does any person applying for coverage currently have **dental** insurance coverage? ☐ Yes ☐ No

If yes, applicant/family member name(s): ____

Type of continuous coverage: ☐ Group ☐ Individual ☐ Other: ____ Includes orthodontia? ☐ Yes ☐ No

Insurance company: ____ Policy no. ____ Phone no. ____

Date coverage began: ____ Date ended: ____ (MM/DD/YY)

D. Does any person applying for coverage currently have **vision** insurance coverage? ☐ Yes ☐ No

If yes, applicant/family member name(s): ____

Type of continuous coverage: ☐ Group ☐ Individual ☐ Other: ____

Insurance company: ____ Policy no. ____ Phone no. ____

Date coverage began: ____ Date ended: ____ (MM/DD/YY)

E. Is any person applying for coverage eligible for Medicare or currently receiving Medicare benefits? ☐ Yes ☐ No

Note: If you are eligible for Medicare, Anthem may not duplicate Medicare benefits.

Section 7: Medicare — Complete if you, your spouse or dependent child(ren) have Medicare coverage. Attach additional sheets if necessary.

Name (last, first, M.I.)	Part A effective date (MM/DD/YY)	Part B effective date (MM/DD/YY)	Medicare claim no.

Section 8: Prior coverage for PPO and dental plans only — Attach additional sheets if necessary.

Please fill out the following information to receive proper credit for **previous coverage** (if immediately prior to becoming eligible for this plan, you have a dependent child(ren) over the age of 26 who cannot get a self-sustaining job due to a physical or mental condition and was covered under any public or private health care coverage, including MediCal or individual coverage). **Note**: If this section is left blank, there may be delays in the processing of claims for these dependents. If any coverage will remain in force once your dependent(s) enroll with Anthem, leave the end date blank.

Name (last, first, M.I.)	Type (check one)	Coverage (check all that apply)	Insurer name	Insurer phone no.	Policy ID no.	Date (if applicable) (MM/DD/YY)	Reason for ending coverage (if applicable)
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				Start: End:	
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				Start: End:	
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				Start: End:	

Section 9: Life insurance beneficiary designation information

Note: Dependent Life payments are always paid to the employee.

Primary Beneficiary — First to receive payment (required) If two beneficiaries are named, enter a % for each. If no % is shown, equal shares are assumed.

Name	Birthdate (MM/DD/YY)	Social Security no.	Relationship		%
Street address		City		State	ZIP code
Name	Birthdate (MM/DD/YY)	Social Security no.	Relationship		%
Street address		City		State	ZIP code

1 Anthem is required by the Internal Revenue Service to collect this information.

Social Security or ID no.[1] (required)

Section 10: Electronic notice – Signature required to opt-in to electronic delivery.

Member email address: ______________________

I (primary applicant) agree to receive my plan-related communications for myself and any dependents, either by email or electronically. This may include my certificate, evidence of coverage, explanation of benefits statements, required notices or helpful information to get the most out of my plan. I agree to provide and update Anthem with my current email address. I know that at any time I can change my mind and request a copy of these materials (or any specific materials) by mail, by contacting Anthem. I or my enrolled dependents will update our communication preferences by going to anthem.com/ca or calling Member Services at 1-877-242-5659.

Member signature X	Date (MM/DD/YY)

Section 11: Please read carefully – Signature required.

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

Deduction authorization: If applicable, I authorize my employer to deduct from my wages the required subscription charges/premiums.

Non-participating provider: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

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.

Effective date: The effective date of coverage is subject to Anthem approval.

COBRA/Cal-COBRA Continuation Coverage

You may continue your health care coverage by: 1) completing the remainder of this form; 2) signing your name in the blank space below; 3) paying your Total Monthly Continuation Payment; and 4) mailing this form to Anthem, no later than sixty (60) days after the date you receive this notice. If you fail to choose COBRA Continuation Coverage within sixty (60) days after the date you receive this notice, your qualification for coverage will end. If you do choose COBRA Continuation Coverage, your current coverage will be continued until the earliest of the following dates:

1. The date eligibility for COBRA Continuation Coverage ends, or
2. The date you fail to make timely payments of your premium for COBRA Continuation Coverage, or
3. The date your employer discontinues coverage with Anthem, or
4. The date you become entitled to Medicare on the basis of age (65 years), or the date thirty (30) months after you become entitled to Medicare on the basis of end stage renal disease, or
5. The date you become covered under another group health plan as a result of employment, re-employment, remarriage, or otherwise.

If, at any time during the first sixty (60) days of your COBRA Continuation Coverage, you are determined under Title II or XVI of the United States Social Security Act to be disabled, you may be entitled to continue coverage while you are disabled for up to 29 months from the date you first qualified for Continuation Coverage under COBRA. Contact the Health Plan Administrator at your previous employer for full information.

The Monthly Continuation Payment is the cost of continued coverage for the month beginning on the date after the Date of Loss of Coverage. If you do not pay your initial monthly premium within 45 days after your election of COBRA Continuation Coverage, or if payment of succeeding premiums are not received within the 30-day grace period thereafter, your coverage will end.

Note: If you do not elect available COBRA Continuation of Medical Coverage, you will lose certain rights under federal law (HIPAA) to guaranteed issue individual coverage.

I certify each Social Security number listed on this application is correct.

REQUIREMENT FOR BINDING ARBITRATION (Not applicable to Life and Disability coverage)

ALL DISPUTES BETWEEN YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY (ANTHEM), 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 AGREE TO BE BOUND BY THIS ARBITRATION PROVISION. YOU ACKNOWLEDGE THAT FOR DISPUTES THAT ARE SUBJECT TO ARBITRATION UNDER STATE OR FEDERAL LAW THE RIGHT TO A JURY TRIAL, THE RIGHT TO A BENCH TRIAL UNDER CALIFORNIA BUSINESS AND PROFESSIONS CODE SECTION 17200, AND/OR THE RIGHT TO ASSERT AND/OR PARTICIPATE IN A CLASS ACTION ARE ALL WAIVED BY YOU. Enforcement of this arbitration clause, including the waiver of class actions, shall be determined under the Federal Arbitration Act ("FAA"), including the FAA's preemptive effect on state law. By providing your "handwritten or electronic" signature below, you acknowledge that such signature is valid and binding.**

Signature (Required)

Applicant X	Date (MM/DD/YY)

1 Anthem is required by the Internal Revenue Service to collect this information.

Get help in your language

Language Assistance Services

Curious to know what all this says? We would be too. Here's the English version:

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 free help, please call right away at 1-888-254-2721. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number on the back of your ID card.

Arabic

مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاستعانة بشخص ما ليساعدك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم1-888-254-2721 (TTY/TDD:711T).

Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող ենք նաև այս նամակը Ձեզ գրավոր տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-888-254-2721 հեռախոսահամարով: (TTY/TDD: 711)

Chinese

重要事項：您能看懂這封信函嗎？如果您看不懂，我們能夠找人協助您。您有可能可以獲得以您的語言而寫的本信函。如需免費協助，請立即撥打1-888-254-2721。(TTY/TDD: 711)

Farsi

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر نمی‌توانید، می‌توانیم شخصی را به شما معرفی کنیم تا در خواندن این نامه شما را کمک کند. همچنین می‌توانید این نامه را به صورت مکتوب به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، همین حالا با شماره 1-888-254-2721 تماس بگیرید.(Y/TDD:711TT)

Hindi

महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम आपको इसे पढ़ने में मदद करने के लिए किसी को उपलब्ध करा सकते हैं। आप यह पत्र अपनी भाषा में लिखवाने में भी सक्षम हो सकते हैं। निःशुल्क मदद के लिए, कृपया 1-888-254-2721 पर तुरंत कॉल करें। (TTY/TDD: 711)

Hmong

TSEEM CEEB: Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwm tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

Japanese

重要：この書簡を読めますか？もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたものを入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。1-888-254-2721 (TTY/TDD: 711)

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Khmer

សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ យើងអាចឲ្យនរណាម្នាក់អានវាជូនអ្នក។ អ្នកក៏អាចទទួលលិខិតនេះដោយសរសេរជាភាសារបស់អ្នកផងដែរ។ ដើម្បីទទួលជំនួយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅលេខ 1-888-254-2721។ (TTY/TDD: 711)

Korean

중요: 이 서신을 읽으실 수 있으십니까? 읽으실 수 없을 경우 도움을 드릴 사람이 있습니다. 귀하가 사용하는 언어로 쓰여진 서신을 받으실 수도 있습니다. 무료 도움을 받으시려면 즉시 1-888-254-2721로 전화하십시오. (TTY/TDD: 711)

Punjabi

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸੀਂ ਸ਼ਾਇਦ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵਬੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਫੌਰਨ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Russian

ВАЖНО. Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

Spanish

IMPORTANTE: ¿Puede leer esta carta? De lo contrario, podemos hacer que alguien lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721. (TTY/TDD: 711)

Tagalog

MAHALAGA: Nababasa ba ninyo ang liham na ito? Kung hindi, may taong maaaring tumulong sa inyo sa pagbasa nito. Maaari ninyo ring makuha ang liham na ito nang nakasulat sa ginagamit ninyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai

หมายเหตุสำคัญ: ท่านสามารถอ่านจดหมายฉบับนี้หรือไม่ หากท่านไม่สามารถอ่านจดหมายฉบับนี้ เราสามารถจัดหาเจ้าหน้าที่มาอ่านให้ท่านฟังได้ ท่านยังอาจให้เจ้าหน้าที่ช่วยเขียนจดหมายในภาษาของท่านอีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อที่หมายเลข 1-888-254-2721 (TTY/TDD: 711)

Vietnamese

QUAN TRỌNG: Quý vị có thể đọc thư này hay không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc thư này. Quý vị cũng có thể nhận thư này bằng ngôn ngữ của quý vị. Để được giúp đỡ miễn phí, vui lòng gọi ngay số 1-888-254-2721. (TTY/TDD: 711)

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