

# Employee Enrollment Application For Small Groups Virginia



PPO health care plans, including dental and vision coverage, are preferred provider organization insurance products offered by Anthem Blue Cross and Blue Shield (Anthem); HMO health care plans are health maintenance organization products offered by HealthKeepers, Inc. (HealthKeepers); Life and disability plans are insurance products offered by Anthem Life Insurance Company (Anthem Life).

The employee who completes this application is solely responsible for its accuracy and completeness. Be sure to answer all questions and to sign and date your application. Please complete in black ink only.

Application completed for (select the company that applies):

- Anthem Blue Cross and Blue Shield       HealthKeepers, Inc.       Anthem Life Insurance Company

<b>Section A: Application Type</b>			
<b>Select one:</b> <input type="checkbox"/> New enrollment <input type="checkbox"/> Open enrollment (not applicable for Life or Disability) <input type="checkbox"/> COBRA <input type="checkbox"/> Family addition <input type="checkbox"/> Rehire date: (MM/DD/YYYY) ___/___/___ <input type="checkbox"/> 12 Month State Continuation effective date: (MM/DD/YYYY) ___/___/___			
<b>Select qualifying event</b> <input type="checkbox"/> Covered employee's Medicare entitlement <input type="checkbox"/> Death <input type="checkbox"/> Divorce or legal separation <input type="checkbox"/> Loss of dependent child status <input type="checkbox"/> Left employment <input type="checkbox"/> Reduction in hours			
<b>Qualifying event date:</b> (MM/DD/YYYY) ___/___/___			

<b>Section B: Employee Information</b>				
Last name		First name	M.I.	Social Security no. <sup>1</sup> (required) / /
Home address - Street and PO Box if applicable		City	State	ZIP code
County	Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner	Primary phone no.	Employee email address	
Occupation	Employer name	Group no. (if known)		
Employer street address		City	State	ZIP code
Employment status <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Disabled <input type="checkbox"/> Retired	Date of hire (MM/DD/YYYY) / /	Date of full-time employment (MM/DD/YYYY) / /	Date waiting period begins (MM/DD/YYYY) / /	No. of hours worked per week
Language choice (optional): <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Other — please specify: _____				

<b>Section C: Type of Coverage</b>		
<b>1. Medical Coverage</b>		
<b>Enter network, product and medical contract code selected:</b>		
Network – Select one: <input type="checkbox"/> KeyCare <input type="checkbox"/> HealthKeepers <input type="checkbox"/> HealthKeepers Open Access <input type="checkbox"/> HealthKeepers Pathway	Product	Medical contract code
Note for Lumenos Health Savings Account (HSA) enrollees: If you enroll in a Lumenos HSA plan, Anthem/HealthKeepers will facilitate the opening of a Health Savings Account in your name, if directed by your employer.  If your employer/group offers EPO coverage, you will also have the option at the time of your initial enrollment and at each renewal to choose a health care plan allowing you to access care from in and out-of-network providers. This may be a “preferred provider organization” or “PPO” plan offered by Anthem or a “point-of-service” or “POS” plan offered by HealthKeepers, Inc.		
<b>Member medical coverage – select one:</b> <input type="checkbox"/> Employee only <input type="checkbox"/> Employee + Spouse or Domestic Partner <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Family <input type="checkbox"/> No coverage <sup>2</sup>		

<sup>1</sup> Anthem/HealthKeepers is required by the Internal Revenue Service to collect this information.

<sup>2</sup> If waiving Medical, Dental and/or Vision coverage for employee and/or any eligible family members, you must complete section F.

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Virginia, Inc. Anthem Blue Cross and Blue Shield, and its affiliate Healthkeepers, Inc., serving all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123, are independent licensees of the Blue Cross Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. Life and Disability products underwritten by Anthem Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association.

**2. Dental Coverage** – Indicate the contract code for the dental plan selected. Your employer will advise you of your plan options and contract codes.

**Anthem Dental Prime, Anthem Dental Complete, and Anthem Essential Choice with product families including Value, Classic, Enhanced, and Voluntary do not include certified pediatric dental essential health benefits.**

Dental product plan name: \_\_\_\_\_ Contract code, if known: \_\_\_\_\_

**Member dental coverage – select one:**

Employee only    Employee + Spouse or Domestic Partner    Employee + Child(ren)    Family    No coverage<sup>2</sup>

**3. Vision Coverage** – Indicate the contract code for the vision plan selected. Your employer will advise you of your plan options and contract codes.

Vision product plan name: \_\_\_\_\_ Contract code, if known: \_\_\_\_\_

**Member vision coverage – select one:**

Employee only    Employee + Spouse or Domestic Partner    Employee + Child(ren)    Family    No coverage<sup>2</sup>

**4. Life, Accidental Death & Dismemberment (AD&D), and Disability Coverage** – A minimum of two employees must enroll.

<input type="checkbox"/> Basic Life and AD&D		<input type="checkbox"/> Short Term Disability
<input type="checkbox"/> Basic Dependent Life		<input type="checkbox"/> Long Term Disability
<input type="checkbox"/> Optional Supplemental/Voluntary Life and AD&D	\$ _____ (employee amount)	<input type="checkbox"/> Voluntary Short Term Disability
<input type="checkbox"/> Optional Supplemental/Voluntary Dependent Life		<input type="checkbox"/> Voluntary Long Term Disability
Spouse or Domestic Partner	\$ _____ (Spouse or Domestic Partner amount)	
<input type="checkbox"/> Optional Supplemental/Voluntary Dependent Life Child	\$ _____ (child amount)	

Current annual income: \$ \_\_\_\_\_ Life and Disability class no.: \_\_\_\_\_

If selecting Short Term Disability coverage: Do you work in New York?  Yes  No      Do you work in New Jersey?  Yes  No

**Primary Beneficiary** – Attach a separate sheet if necessary.

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
			/ /	/ /	

Address \_\_\_\_\_ Percentage to be paid to beneficiary \_\_\_\_\_

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
			/ /	/ /	

Address \_\_\_\_\_ Percentage to be paid to beneficiary \_\_\_\_\_

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
			/ /	/ /	

Address \_\_\_\_\_ Percentage to be paid to beneficiary \_\_\_\_\_

**Contingent Beneficiary**

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
			/ /	/ /	

Address \_\_\_\_\_ Percentage to be paid to beneficiary \_\_\_\_\_

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
			/ /	/ /	

Address \_\_\_\_\_ Percentage to be paid to beneficiary \_\_\_\_\_

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

If an applicant's age at the time of application is at least 15 but less than 18, and the applicant lives with a parent, the applicant must submit a written statement, signed by the parent, consenting to the minor's application for coverage.

Spouse or Domestic Partner signature <b>X</b>	Spouse or Domestic Partner name	Date (MM/DD/YYYY)
		/ /

<sup>2</sup> If waiving Medical, Dental and/or Vision coverage for employee and/or any eligible family members, you must complete section F.

**Section D: Coverage Information** – All fields required. Attach a separate sheet if necessary. Complete this section for yourself and all dependents.

Dependent information must be completed for all additional dependents to be covered under this coverage. An eligible dependent may be your Spouse or Domestic Partner, or your children, or your Spouse's or Domestic Partner's children (to the end of the calendar month in which they turn age 26 unless they qualify as a disabled person). List all dependents beginning with the eldest.

<b>Employee</b> Last name		First name		M.I.
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled: <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate(MM/DD/YYYY):     /     /		
Primary Care Physician (PCP) name		PCP ID no.	Existing patient <input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>Spouse or Domestic Partner</b> Last name		First name	M.I.	Social Security no. <sup>1</sup> (required) / /
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate(MM/DD/YYYY) / /	Relationship to applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	
PCP name		PCP ID no.	Existing patient <input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>Dependent</b> Last name		First name	M.I.	Social Security no. <sup>1</sup> (required) / /
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate(MM/DD/YYYY) / /	Relationship to applicant <input type="checkbox"/> Child <input type="checkbox"/> Other    If other, what is relationship? _____	
PCP name		PCP ID no.	Existing patient <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does this dependent have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, please enter: _____				

<b>Dependent</b> Last name		First name	M.I.	Social Security no. <sup>1</sup> (required) / /
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate(MM/DD/YYYY) / /	Relationship to applicant <input type="checkbox"/> Child <input type="checkbox"/> Other    If other, what is relationship? _____	
PCP name		PCP ID no.	Existing patient <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does this dependent have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, please enter: _____				

<sup>1</sup> Anthem/HealthKeepers is required by the Internal Revenue Service to collect this information.

**Section E: Prior and Other Group Coverage**Is anyone applying for coverage currently eligible for Medicare?  Yes  No If yes, give name: \_\_\_\_\_

Medicare ID no.	Part A effective date (MM/DD/YYYY) / /	Part B effective date (MM/DD/YYYY) / /	Medicare eligibility reason(select all that apply) <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD: Onset date (MM/DD/YYYY) _____ / _____ / _____
Medicare Part D ID no.	Medicare Part D Carrier		Part D effective date (MM/DD/YYYY) / /

Is anyone applying for coverage covered by other health insurance?  Yes  No If yes, please provide the following:

Name of person covered (Last, First, M.I.)	Type (select one)	Coverage (select all that apply)	Insurer name	Insurer phone no.	Policy ID no.	Dates (if applicable) (MM/DD/YYYY)
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia				Start: ____ / ____ / ____ End: ____ / ____ / ____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia				Start: ____ / ____ / ____ End: ____ / ____ / ____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia				Start: ____ / ____ / ____ End: ____ / ____ / ____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia				Start: ____ / ____ / ____ End: ____ / ____ / ____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia				Start: ____ / ____ / ____ End: ____ / ____ / ____

**Section F: Waiver/Declining Coverage – Proof of coverage will be required. (Proof of coverage not applicable for Life and Disability.)**

Type of coverage/Declined for – Select all that apply.		Reason for declining/refusing coverage – Select all that apply.
<input type="checkbox"/> Employee	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> *Life/AD&D (Spouse or Domestic Partner and Dependent coverage not available if life coverage is waived/declined) <input type="checkbox"/> Short Term Disability <input type="checkbox"/> Long Term Disability <input type="checkbox"/> Optional Supplemental/Voluntary Life <input type="checkbox"/> Voluntary Short Term Disability <input type="checkbox"/> Voluntary Long Term Disability	<input type="checkbox"/> No coverage <input type="checkbox"/> Covered by Spouse's or Domestic Partner's group coverage <input type="checkbox"/> Spouse or Domestic Partner covered by employer's group medical coverage <input type="checkbox"/> Enrolled in individual coverage <input type="checkbox"/> Medicare/Medicaid/VA <input type="checkbox"/> Enrolled in other Insurance — Please provide company name and plan: _____ <input type="checkbox"/> Other — please explain: _____ _____
<input type="checkbox"/> Spouse or Domestic Partner	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Dependent Life <input type="checkbox"/> Optional Supplemental/Voluntary Dependent Life	
<input type="checkbox"/> Dependent(s)	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Dependent Life <input type="checkbox"/> Optional Supplemental/Voluntary Dependent Life List name of dependents to be waived: _____	

\*I hereby certify that I have been given the opportunity to apply for the available group life benefits offered by my employer, the benefits have been explained to me, and I and/or my dependent(s) decline to participate. Neither I nor my dependent(s) were induced or pressured by my employer, agent, or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for such coverage in the future, I may be required to provide evidence of insurability at my expense.

**Sign here only if you are declining coverage.**

Signature of applicant <b>X</b>	Printed name	Today's date (MM/DD/YYYY) / /
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**Section G: Terms, Conditions and Authorizations** – Please read this section carefully before signing the application.**Eligible employee:**

- An active employee of the Employer who works the number of hours per week to be eligible for benefits as defined by the Employer and approved by Anthem/HealthKeepers/Anthem Life as of the effective date. Employment must be verifiable from state or federal wage tax reports.
- An employee, as defined above, who enters into employment after the coverage effective date and who completes the group imposed waiting period for eligibility (if any) and applies for coverage within 31 days.
- Any other class of persons identified by the Employer, provided that written approval of their eligibility is obtained from Anthem/Healthkeepers/Anthem Life; or
- Employees eligible for continuous coverage under state or federal laws.

Eligible employee does not include independent contractors (whose compensation is reported on IRS Form 1099) and directors and officers of the Group Policyholder if they do not work the required number of hours per week described above.

**Eligible dependent (for plans offered by Anthem/HealthKeepers):**

- Employee's Spouse, Domestic Partner, or children younger than age 26, which includes a newborn, natural child, or a child placed with the employee for adoption, a stepchild, Domestic Partner's child, foster child, or any other child for whom the employee has legal guardianship or court-ordered custody. Coverage for children will end on the last day of the month in which the children reach age 26.
- The age limit of 26 does not apply for the initial enrollment or maintaining enrollment of a child who cannot support himself or herself because of intellectual disability or physical handicap that began prior to the child reaching the age limit. Coverage may be obtained for the child who is beyond the age limit at the initial enrollment if the employee provides proof of handicap and dependence at the time of enrollment. (The employee may be asked to provide a physician's certification of the dependent's condition.)
- Dependents eligible for continuous coverage under state or federal laws.

As an eligible employee, I am requesting coverage for myself and all eligible dependents listed and authorize my employer to deduct any required contributions for this insurance from my earnings. All statements and answers I have given are true and complete. I understand all benefits are subject to conditions stated in the Group Contract and coverage document. ANY PERSON WHO, WITH THE INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY HAVE VIOLATED STATE LAW.

**Special Enrollment Rights For Medical Coverage Only**

If you declined enrollment for yourself or your dependent(s) (including a Spouse or Domestic Partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependent(s) in this plan if you or your dependent(s) lose eligibility for the other health insurance or group health plan coverage (or if the employer stops contribution towards your coverage or your dependent's other coverage). However, you must request enrollment within 31 days after coverage ends (or after the employer stops contribution toward the other coverage). In addition, if you have a dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependent(s) provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. I also understand that my dependents and I may enroll under two additional circumstances:

- Either your or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- You or your dependent becomes eligible for a subsidy (state premium assistance program).

In these cases, you may be able to enroll yourself and your dependents provided that you request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

**In signing this application I represent that:**

I certify that I have read or have had read to me the completed application, and I realize any false statement or misrepresentation in the application may result in loss of coverage.

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

I agree to receive emails with supplemental information, such as newsletters, for myself and my dependents, to help me get the most out of our plan. I agree to provide Anthem/HealthKeepers/Anthem Life with my most up to date email address. I know I, or my enrolled dependents, can opt out or change our minds at any time by contacting Anthem/HealthKeepers/Anthem Life.

**For Health Savings Account enrollees:** Except as otherwise provided in any agreement between me and the financial custodian, the custodian of my Health Savings Account (HSA), I understand that my authorization is required before the financial custodian may provide Anthem/HealthKeepers with information regarding my HSA. I hereby authorize the financial custodian to provide Anthem/HealthKeepers with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide Anthem/HealthKeepers with a written request to revoke my authorization at any time.

**Life and/or Disability enrollees:**

Payment of proceeds shall be made in accordance with the terms of the group contract. Unless otherwise provided herein, if one or more life insurance beneficiaries are named, the proceeds due shall be paid in equal shares to the named beneficiaries surviving the insured. Beneficiaries may be changed by the insured employee's written notice to his or her employer.

These coverages will become effective on the date established by the provisions of the group contract and certificates issued thereunder.

Incomplete applications will be mailed back to you for completion. This may delay the effective date of your coverage.

<b>Sign here</b>	Applicant Signature	Date (MM/DD/YYYY)
	X Spouse or Domestic Partner signature	/ / Date (MM/DD/YYYY)
	X	/ /

# Get help in your language

## Language Assistance Services



And Its Affiliate HealthKeepers, Inc.

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

If you need assistance to understand this document in an alternate language, you may request it at no additional cost by calling the Member Services number (855-748-1810). (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.

### Spanish

Si necesita ayuda para entender este documento en otro idioma, puede solicitarla sin costo adicional llamando al número de Servicios para Miembros (855-748-1810). (TTY/TDD: 711)

### Amharic

ይህንን ሰነድ ለመረዳት በአማራጭ ቋንቋ እርዳታ ማግኘት ከፈለጉ፣ የአባል አገልግሎቶች ቁጥርን (855-748-1810) በመደወል ያለምንም ክፍያ ማግኘት ይችላሉ። (TTY/TDD: 711)

### Arabic

إذا احتجت إلى المساعدة لفهم هذا المستند بلغة أخرى، فيمكنك طلب المساعدة دون تكلفة إضافية من خلال الاتصال برقم خدمات الأعضاء (855-748-1810). (TTY/TDD: 711)

### Bassa

Ɔ jũ ké m̄ dyi gbo-kpá-kpá m̄ó b̄é m̄ ké c̄èè-d̄ɛ n̄à ke m̄úin w̄o d̄é b̄ɛ̄-w̄eɪn w̄ùd̄ù d̄ò m̄ú ní, m̄ b̄éin ɔ zòò dyiìn d̄é Mébà jè gbo-gm̄ò Kpòè n̄òbà n̄à ke <855-748-1810> d̄á d̄á m̄ú. M̄ se w̄íq̄í kàkò d̄ò p̄éin m̄. (TTY/TDD: 711)

### Bengali

একটি বিকল্প ভাষায় এই তথ্য পুস্তিকাটি বোঝার জন্য। যদি আপনার সহায়তার প্রয়োজন হয়, তাহলে কোনো অতিরিক্ত খরচ ছাড়া সদস্য পরিষেবা নম্বর (855-748-1810)-তে কল করে আপনি এটির অনুরোধ করতে পারেন। (TTY/TDD: 711)

### Chinese

如果您需要協助以便以另一種語言理解本文件，您可以撥打成員服務號碼(855-748-1810)請求免費協助。(TTY/TDD: 711)

### Farsi

در صورتی که برای درک این سند به زبانی دیگر نیازمند کمک هستید، می‌توانید بدون هیچ هزینه اضافی این را درخواست کنید. برای این کار با مرکز خدمات اعضاء به شماره (855-748-1810) تماس بگیرید. (TTY/TDD: 711)

## French

Si vous avez besoin d'aide pour comprendre ce document dans une autre langue, vous pouvez en faire la demande gratuitement en appelant les Services destinés aux membres au numéro suivant : 855-748-1810. (TTY/TDD: 711)

## German

Falls Sie Hilfe in einer anderen Sprache benötigen, um dieses Dokument zu verstehen, können Sie diese kostenlos anfordern, indem Sie die Servicenummer für Mitglieder anrufen (855-748-1810). (TTY/TDD: 711)

## Hindi

अगर आपको यह दस्तावेज़ वैकल्पिक भाषा में समझने के लिए सहायता की ज़रूरत है, तो आप सदस्य सेवाएँ नंबर (855-748-1810) पर कॉल करके अतिरिक्त लागत के बिना इसके लिए अनुरोध कर सकते हैं। (TTY/TDD: 711)

## Igbo

Ọ bụrụ na ị chọrọ enyemaka ịi ghọta dọkumentị a n'asụsụ dị iche, ị nwere ike ịrịọ ya na akwụghị ụgwọ ọ bụla ọzọ site na ịkpo nọmba Ọrụ Onye Otu (855-748-1810). (TTY/TDD: 711)

## Korean

다른 언어로 본 문서를 이해하기 위해 도움이 필요하실 경우, 추가 비용 없이 회원 서비스 번호(855-748-1810)로 전화를 걸어 도움을 요청할 수 있습니다. (TTY/TDD: 711)

## Russian

Если вам нужна помощь, чтобы понять содержание настоящего документа на другом языке, вы можете бесплатно запросить ее, позвонив в отдел обслуживания участников (855-748-1810). (TTY/TDD: 711)

## Tagalog

Kung kailangan ninyo ng tulong upang maunawaan ang dokumentong ito sa ibang wika, maaari ninyo itong hilingin nang walang karagdagang bayad sa pamamagitan ng pagtawag sa Member Services sa numerong (855-748-1810). (TTY/TDD: 711)

## Urdu

تو آپ ممبر سروس نمبر پر کال اگر آپ کو کسی دوسری زبان میں اس دستاویز کو سمجھنے کے لیے مدد کی ضرورت ہو جس کے لئے آپ پر کوئی اضافی اخراجات عائد نہیں ہوں گے نمبر کر کے اس کی درخواست کرسکتے ہیں  
(711:TDD/TTY) (855-748-1810)

## Vietnamese

Nếu quý vị cần hỗ trợ để hiểu được tài liệu này bằng một ngôn ngữ thay thế, quý vị có thể yêu cầu mà không tốn thêm chi phí bằng cách gọi số của Dịch Vụ Thành Viên (855-748-1810). (TTY/TDD: 711)

## Yoruba

Tí o bá nílò ìrànwọ́ kí àkọsílẹ̀ yíí le yé ọ ní èdè míràn, o le bèrè rẹ láísí àfikún owó nípa pípe Nọmbà Àwọn ìpèsè ọmọ-ẹgbé (855-748-1810). (TTY/TDD: 711)

**It's important we treat you fairly**

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling [1-800-368-1019](tel:1-800-368-1019) (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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