

Mail Administrator
 PO Box 14651
 Lexington, KY 40512
 Fax: 410-505-2901
 800-305-1351



CareFirst of Maryland, Inc.
MEMBERSHIP CHANGE FORM
(Maryland Individual Plans Only)
This is not an application for insurance

Subscriber's Name:		Last	First	MI	Birth Date: ___/___/___ <i>Month/Day/Year</i>	
Residence Address:		Street	City	County	State	Zip
Subscriber ID #(SID)			SSN		Phone Number:	
Requested Effective Date of Change: ___/___/___ <i>Month/Day/Year</i>						
CHANGES REQUESTED (Please check box of requested change)						
<input type="checkbox"/> Address Change						
<input type="checkbox"/> Residence Address:		Street	City	County	State	Zip
<input type="checkbox"/> Billing Address:		Street	City	County	State	Zip
<input type="checkbox"/> Phone Number Change:						
Old Phone Number:			New Phone Number:			
<input type="checkbox"/> Name Change (Documentation required)						
Change from:	Last	First	MI			
Change to:	Last	First	MI			
Name Change Reason: <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Other _____						
<input type="checkbox"/> COMBINING SAME PRODUCT POLICIES (benefits must be the same or greater, if not a Minor, signature required.)						
Subscriber		Subscriber ID # (SID)		Relationship		
Last	First					
<input type="checkbox"/> Add a Dependent:						
<input type="checkbox"/> Newborn of Subscriber/Partner						
<input type="checkbox"/> Child being adopted Month/Year in which final adoption papers are granted: ___/___						
<input type="checkbox"/> Child for whom subscriber has been appointed legal guardian Date appointed legal guardian: ___/___/___						
Documentation required if adoption proceedings are underway or if you are a court-appointed legal guardian						
DEPENDENT INFORMATION (Please list all persons to be added)						
Last	First	MI	Relationship	Sex	Date of Birth	SSN
					___/___/___	
					___/___/___	
					___/___/___	
<input type="checkbox"/> Remove a Dependent:						
Due to:	<input type="checkbox"/> Divorce	Date of Divorce: ___/___/___	<input type="checkbox"/> Extended Military	<input type="checkbox"/> Other: _____		
	<input type="checkbox"/> Death*	Date of Death: ___/___/___	*Documentation required.			
DEPENDENT INFORMATION (Please list all persons to be removed)						
Last	First	MI	Relationship	Sex	Date of Birth	SSN
					___/___/___	
					___/___/___	
					___/___/___	

SPLIT MEMBERSHIP - DEPENDENT TO HIS/HER OWN POLICY (non-Medicare related)

Dependent Information - Set up for continuous coverage

Last	First	MI	Type of Current Coverage	SSN	Effective Date
					__/__/__
					__/__/__

Split Reason: Death of Subscriber* Other _____ * **Documentation required.**

Change from:	<input type="checkbox"/> Individual and Child(ren)	Change to:	<input type="checkbox"/> Individual
	<input type="checkbox"/> Individual and Adult		<input type="checkbox"/> Individual and Child(ren)
	<input type="checkbox"/> Family		<input type="checkbox"/> Family

SPLIT MEMBERSHIP - DEPENDENT TO HIS/HER OWN POLICY (Subscriber moving to MediGap)

MOVING MEMBER: PLEASE ATTACH THIS FORM TO THE COMPLETED MEDIGAP APPLICATION

Dependent Information - Set up for continuous coverage

Last	First	MI	Type of Current Coverage	SSN	Effective Date
					__/__/__
					__/__/__

Remaining Members:

Keep remaining family member(s) in the current policy/product.
 Remaining family member(s) to move to a Healthcare Reform compliant same or higher deductible policy. Complete **Policy Changes** section below.
**Remaining family members(s) requesting policy/plan changes(s) should visit www.carefirst.com/individual or, call a Product Specialist, M-F 8am-8pm at (410) 356-8000/(800) 544-8703 to learn more.*

Change from:	<input type="checkbox"/> Individual and Child(ren)	Change to:	<input type="checkbox"/> Individual
	<input type="checkbox"/> Individual and Adult		<input type="checkbox"/> Individual and Child(ren)
	<input type="checkbox"/> Family		<input type="checkbox"/> Family

POLICY CHANGES

Select Existing plan	Change to: (higher)
<input type="checkbox"/> BluePreferred \$100	<input type="checkbox"/> BluePreferred \$100
<input type="checkbox"/> BluePreferred \$300 - 90/10	<input type="checkbox"/> BluePreferred \$300 - 90/10
<input type="checkbox"/> BluePreferred \$300 - 80/20	<input type="checkbox"/> BluePreferred \$300 - 80/20
<input type="checkbox"/> BluePreferred \$500	<input type="checkbox"/> BluePreferred \$500
<input type="checkbox"/> BluePreferred HSA \$1,200	<input type="checkbox"/> BluePreferred HSA \$1,400
<input type="checkbox"/> BluePreferred HSA \$2,700	<input type="checkbox"/> BluePreferred HSA \$2,700
<input type="checkbox"/> BluePreferred Saver \$2,500	<input type="checkbox"/> BluePreferred Saver \$2,500
<input type="checkbox"/> BluePreferred Saver \$5,000	<input type="checkbox"/> BluePreferred Saver \$5,000
<input type="checkbox"/> BluePreferred Saver \$10,000	<input type="checkbox"/> BluePreferred Saver \$10,000
<input type="checkbox"/> Personal Comp \$100	<input type="checkbox"/> Personal Comp \$1,000
<input type="checkbox"/> Personal Comp \$200	
<input type="checkbox"/> Personal Comp \$400	
<input type="checkbox"/> Personal Comp \$500	
<input type="checkbox"/> Personal Comp \$800	
<input type="checkbox"/> Personal Comp \$1,000	
<input type="checkbox"/> Personal Comp HSA \$1,700	
<input type="checkbox"/> Personal Comp \$2,500	
<input type="checkbox"/> Personal Comp HSA \$2,500	
<input type="checkbox"/> Personal Comp \$5,000	
<input type="checkbox"/> Personal Comp \$10,000	<input type="checkbox"/> Personal Comp \$2,500
	<input type="checkbox"/> Personal Comp HSA \$2,500
	<input type="checkbox"/> Personal Comp \$5,000
	<input type="checkbox"/> Personal Comp \$10,000
<input type="checkbox"/> Other Product not listed _____	<input type="checkbox"/> Other Product not listed _____

Change Rider (where product/rider available)

<input type="checkbox"/> Add:	<input type="checkbox"/> Extended Maternity <input type="checkbox"/> Vision
<input type="checkbox"/> Remove:	<input type="checkbox"/> Extended Maternity <input type="checkbox"/> Vision <input type="checkbox"/> Dental

<input type="checkbox"/> BROKER CHANGES (Limited to changes of Personal Comp to BluePreferred only)				
	Name	SSN/Tax ID #	CareFirst-Assigned ID #	
Contracted Broker:				
Sub-Agent/Sub-Agency:				
Writing Agent:				
<input type="checkbox"/> ELECTRONIC COMMUNICATION CONSENT				
You can receive electronic notices via email and/or text messaging instead of paper notices for your CareFirst BlueCross BlueShield (CareFirst) health care coverage by providing your email address and/or cell phone number and consent below. These will include but are not limited to:				
<ul style="list-style-type: none"> Explanation of Benefits alerts Appeal decision alerts 		<ul style="list-style-type: none"> Notice of HIPAA Privacy Practices Certification of Creditable Coverage 		
You may also receive information on programs related to your existing products and services along with new products and services that may be of interest to you.				
<ul style="list-style-type: none"> You may change your email and consent information anytime by logging into www.carefirst.com/myaccount or by calling the customer service phone number on your ID card. You can request a paper copy of electronic notices at anytime by calling the customer service phone number on your ID card. 				
I understand that to access the information provided electronically, I must have the following:				
<ul style="list-style-type: none"> Internet access; An email account that allows me to send and receive emails; and Microsoft Explorer 7.0 (or higher) or Firefox 3.0 (or higher), and Adobe Acrobat Reader 4 (or higher). 				
<input type="checkbox"/> By checking this box, I hereby agree to electronic delivery of notices and documents				
			Is this an update? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Subscriber Name		Email Address		Cell Phone Number
Last	First	MI		
Spouse/Partner/Dependent Name(s)		Email Address		Cell Phone Number
Last	First	MI		
Last	First	MI		
Last	First	MI		
CareFirst will not sell your email to any third party and we do not share it with third parties except for CareFirst business associates that perform functions on our behalf or to comply with the law.				
<input type="checkbox"/> OTHER HEALTH INSURANCE INFORMATION				
Is any person listed on the change form covered by another health care plan or HMO? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, will this coverage be continued? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, please provide the cancellation date: __/__/__				
Policy Holder's Name:	Last	First	MI	Phone # of Other Insurer:
Name of Insurance Company:				
Address of Insurance Company:	Street	City	State	Zip
Policy Number:	Group Number:	Effective Date of Policy: __/__/__		
Name of Employer providing coverage (if applicable):				
Does this policy cover: You? <input type="checkbox"/> Yes <input type="checkbox"/> No Your Spouse/Partner? <input type="checkbox"/> Yes <input type="checkbox"/> No Your children? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Please list the name(s) of child(ren) covered: _____				
Policyholder's working status: <input type="checkbox"/> Active <input type="checkbox"/> Retired Retirement date: __/__/__				
IF YOU HAVE OTHER HEALTH INSURANCE COVERAGE, FAILURE TO COMPLETE THIS SECTION WILL CAUSE SIGNIFICANT DELAYS IN PROCESSING ANY CLAIMS SUBMITTED.				

<input type="checkbox"/> Court Assigned Responsibility for Child(ren)'s Medical Expenses				
To be completed by the natural parents that live apart and provide medical coverage for their child(ren). Please indicate relationship to child(ren) (natural mother, natural father, step-parent). *Please provide legal documentation				
Parent with Court Assigned Responsibility for Child(ren)'s Medical Expenses				
Parent Name	Last	First	MI	Parent Date of Birth ___/___/___
Child Name	Last	First	MI	Child Date Of Birth ___/___/___
Child Name	Last	First	MI	Child Date Of Birth ___/___/___
Child Name	Last	First	MI	Child Date Of Birth ___/___/___
Relationship to child: <input type="checkbox"/> Natural mother <input type="checkbox"/> Natural father <input type="checkbox"/> Step-parent				
Parent with Custody of Child(ren)				
Parent Name	Last	First	MI	Parent Date of Birth ___/___/___
Child Name	Last	First	MI	Child Date Of Birth ___/___/___
Child Name	Last	First	MI	Child Date Of Birth ___/___/___
Child Name	Last	First	MI	Child Date Of Birth ___/___/___
Relationship to child: <input type="checkbox"/> Natural mother <input type="checkbox"/> Natural father <input type="checkbox"/> Step-parent				
WARNING: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.				
Required Signature(s) and Date				
Subscriber's signature			Date ___/___/___	
Member's signature			Date ___/___/___	

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www.carefirst.com

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Notice of Nondiscrimination and Availability of Language Assistance Services

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

CareFirst:

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

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

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

Civil Rights Coordinator, Corporate Office of Civil Rights

Telephone Number 410-528-7820
Mailing Address P.O. Box 8894
Baltimore, Maryland 21224
Fax Number 410-505-2011
Email Address civilrightscordinator@carefirst.com

You can file a grievance by mail, fax or email. If you need help filing a grievance, our CareFirst 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, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

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

Foreign Language Assistance

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

አማርኛ (Amharic) ማሳሰቢያ፡- ይህ ማስታወቂያ ስለ መድን ሽፋንዎ መረጃ ይዟል። ከተወሰኑ ቀን-ገደቦች በፊት ሊፈጽሟቸው የሚገቡ ነገሮች ሊኖሩ ስለሚችሉ እነዚህን ወሳኝ ቀናት ሊይዝ ይችላሉ። ይኸን መረጃ የማግኘት እና ያለምንም ክፍያ በቋንቋዎ አገዛ የማግኘት መብት አለዎት። አባል ከሆኑ ከመታወቂያ ካርድዎ በስተጀርባ ላይ ወደተጠቀሰው የስልክ ቁጥር መደወል ይችላሉ። አባል ካልሆኑ ደግሞ ወደ ስልክ ቁጥር 855-258-6518 ደውለው 0ን እንዲጫኑ እስኪነገርዎ ድረስ ንግግሩን መጠበቅ አለብዎ። አንድ ወኪል መልስ ሲሰጥዎ፣ የሚፈልጉትን ቋንቋ ያሳውቁ፣ ከዚያም ከተርጓሚ ጋር ይገናኛሉ።

Èdè Yorùbá (Yoruba) Ìtẹ̀tíléko: Àkíyèsí yìí ní iwífún nípa isẹ̀ adójú̀tòfò rẹ̀. Ó le ní àwọn déèti pàtó o sì le ní láti gbé ìgbésẹ̀ ní àwọn ojú gbèdèké kan. O ni ètò láti gba iwífún yìí àti irànlówó ní èdè rẹ̀ lófèfè. Àwọn omọ-egbé gbòdò pe nóm̀bà fòdùn tò wà lẹ̀yìn kààdì idánimò wọn. Àwọn mírán le pe 855-258-6518 kí o sì dúró nípasẹ̀ ijíròrò tí tí a ó fí sọ fún ọ̀ láti tẹ̀ 0. Níg̀bàtí așojú kan bá dáhùn, sọ èdè tí o fẹ̀ a ó sì sọ ọ̀ pò mò ògbufò kan.

Tiếng Việt (Vietnamese) Chú ý: Thông báo này chứa thông tin về phạm vi bảo hiểm của quý vị. Thông báo có thể chứa những ngày quan trọng và quý vị cần hành động trước một số thời hạn nhất định. Quý vị có quyền nhận được thông tin này và hỗ trợ bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Các thành viên nên gọi số điện thoại ở mặt sau của thẻ nhận dạng. Tất cả những người khác có thể gọi số 855-258-6518 và chờ hết cuộc đối thoại cho đến khi được nhắc nhấn phím 0. Khi một tổng đài viên trả lời, hãy nêu rõ ngôn ngữ quý vị cần và quý vị sẽ được kết nối với một thông dịch viên.

Tagalog (Tagalog) Atensyon: Ang abisong ito ay naglalaman ng impormasyon tungkol sa nasasaklawan ng iyong insurance. Maaari itong maglaman ng mga pinakamahalagang petsa at maaaring kailangan mong gumawa ng aksyon ayon sa ilang deadline. May karapatan ka na makuha ang impormasyong ito at tulong sa iyong sariling wika nang walang gastos. Dapat tawagan ng mga Miyembro ang numero ng telepono na nasa likuran ng kanilang identification card. Ang lahat ng iba ay maaaring tumawag sa 855-258-6518 at maghintay hanggang sa dulo ng diyalogo hanggang sa diktahan na pindutin ang 0. Kapag sumagot ang ahente, sabihin ang wika na kailangan mo at ikokonekta ka sa isang interpreter.

Español (Spanish) Atención: Este aviso contiene información sobre su cobertura de seguro. Es posible que incluya fechas clave y que usted tenga que realizar alguna acción antes de ciertas fechas límite. Usted tiene derecho a obtener esta información y asistencia en su idioma sin ningún costo. Los asegurados deben llamar al número de teléfono que se encuentra al reverso de su tarjeta de identificación. Todos los demás pueden llamar al 855-258-6518 y esperar la grabación hasta que se les indique que deben presionar 0. Cuando un agente de seguros responda, indique el idioma que necesita y se le comunicará con un intérprete.

Русский (Russian) Внимание! Настоящее уведомление содержит информацию о вашем страховом обеспечении. В нем могут указываться важные даты, и от вас может потребоваться выполнить некоторые действия до определенного срока. Вы имеете право бесплатно получить настоящие сведения и сопутствующую помощь на удобном вам языке. Участникам следует обращаться по номеру телефона, указанному на тыльной стороне идентификационной карты. Все прочие абоненты могут звонить по номеру 855-258-6518 и ожидать, пока в голосовом меню не будет предложено нажать цифру «0». При ответе агента укажите желаемый язык общения, и вас свяжут с переводчиком.

हिन्दी (Hindi) ध्यान दें: इस सूचना में आपकी बीमा कवरेज के बारे में जानकारी दी गई है। हो सकता है कि इसमें मुख्य तिथियों का उल्लेख हो और आपके लिए किसी नियत समय-सीमा के भीतर काम करना ज़रूरी हो। आपको यह जानकारी और संबंधित सहायता अपनी भाषा में निःशुल्क पाने का अधिकार है। सदस्यों को अपने पहचान पत्र के पीछे दिए गए फ़ोन नंबर पर कॉल करना चाहिए। अन्य सभी लोग 855-258-6518 पर कॉल कर सकते हैं और जब तक 0 दबाने के लिए न कहा जाए, तब तक संवाद की प्रतीक्षा करें। जब कोई एजेंट उत्तर दे तो उसे अपनी भाषा बताएँ और आपको व्याख्याकार से कनेक्ट कर दिया जाएगा।

Bàsòò-wùdù (Bassa) Tò Dùù Cáò! Bǎ nìà kè bá nyò bě kè m̄ gbo kpá bó nì fùà-fúà-tiìn nyεε jè dyí. Bǎ nìà kè bédé wé jéé bě b́é m̄ kè dε wa ḿ m̄ kè nyuεε nyu hwè b́é wé b́éa kè zi. Ǿ m̀ò nì kpé b́é m̄ kè bǎ nìà kè kè gbo-kpá-kpá m̄ ḿεε dyé dé nì bídí-wùdù mú b́é m̄ kè se wídí d̀ò péè. Kpooò nyò b́é m̄ dá fúùn-nòbà nìà dé waa I.D. káàò dεín nyε. Nyò t̀òò séín m̄ dá nòbà nìà kè: 855-258-6518, kè m̄ m̄ f̀ò tee b́é wa ḱε m̄ gbo ćé b́é m̄ kè nòbà m̀ò 0 ḱε dyi pàd̀àn hwè. Ǿ j̀ú kè nyò d̀ò dyi m̄ g̀ǎ j̀ùìn, po wuqu m̄ ḿ poε dyie, kè nyò d̀ò mu bó nììn b́é Ǿ kè nì wuquò mú zà.

বাংলা (Bengali) লক্ষ্য করুন: এই নোটিশে আপনার বিমা কভারেজ সম্পর্কে তথ্য রয়েছে। এর মধ্যে গুরুত্বপূর্ণ তারিখ থাকতে পারে এবং নির্দিষ্ট তারিখের মধ্যে আপনাকে পদক্ষেপ নিতে হতে পারে। বিনা খরচে নিজের ভাষায় এই তথ্য পাওয়ার এবং সহায়তা পাওয়ার অধিকার আপনার আছে। সদস্যদেরকে তাদের পরিচয়পত্রের পিছনে থাকা নম্বরে কল করতে হবে। অন্যেরা 855-258-6518 নম্বরে কল করে 0 টিপতে না বলা পর্যন্ত অপেক্ষা করতে পারেন। যখন কোনো এজেন্ট উত্তর দেবেন তখন আপনার নিজের ভাষার নাম বলুন এবং আপনাকে দোভাষীর সঙ্গে সংযুক্ত করা হবে।

اردو (Urdu) توجہ: یہ نوٹس آپ کے انشورینس کوریج سے متعلق معلومات پر مشتمل ہے۔ اس میں کلیدی تاریخیں ہو سکتی ہیں اور ممکن ہے کہ آپ کو مخصوص آخری تاریخوں تک کارروائی کرنے کی ضرورت پڑے۔ آپ کے پاس یہ معلومات حاصل کرنے اور بغیر خرچہ کیے اپنی زبان میں مدد حاصل کرنے کا حق ہے۔ ممبران کو اپنے شناختی کارڈ کی پشت پر موجود فون نمبر پر کال کرنی چاہیے۔ سبھی دیگر لوگ 855-258-6518 پر کال کر سکتے ہیں اور 0 دبانے کو کہے جانے تک انتظار کریں۔ ایجنٹ کے جواب دینے پر اپنی مطلوبہ زبان بتائیں اور مترجم سے مربوط ہو جائیں گے۔

فارسی (Farsi) توجه: این اعلامیه حاوی اطلاعاتی درباره پوشش بیمه شما است. ممکن است حاوی تاریخ های مهمی باشد و لازم است تا تاریخ مقرر شده خاصی اقدام کنید. شما از این حق برخوردار هستید تا این اطلاعات و راهنمایی را به صورت رایگان به زبان خودتان دریافت کنید. اعضا باید با شماره درج شده در پشت کارت شناسایی شان تماس بگیرند. سایر افراد می توانند با شماره 855-258-6518 تماس بگیرند و منتظر بمانند تا از آنها خواسته شود عدد 0 را فشار دهند. بعد از پاسخگویی توسط یکی از اپراتورها، زبان مورد نیاز را تنظیم کنید تا به مترجم مربوطه وصل شوید.

اللغة العربية (Arabic) تنبيه: يحتوي هذا الإخطار على معلومات بشأن تغطيتك التأمينية، وقد يحتوي على تواريخ مهمة، وقد تحتاج إلى اتخاذ إجراءات بحلول مواعيد نهائية محددة. يحق لك الحصول على هذه المساعدة والمعلومات بلغتك بدون تحمل أي تكلفة. ينبغي على الأعضاء الاتصال على رقم الهاتف المذكور في ظهر بطاقة تعريف الهوية الخاصة بهم. يمكن للأخريين الاتصال على الرقم 855-258-6518 والانتظار خلال المحادثة حتى يطلب منهم الضغط على رقم 0. عند إجابة أحد الوكلاء، اذكر اللغة التي تحتاج إلى التواصل بها وسيتم توصيلك بأحد المترجمين الفوريين.

中文繁体 (Traditional Chinese) 注意：本聲明包含關於您的保險給付相關資訊。本聲明可能包含重要日期及您在特定期限之前需要採取的行動。您有權利免費獲得這份資訊，以及透過您的母語提供的協助服務。會員請撥打印在身分識別卡背面的電話號碼。其他所有人士可撥打電話 855-258-6518，並等候直到對話提示按下按鍵 0。當接線生回答時，請說出您需要使用的語言，這樣您就能與口譯人員連線。

Igbo (Igbo) Nrubama: Okwa a nwere ozi gbasara mkpuchi nchekwa onwe gi. O nwere ike inwe ubochi ndi di mkpa, i nwere ike ime ihe tupu ufodu ubochi njedebe. I nwere ikike inweta ozi na enyemaka a n'asusu gi na akwughi ugwo o bula. Ndi otu kwesiri ikpo akara ekwentidi di n'azu nke kaadi njirimara ha. Ndi ozo niile nwere ike ikpo 855-258-6518 wee chere ububo ahuru roo mgbe amanyere ipi 0. Mgbe onye nnochite anya zara, kwuo asusu i choro, a ga-ejiko gi na onye okowa okwu.

Deutsch (German) Achtung: Diese Mitteilung enthält Informationen über Ihren Versicherungsschutz. Sie kann wichtige Termine beinhalten, und Sie müssen gegebenenfalls innerhalb bestimmter Fristen reagieren. Sie haben das Recht, diese Informationen und weitere Unterstützung kostenlos in Ihrer Sprache zu erhalten. Als Mitglied verwenden Sie bitte die auf der Rückseite Ihrer Karte angegebene Telefonnummer. Alle anderen Personen rufen bitte die Nummer 855-258-6518 an und warten auf die Aufforderung, die Taste 0 zu drücken. Geben Sie dem Mitarbeiter die gewünschte Sprache an, damit er Sie mit einem Dolmetscher verbinden kann.

Français (French) Attention: cet avis contient des informations sur votre couverture d'assurance. Des dates importantes peuvent y figurer et il se peut que vous deviez entreprendre des démarches avant certaines échéances. Vous avez le droit d'obtenir gratuitement ces informations et de l'aide dans votre langue. Les membres doivent appeler le numéro de téléphone figurant à l'arrière de leur carte d'identification. Tous les autres peuvent appeler le 855-258-6518 et, après avoir écouté le message, appuyer sur le 0 lorsqu'ils seront invités à le faire. Lorsqu'un(e) employé(e) répondra, indiquez la langue que vous souhaitez et vous serez mis(e) en relation avec un interprète.

한국어(Korean) 주의: 이 통지서에는 보험 커버리지에 대한 정보가 포함되어 있습니다. 주요 날짜 및 조치를 취해야 하는 특정 기한이 포함될 수 있습니다. 귀하에게는 사용 언어로 해당 정보와 지원을 받을 권리가 있습니다. 회원이신 경우 ID 카드의 뒷면에 있는 전화번호로 연락해 주십시오. 회원이 아닌 경우 855-258-6518 번으로 전화하여 0을 누르라는 메시지가 들릴 때까지 기다리십시오. 연결된 상담원에게 필요한 언어를 말씀하시면 통역 서비스에 연결해 드립니다.