



**BlueCross BlueShield
of Texas**

Group Enrollment Application Change Form

Please read the instructions on the inside thoroughly before completing this enrollment application/change form.

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association Life, Accidental Death & Dismemberment and Disability insurance is underwritten by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148. Dearborn Life Insurance Company is an independent Blue Cross and Blue Shield licensee. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

ENROLLMENT APPLICATION/CHANGE FORM INSTRUCTIONS

PLEASE READ THOROUGHLY BEFORE COMPLETING ENROLLMENT APPLICATION/CHANGE FORM
Use a black or blue ballpoint pen only. Print neatly. Do not abbreviate.

SECTION 1 ENROLLMENT EVENTS	<p>Check all the boxes that apply to indicate if you are a new enrollee or if you are requesting a change to your coverage. Indicate the event and date, if applicable. Complete the additional sections that correspond to your selection.</p> <p>New Enrollee: Complete all sections where applicable.</p> <p>Add Dependent: Complete all sections where applicable.</p> <ul style="list-style-type: none">If you are enrolling a court-ordered dependent for coverage beyond the automatic 31-day period for coverage, you must submit a copy of the court order or decree.If you are applying for coverage for a disabled dependent over the age limit of your employer's plan, please provide the additional information requested in Section 5. Additional documentation may be required as addressed in that section.If student dependent coverage is part of your employer's plan and you are adding or enrolling a dependent child age 26 or over who is a student, you may be required to submit a completed Student Certification form. <p>Open Enrollment: The period of time offered on a regular basis during which you can elect to enroll in a specific group health insurance plan or make changes to your current membership.</p> <p>Special Enrollment Event: If you qualify, special enrollment is any change to your current membership such as marriage*, divorce**, adoption, suit for adoption, leave/layoff, moving out of the service area, etc. This change may occur outside of open enrollment.</p> <p>Effective Date of Benefits: Field is mandatory.</p> <p>Completion of Other Eligibility Requirements: Check this box only if your employer has eligibility requirements that you have met/completed prior to enrollment, such as measurement period or orientation period.</p> <p>Cancel Enrollee/Cancel Dependent/Cancel Coverage: Complete Sections 1, 2, 4 (skip Section 4 if declining coverage) and 9. In Section 4 include name, social security number and date of birth of individual(s) canceling.</p>
SECTION 2 YOUR INFORMATION	Complete this section with details about yourself even if you are declining coverage.
SECTION 3 YOUR COVERAGE	<p>Complete all portions related to the coverages for which you are applying. Please list the seven character plan ID for your selected benefit design (example for a small group plan: B634ADT) in the plan # field. If you are unsure of your group size or do not know your plan ID, please ask for guidance from your employer.</p> <p>If you are enrolling for life or disability insurance, enter the information requested. When listing the beneficiary, provide both the first and last name and the relationship to you. List all beneficiaries that apply.</p>
SECTION 4 COVERAGE OPTIONS	<p>Complete all areas that apply to you and each dependent.</p> <p>For HMO Plans Only:</p> <ul style="list-style-type: none">Blue Essentials AccessSM or Blue Premier AccessSM plans do not require a PCP selection.Those applying for Blue Advantage HMOSM, Blue EssentialsSM or Blue PremierSM plans are required to select a primary care physician/practitioner (PCP) for each covered individual. List the name of the physician/practitioner and the provider number from the provider directory or Provider Finder[®] at bcbstx.com. Be sure to check the appropriate box for a new patient.ATTENTION FEMALE MEMBERS: If you select an HMO plan that requires PCP selection, remember that your PCP's network may affect your choice of an OB/GYN. You have the right to receive services from an OB/GYN without first obtaining a referral from your PCP. However, for HMO members, the OB/GYN from whom you receive services must belong to the same physician practice group or independent practice association (IPA) as your PCP. This is another reason to make certain that your PCP's network includes the specialists – particularly the OB/GYN – and hospitals that you prefer. You are not required to designate an OB/GYN. You may elect to receive OB/GYN services from your PCP. <p>Change Primary Care Physician/Practitioner: Complete Section 1 and check the "Other Change(s)" box; then, complete Sections 2, 3, 4 and 9. In Section 4, please include enrollee's or dependent's name, social security number, date of birth, and name and number of the new PCP.</p> <p>Change Address/Name: Complete Section 1 and check the "Other Change(s)" box; then, complete Sections 2 and 9.</p>
SECTION 5 DISABLED DEPENDENT	A disabled dependent must be medically certified as disabled and dependent upon you or your spouse**/domestic partner in order to be considered for coverage if disabled dependent coverage is part of your employer's plan. A Disabled Dependent Authorization and Disabled Dependent Physician Certification form must be completed and submitted with this enrollment application, if applicable.
SECTION 6 OTHER COVERAGE	Complete this section if you or any dependent have other group or individual health and/or dental coverage (if applicable) that will not be canceled when the coverage under this application becomes effective.
SECTION 7 MEDICARE COVERAGE	Complete this section if you or any of your dependents are covered by Medicare. Enter the start and end dates for the coverage that applies. Your Medicare HIC number must be listed (it can be found on your Medicare ID card). Check the reason for your Medicare coverage.
SECTION 8 DECLINATION OF COVERAGE	<p>Complete this section if you are declining health coverage for yourself and your dependents. Anyone declining coverage for any reason should complete Section 8, not just those declining because of other coverage.</p> <p>IMPORTANT NOTICE: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health care coverage, you may, in the future, be able to enroll yourself or your dependents in the plan if you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of a marriage, birth, adoption, suit for adoption or placement of a foster child in your home, you may be able to enroll yourself and your dependents if you request enrollment within 31 days after the marriage, birth, adoption, suit for adoption or placement of an eligible foster child in your home.</p>
SECTION 9 COVERAGE CONDITIONS	<p>Sign your name and date the enrollment application if you agree to the conditions set forth in this section. Your enrollment application should be submitted to your employer's Enrollment Department, which will then submit your form by mail or email to: BCBSTX • Group Accounts Dept. • PO Box 655730 • Dallas, TX 75265-5730.</p> <p>* The term "marriage" includes legal marriage and the establishment of a domestic partnership (coverage subject to your employer's plan). ** The term "divorce" includes legal divorce and the comparable termination of a domestic partnership (coverage subject to your employer's plan). *** The use of the term "spouse" includes a legal spouse. It also includes a party to a domestic partnership (coverage subject to your employer's plan).</p>

Changes in state or federal law or regulations, or interpretations thereof, may change the terms and conditions of coverage.

Forms referenced above may be obtained by accessing the Blue Cross and Blue Shield of Texas website at bcbstx.com, or from your employer. If you are a current member and have questions, you may also call the Customer Service number on the back of your member ID card.

ENROLLMENT APPLICATION/CHANGE FORM



Group #

Section #

Social Security #

Account #

Category

Please Note: If your group offers a Consumer Choice health plan you have the option to choose a Consumer Choice of Benefits Health Insurance Plan or Consumer Choice of Benefits Health Maintenance Organization health care plan that, either in whole or in part, does not provide state-mandated health benefits normally required in accident and sickness insurance policies or evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health insurance policy or health plan for you, although, at the same time, it may provide you with fewer health benefits than those normally included as state-mandated health benefits in policies or evidences of coverage in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this policy or evidence of coverage.

SECTION 1 — ENROLLMENT EVENTS

PLEASE CHECK ALL THAT APPLY – IF YOU ARE DECLINING COVERAGE, COMPLETE SECTIONS 2, 8 AND 9 ONLY

New Enrollee Add Dependent Open Enrollment Other Changes

Are you applying as a result of a Special Enrollment Event?

No Yes, Event Date: ___/___/___

Event: New Hire Marriage* Birth
 Adoption or Suit for Adoption (provide legal documents)
 Court Order (provide court order or decree)
 Loss of Other Coverage
 Other (explain): _____

Effective Date of Benefits: ___/___/___ Completion of Other Eligibility Requirements

Cancel Enrollee Cancel Dependent

Cancel Coverage: Health Dental

Term Life Dependent Life
 Short-Term Disability Long-Term Disability
 List names of those canceling in Section 4 below

Event: Divorce** Death
 Terminated Employment Other

Indicate Event Date: ___/___/___

SECTION 2 — PLEASE TELL US ABOUT YOURSELF

COMPLETE EVEN IF DECLINING COVERAGE

Last Name	First Name	MI (opt)	Suffix	Birth Date (MM/DD/YYYY)	Social Security #
Mailing Address - Street - Apt #			City	State	ZIP code
Email Address		<input type="checkbox"/> Male <input type="checkbox"/> Female	Home/Cell Phone #		
Name of Employer	Job Title	Business Phone #	Employment Date (MM/DD/YYYY)	Do you usually work at least 30 hours a week for this employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Eligibility Status: <input type="checkbox"/> Active Employee <input type="checkbox"/> Retired Employee - Date of Retirement: _____ <input type="checkbox"/> COBRA Continuation					
<input type="checkbox"/> State Continuation of Group Coverage (insured plans only) <input type="checkbox"/> Dependent State Continuation of Group Coverage (insured plans only)					

SECTION 3 — SELECT YOUR COVERAGE

PLEASE CHECK ALL THAT APPLY

Small Group Plans (2-50 Employees)			
Health Coverage (select one) <input type="checkbox"/> Blue Premier Access SM <input type="checkbox"/> Blue Choice PPO SM <input type="checkbox"/> Blue Essentials SM <input type="checkbox"/> Blue Advantage HMO SM <input type="checkbox"/> Blue Essentials Access SM <input type="checkbox"/> Other _____ Plan # (required) _____	Who is covered for health? (select one) <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee/Spouse*** <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Family <input type="checkbox"/> I am not applying for Health coverage	BlueCare DentalSM Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	Who is covered for dental? (select one) <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Family <input type="checkbox"/> I am not applying for Dental coverage
Large Group Plans (more than 50 Employees)			
Health Coverage (select one) <input type="checkbox"/> Blue Choice PPO SM <input type="checkbox"/> Blue Essentials SM <input type="checkbox"/> Blue Premier SM <input type="checkbox"/> Blue Essentials Access SM <input type="checkbox"/> Blue Premier Access SM <input type="checkbox"/> Other _____ Plan # _____	Who is covered for health? (select one) <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Family <input type="checkbox"/> I am not applying for Health coverage	Dental Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No Plan # (required) _____	Who is covered for dental? (select one) <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Family <input type="checkbox"/> I am not applying for Dental coverage

Primary Language: _____ English Spanish Other
 Do you have a disability affecting your ability to communicate or read? Yes No
 If "Yes," describe special communication materials needed: _____

Group Term Life, Accidental Death and Dismemberment (AD&D) and Disability Insurance[^]

I am not applying for Group Term Life, AD&D or Disability Insurance coverage

Employee Occupation/Job Title: _____ Wage Rate \$ _____ per hour week month year

Group Basic Term Life and AD&D I do not apply I do apply Amount \$ _____

Group Dependents' Life I do not apply I do apply

Group Supplemental Life I do not apply I do apply

Employee Election: \$ _____ Spouse Election: \$ _____ Child Election: \$ _____

Short-Term Disability I do not apply I do apply

Long-Term Disability I do not apply I do apply

Primary Beneficiary	First Name	Initial	Last Name	Relationship	Birth Date (MM/DD/YYYY)	Social Security #
Contingent Beneficiary	First Name	Initial	Last Name	Relationship	Birth Date (MM/DD/YYYY)	Social Security #

* The term "marriage" includes legal marriage and the establishment of a domestic partnership (coverage subject to your employer's plan).
 ** The term "divorce" includes legal divorce and the comparable termination of a domestic partnership (coverage subject to your employer's plan).
 *** The use of the term "spouse" includes a legal spouse. It also includes a party to a domestic partnership (coverage subject to your employer's plan).
[^] Life, Accidental Death & Dismemberment and Disability insurance is underwritten by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148. Dearborn Life Insurance Company is an independent Blue Cross and Blue Shield licensee. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

Last Name: _____

Social Security #: _____

Group #

SECTION 4 — COVERAGE OPTIONS		PLEASE COMPLETE ALL AREAS THAT APPLY. PCP SELECTION IS REQUIRED FOR BLUE ADVANTAGE, BLUE PREMIER AND BLUE ESSENTIALS PLANS. PCP SELECTION IS NOT REQUIRED FOR BLUE PREMIER ACCESS AND BLUE ESSENTIALS ACCESS PLANS.			
Employee/Enrollee's Name	PCP Name	PCP #	New Patient? <input type="checkbox"/> Y <input type="checkbox"/> N	HMO OB/GYN Name (optional)	HMO OB/GYN #
Dependent's Name <input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Domestic Partner	Dependent's PCP Name	PCP #	New Patient? <input type="checkbox"/> Y <input type="checkbox"/> N	HMO OB/GYN Name (optional)	HMO OB/GYN #
Dependent's Social Security #	Birth Date (MM/DD/YYYY)	Address (if different) - # and Street Address		City	State ZIP code
Dependent's Name <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other Eligible Dependent	Dependent's Social Security #	Dependent's PCP Name	PCP #	New Patient? <input type="checkbox"/> Y <input type="checkbox"/> N	HMO OB/GYN Name (optional) HMO OB/GYN #
Birth Date (MM/DD/YYYY)	Home Address (If different) Street/City/State/ZIP code	Is this dependent a natural child, stepchild, foster child, adopted child, or a child in suit for adoption? <input type="checkbox"/> Y <input type="checkbox"/> N		If not your eligible natural child, stepchild, foster child, adopted child or child in suit for adoption, are you (or your spouse) responsible for this dependent? <input type="checkbox"/> Y <input type="checkbox"/> N	
Dependent's Name <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other Eligible Dependent	Dependent's Social Security #	Dependent's PCP Name	PCP #	New Patient? <input type="checkbox"/> Y <input type="checkbox"/> N	HMO OB/GYN Name (optional) HMO OB/GYN #
Birth Date (MM/DD/YYYY)	Home Address (If different) Street/City/State/ZIP code	Is this dependent a natural child, stepchild, foster child, adopted child, or a child in suit for adoption? <input type="checkbox"/> Y <input type="checkbox"/> N		If not your eligible natural child, stepchild, foster child, adopted child or child in suit for adoption, are you (or your spouse) responsible for this dependent? <input type="checkbox"/> Y <input type="checkbox"/> N	
Dependent's Name <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other Eligible Dependent	Dependent's Social Security #	Dependent's PCP Name	PCP #	New Patient? <input type="checkbox"/> Y <input type="checkbox"/> N	HMO OB/GYN Name (optional) HMO OB/GYN #
Birth Date (MM/DD/YYYY)	Home Address (If different) Street/City/State/ZIP code	Is this dependent a natural child, stepchild, foster child, adopted child, or a child in suit for adoption? <input type="checkbox"/> Y <input type="checkbox"/> N		If not your eligible natural child, stepchild, foster child, adopted child or child in suit for adoption, are you (or your spouse) responsible for this dependent? <input type="checkbox"/> Y <input type="checkbox"/> N	

SECTION 5 — DISABLED DEPENDENT		PLEASE COMPLETE IF APPLICABLE	
Name of Disabled Dependent			Nature of Disability
Name of Disabled Dependent			Nature of Disability

If disabled child is over the dependent age limit of your employer's plan, please attach a completed Disabled Dependent Authorization and Disabled Dependent Physician Certification.

SECTION 6 — OTHER COVERAGE INFORMATION		PLEASE COMPLETE ALL AREAS THAT APPLY			
Complete this section only if you or any of your dependents have other health and/or dental coverage that will not be canceled when the coverage under this application becomes effective. List names of each individual covered:					
Group Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	Individual Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	Name and Address of Other Insurance Carrier	Effective Date (MM/DD/YYYY)	Type of Policy <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Family	
Name of Policyholder	Birth Date (MM/DD/YYYY)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Applicant <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent		
Employer's Name	Employment Date (MM/DD/YYYY)	Health Group #	Health ID #	Dental Group #	Dental ID #

SECTION 7 — MEDICARE COVERAGE INFORMATION		PLEASE COMPLETE IF APPLICABLE	
Name of person covered:	Medicare A (Hospital) Effective Date: _____ End Date: _____	Medicare B (Medical) Effective Date: _____ End Date: _____	Medicare HIC # (From Medicare Card)
	Medicare D (Drug) Effective Date: _____ End Date: _____	Medicare D (Drug) Carrier: _____	
Please indicate reason for Medicare Eligibility: <input type="checkbox"/> Entitled Age <input type="checkbox"/> Entitled Disability <input type="checkbox"/> End-Stage Renal Disease <input type="checkbox"/> Disability and Current Renal Disease			
Name of person covered:	Medicare A (Hospital) Effective Date: _____ End Date: _____	Medicare B (Medical) Effective Date: _____ End Date: _____	Medicare HIC # (From Medicare Card)
	Medicare D (Drug) Effective Date: _____ End Date: _____	Medicare D (Drug) Carrier: _____	
Please indicate reason for Medicare Eligibility: <input type="checkbox"/> Entitled Age <input type="checkbox"/> Entitled Disability <input type="checkbox"/> End-Stage Renal Disease <input type="checkbox"/> Disability and Current Renal Disease			

SECTION 8 — DECLINATION OF COVERAGE		PLEASE COMPLETE IF YOU ARE DECLINING COVERAGE	
This is to certify the available coverage has been explained to me. I have been given the opportunity to apply for the coverage offered to me and my eligible dependents and have voluntarily elected to decline the coverage as indicated below. If I desire to apply for coverage at a later date, I understand there may be a delay in the effective date of the coverage.			
Name <input type="checkbox"/> Employee	Reason for declining Health : <input type="checkbox"/> Other Group Health Coverage - Carrier: _____ <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other Individual Health Coverage - Carrier: _____ <input type="checkbox"/> Other (explain) _____ <input type="checkbox"/> I am not enrolled in any health insurance plan, but do not want this coverage		
Name <input type="checkbox"/> Employee	Reason for declining Dental : <input type="checkbox"/> Other Group Dental Coverage <input type="checkbox"/> Medicaid <input type="checkbox"/> Individual Dental Coverage <input type="checkbox"/> Other (explain) _____ <input type="checkbox"/> I am not enrolled in any dental insurance plan, but do not want this coverage		
Name <input type="checkbox"/> Spouse	Reason for declining: <input type="checkbox"/> Other Group Health Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other Individual Health Coverage <input type="checkbox"/> Other (explain) _____ <input type="checkbox"/> I am not enrolled in any health insurance plan, but do not want this coverage		
Name <input type="checkbox"/> Dependent	Reason for declining: <input type="checkbox"/> Other Group Health Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other Individual Health Coverage <input type="checkbox"/> Other (explain) _____ <input type="checkbox"/> I am not enrolled in any health insurance plan, but do not want this coverage		
Name <input type="checkbox"/> Dependent	Reason for declining: <input type="checkbox"/> Other Group Health Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other Individual Health Coverage <input type="checkbox"/> Other (explain) _____ <input type="checkbox"/> I am not enrolled in any health insurance plan, but do not want this coverage		

SECTION 9 — COVERAGE CONDITIONS	
<ul style="list-style-type: none"> I am an employee of the employer named in this enrollment application. I am eligible to participate in the coverage(s) afforded by my employer's plan, which is either underwritten or administered by Blue Cross and Blue Shield of Texas (BCBSTX) or Dearborn Life Insurance Company. On behalf of myself and any dependents listed on this enrollment application, I apply for those coverage(s) for which I am eligible. I state that the information given on this enrollment application is true and correct. I understand and agree that any intentional misrepresentation of a material fact made by me will invalidate my coverage(s). Only those coverage(s) and amounts for which I am eligible will be available to me. I understand that if this enrollment application is accepted, the coverage(s) will become effective in accordance with the provisions of the Contract(s)/Plan(s). I agree that my employer acts as my agent. I authorize necessary payroll deduction by my employer, if any, to cover the cost of my coverage(s). As applies to insurance coverage, I will accept an electronic copy of my coverage documents (whether certificate of coverage or benefit booklet) if my employer requests that BCBSTX deliver the information electronically. I understand that a hard copy is available to me upon request. I understand that my participation in the coverage(s) is subject to any future amendment. I also understand that all notices given to my employer are applicable to me. I understand that written communications that are required by law may be delivered to me electronically, with my consent. I understand that if I withdraw consent to receive my documents electronically, that will receive a written communication in paper form. <input type="checkbox"/> Accept receiving communications electronically <input type="checkbox"/> Reject receiving communications electronically I understand to withdraw consent to receive documents electronically, I will need to call the Customer Service number on the back of my member ID card. I understand to update information needed for BCBSTX to contact me electronically, I will need to call the Customer Service number on the back of my member ID card. 	
WARNING: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.	
Applicant's Signature _____	Date _____



Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984

العربية Arabic	إن كان لديك أو لدى شخص تساعد أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您，或您正在協助的對象，對此有疑問，您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員，請撥電話號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય અવા કોઈ બાજુ વ્યક્તને અસુબા, અમ. કાયકમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કોલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें।
日本語 Japanese	ご本人様、またはお客様の身の回りの方でも、ご質問がございましたら、ご希望の言語でサポートを受けたり、情報入手したり することができます。料金はかかりません。通訳とお話される場合、855-710-6984 までお電話ください。
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
ພາສາລາວ Laotian	ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄຳຖາມ, ທ່ານມີສິດຂໍເອົາການຊ່ວຍເຫຼືອ ແລະ ຂໍ ມູນເບິ່ງພາສາຂອງທ່ານໄດ້ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອສົມກັບນາຍແປພາສາ, ໃຫ້ໃຫ້ຫາເບີ 855-710-6984.
Diné Navajo	T'áá ni, éí doodago ła'da biká anánłwo'ígíí, na'idíłkidgo, ts'idá bee ná ahóótí'i' t'áá ník'e níká a'doolwoł dóó bína'idíłkidígíí bee níł hodoonih. Ata'dahalne'ígíí bich'í' hodíílnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سوالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulongan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị đang giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 855-710-6984.