MTA Maryland

MTA Health & Welfare Plan Enrollment/Change Form

GROUP HEALTH INSURANCE PLAN ENROLLMENT FORM

COMPLETION OF THIS FORM MEANS THAT YOU HAVE READ AND AGREE TO COMPLY WITH THE FOLLOWING CONDITIONS OF ENROLLMENT:

- **Review your current Health Plan enrollment and the available plans and options.**
- **Submit supporting documentation, if required, for dependent enrollments to the MTA Benefits Office (see contact information below). *THE MTA CANNOT COMPLETE AN ENROLLMENT UNTIL ALL REQUIRED DOCUMENTS ARE RECEIVED*.**
- **For changes to your coverage outside of open enrollment, it is your responsibility to report any Changes, Additions, or Deletions to your coverage WITHIN 60 DAYS to the MTA Benefits Section (See Below).**
- **If you DROP or WAIVE enrollment in any MTA Health Plan enrollment, you will not be able to enroll again until the next annual open enrollment period unless you experience a Qualifying Event.**
- **If enrolling in an HMO, you must work *or* reside in the HMO service area.**

DOCUMENTS REQUIRED TO ADD A DEPENDENT:

	State Marriage Certificate	Birth Certificate	Other Required Documents
Spouse	Yes	No	None
Biological Child	No	Yes	None
Adopted Child or child placed with you for Adoption	No	Yes	Adoption placement papers including child's date of birth are required if new birth certificate is not yet issued; Official birth certificate is required when issued.
Stepchild	No	Yes	Birth Certificate must indicate Spouse of employee as the parent
Grandchild/Legal Ward	No	Yes	A grandchild/legal ward who is in your custody *through court order*, and resides with and is the dependent of the Employee or Dependent spouse is eligible for coverage if all criteria is met. A copy of the court order must be submitted.

Maryland Transit Administration (MTA)
Office of Human Resources – Benefits Section
6 St. Paul Street – 5th Floor
Baltimore, MD 21202
Please contact the MTA Benefits Office if you have questions:
(410) 767-3755 (410) 767-3845 (410) 767-3852 (410) 767-3853

Rev 10/11/2013

MTA Health & Welfare Plan Enrollment/Change Form

MTA Department of Human Resources-Benefits Office
6 St. Paul Street, 5th Floor
Baltimore, MD 21202-6806

Phone: (410) 767-3845; 3852; 3755; 3853
Fax: (410) 333-4631

SUBSCRIBER INFORMATION – Please Type or Print All Information.

☐ ACTIVE ☐ RETIRED ☐ COBRA ☐ SURV ☐ PT ☐ FT ☐ OTHER_____ DATE OF HIRE/STATUS CHANGE:_____

Applicant SSN | Applicant Name (Last, First, Middle Initial) | Applicant Date of Birth

Payroll No. | Address | Apt/Unit No. | City | State | Zipcode

Home Phone Number | Cell Phone Number | E-mail address

Gender: ☐ Male ☐ Female Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

REASON FOR ENROLLMENT/CHANGE *Enrollment changes being requested outside of the annual open enrollment period must be related to an event that allows for a special enrollment. Check the event below that triggered the requested change:*

☐ NEW HIRE/REHIRE ☐ OPEN ENROLLMENT ☐ ROLLOVER TO FT ☐ NEW RETIREE ☐ COBRA ☐ SURVIVOR

☐ CHANGE IN RESIDENCE AFFECTING HEALTH PLAN ELIGIBILITY ☐ CHANGE MEDICAL PLAN ONLY: _____ TO _____

☐ *ADDING NEW DEPENDENT**
Date of Event: ___/___/_____
Select Reason

☐	*Marriage**
☐	*Birth/Adoption of Child**
☐	*Guardianship/Court Order**
☐	*Loss of Other Coverage**
☐	*Loss of Medical Assistance/Medicaid**
☐	*Special Enrollment – Adult Child to age 26/Disabled Child**

☐ *REMOVING CURRENT DEPENDENT**
Date of Event: ___/___/_____
Select Reason

☐	*Divorce**
☐	*Death**
☐	*Loss of Eligibility**
☐	*Gaining Other Coverage**
☐	*Gaining Medical Assistance/Medicaid**
☐	*Other Reason**

☐ OTHER REASON – PLEASE EXPLAIN:_____

_____

_____

***DOCUMENTATION REQUIRED. CONTACT THE BENEFITS OFFICE TO DETERMINE DOCUMENTATION NEEDED.**

For events italicized and indicated by asterisk (*) above, you must submit this form and any necessary documents that support your status change within 60 days of the date that your status changed. Otherwise, you will have to wait until Open Enrollment to make your enrollment change

MTA HEALTH PLAN ENROLLMENT ELECTIONS

MEDICAL PLAN	*PRESCRIPTION PLAN*	*DENTAL PLAN*	*VISION PLAN*
Elect only one Medical Plan Or Elect Waiver – Subscriber and All dependents must be in SAME PLAN	Elect or Waive	Elect or Waive	Elect or Waive
☐ HMO	☐ PPO	☐ Prescription Plan	☐ Dental Plan	☐ Vision Plan
☐ Self Only	☐ Self Only	☐ Self Only	☐ Self Only	☐ Self Only
☐ Self & 1 Child	☐ Self & 1 Child	☐ Self & 1 Child	☐ Self & 1 Child	☐ Self & 1 Child
☐ Self & Spouse	☐ Self & Spouse	☐ Self & Spouse	☐ Self & Spouse	☐ Self & Spouse
☐ Family	☐ Family	☐ Family	☐ Family	☐ Family
☐ WAIVE	☐ WAIVE	☐ WAIVE	☐ WAIVE	☐ WAIVE

NOTE: If you Waive enrollment in any MTA H&W plan, you CANNOT enroll your dependents in that Plan

This section is for MTA Benefits Office use only. Effective Date: _____ Date Entered into Sys K: _____ By: _____

MTA Health & Welfare Plan Enrollment/Change Form

DEPENDENT INFORMATION & ENROLLMENT INSTRUCTIONS

- **List ALL family members that you wish to cover (ADD) or disenroll (DROP) on this form**
- **DEFINITION OF ELIGIBLE DEPENDENT CHILDREN: Your unmarried child, under the age of 26 unless disabled, is eligible for coverage if s/he is: Your natural child, your stepchild or adopted child, child placed with you for adoption, or is a child related to you by blood or marriage for whom you are the legal guardian. In some instances, a signed court order will be required that documents legal guardianship and/or custody.**
- **In the DEPENDENT INFORMATION section below, enter one of these letters in the circles beside each dependent's name:**
- **(A)ADD , (D)DROP , (K)KEEP or (W)WAIVE in the circled areas for EACH MTA Health Plan for EACH OF YOUR DEPENDENTS.**
- **Type or print clearly. Inaccurate, incomplete, or illegible information may delay processing of your enrollments.**
- **ALL applicable documents should be submitted to the MTA Benefits Office with this enrollment form. Otherwise, your elections will not be put into effect. *YOU HAVE 60 DAYS FROM YOUR ELIGIBILITY DATE TO PROVIDE MTA WITH THE REQUIRED DOCUMENTS. IF REQUIRED DOCUMENTS ARE NOT SUBMITTED, MTA WILL NOT ENROLL YOUR DEPENDENTS.***
- **For Dependent RELATIONSHIP CODE ("REL CODE"), please enter one of the following: *Spouse = 1; Child=2; Legal Guardianship=3; Adopted Child = 4 Stepchild = 5 Disabled Child = 6.***
- **To enroll your Spouse – *Please attach a copy of your marriage certificate to this application.***
- **To enroll your Biological or Adopted Child – *Please attach a copy of each child's birth certificate.***
- ***For Stepchildren, submit child's birth certificate and copy of your spouse's birth certificate.***
- ***FOR ALL OTHER CHILDREN, PLEASE CONTACT THE MTA'S BENEFITS OFFICE FOR DIRECTIONS AND INSTRUCTIONS REGARDING DOCUMENTS REQUIRED FOR ENROLLMENT.***
- ***If you are disenrolling ("DROPPING") a dependent due to death or divorce, please submit copy of death certificate or divorce decree.***
- **Social Security numbers are required for all dependents. *In compliance with the Federal Privacy Act of 1974, the disclosure of an individual's Social Security number is mandatory on this form pursuant to 26 U. S. C. Section 3402. The individual's Social Security number will be used exclusively for regulatory reporting purposes and as a means of proper identification as permitted.***

DEPENDENT INFORMATION

You may **ADD** eligible dependents not currently covered or **DROP** ineligible dependents. **A= ADD; D=DROP.** If you want to keep a coverage you may have at its present level, enter **K=KEEP.** If WAIVING enrollment in a certain plan, enter **W = WAIVE. Write one of these letters in the circled areas beside each of your dependent's names. Use an additional form if you have more than 5 dependents.**

RELATIONSHIP CODE: Enter one of these numbers in the "REL CODE" column for each dependent. Example: Spouse = 1, then enter one in Relationship Code column for your Spouse. **Spouse=1 Child=2 Legal Guardianship=3 Adopted Child=4 Stepchild=5 Disabled Child = 6**

***Medical Plan -Either **HMO** OR **PPO**; **Rx=** Prescription Drug Plan; **Vis**=Vision Care Plan **De**= Dental Plan

SOCIAL SECURITY NUMBER	NAME: FIRST, MID. INITIAL, LAST	ENTER (A) ADD, (D) DROP, (K)KEEP or (W) WAIVE IN EACH BUBBLE – Indicate for EACH coverage for SELF and EACH dependent	BIRTH DATE	M/F	REL CODE	FOR HMO ONLY: PRIMARY CARE DOCTOR ID# or NAME:
	SELF	◯ ◯ ◯ ◯ ◯ HMO PPO Rx Vis De			**SELF**	
		◯ ◯ ◯ ◯ ◯ HMO PPO Rx Vis De				
		◯ ◯ ◯ ◯ ◯ HMO PPO Rx Vis De				
		◯ ◯ ◯ ◯ ◯ HMO PPO Rx Vis De				
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OTHER COVERAGE

Are you, or any of your Eligible Dependents covered by any other health insurance plan? ☐ YES ☐ NO If YES, please complete this section and indicate type of coverage: Medical, Dental, Prescription, or Vision.

Type of Coverage	Insurance Co.	Policy Number	Policyholder (First, M.I. Last Name)	Birth Date	Policy Coverage Dates (MM-DD-YYYY)	Name of Person(s) Covered by this Plan
					From: To:	
					From: To:	

MEDICARE INFORMATION (This section is to be completed by RETIREES ONLY!)

FOR RETIREES ONLY ---If you, or any of your Dependents, are enrolled in Medicare, use the information shown on your Medicare card to complete this section. Fill in the blank Medicare cards in this section so that the information you give matches the information on your Red, White and Blue Medicare card. Please attach a copy of your Medicare card(s) or a copy of your Social Security award letter to this application as verification of your enrollments.

********RETIREES ARE REQUIRED TO ENROLL IN MEDICARE WHEN ELIGIBLE*******

RETIREE MEDICARE CARD INFORMATION

SPOUSE/DEPENDENT MEDICARE CARD INFORMATION

AUTHORIZATION AND CERTIFICATION

I understand and agree that:

- I authorize MTA to take the appropriate actions to enroll me and/or my dependents in the MTA Health Plans selected on this form. I have reviewed these plans as outlined in the MTA Health Benefits Option booklet . I further understand that all benefits under the enrollments elected by me on this application will be provided in accordance with the terms of the applicable collective bargaining agreement, insurance company, third party administrator, or related vendor or other service contracts and/or agreements that have been executed by MTA and these respective parties. I will abide by the terms and conditions of these contracts and/or agreements governing eligibility and receipt of services under the MTA Health Plan(s) in which I have elected enrollment for myself and/or my eligible dependents as set forth on this application.
- I understand that if I waive enrollment in any MTA Health Plan as set forth on this application, that I cannot reenroll until the annual open enrollment period, or within 60 days of a Qualifying Event, as indicated in the next statement. I understand that these same conditions apply to dependent enrollments. If I waive enrollment in any MTA Health Plan, I will only be able to enroll my eligible dependents during the next open enrollment or if a Qualifying Event should occur prior to open enrollment.
- The elections indicated on this application may not be changed or cancelled during the plan year without a permitted Qualifying Event. The most common examples of Qualifying Events include a change in marital status, a change in the number of dependents due to birth or adoption, death, or termination of coverage provided elsewhere. Under IRS regulations pursuant to Section 125 of the Internal Revenue Code, the enrollments set forth in this form are irrevocable until January 1st of the next Plan Year unless I experience a specific change in status (Qualifying Event) prior to the January 1st Plan year commencement date.
- I certify that each enrolled dependent meets MTA eligibility requirements. I understand that MTA requires supporting documentation to verify the eligibility of any dependents enrolled or requesting to be enrolled in any MTA sponsored Health Plan. I understand that enrollments in an MTA Health Plan in which I or my dependents are not entitled is considered fraud. In all cases, I am responsible for the accuracy of my enrollments, coverage levels, and deductions. I further understand that if I willfully misrepresent the eligibility of myself or my dependents on this application, or any future supplemental application, or fail to take the necessary actions to remove ineligible dependents, or in any way obtain benefits from any MTA Health Plan to which I am not entitled, my enrollments may be cancelled. I may be required to repay any claims and insurance premiums which have been paid inappropriately, and I may also face charges up to dismissal from MTA service and/or criminal investigation and prosecution.
- For ACTIVE Employees ONLY: I authorize MTA to deduct from my earnings any amounts required to cover my share of the coverage(s) I have elected as set forth on this application, including any arrears I may owe. I authorize payment of my employee contributions to be made on a Pre-Tax Basis, unless I have signed a Post-Tax form. I also understand that my share of the benefit costs related to any MTA Health Plan enrollment is determined by the applicable collective bargaining agreement and as such, may be subject to change. This authorization will automatically renew in subsequent Plan years unless cancelled in writing.
- FOR RETIREES ONLY: I acknowledge that I and my dependents are required to enroll in Medicare Parts A & B as soon as eligible. I authorize the deduction of my share of cost for enrolled benefits from my pension payment.

_____ _____

Applicant Signature Date

CareFirst
Family of health care plans

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	civilrightscoordinator@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.

CareFirst
Family of health care plans

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 ቀነ-ገደቦች በፊት ሊፈጽሟቸው የሚገቡ ነገሮች ሊኖሩ ስለሚችሉ እነዚህን ወሳኝ ቀናት ሊይዝ ይችላል። ይኽን መረጃ የማግኘት እና ያለምንም ክፍያ በቋንቋዎ እገዛ 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) Ìtẹ́tíléko: Àkíyèsí yìí ní ìwífún nípa iṣẹ́ adójútòfò rẹ. Ó le ní àwọn déètì pàtó o sì le ní láti gbé ìgbésẹ̀ ní àwọn ọjọ́ gbèdéke kan. O ni ẹ̀tọ́ láti gba ìwífún yìí àti ìrànlọ́wọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Àwọn ọmọ-ẹgbẹ́ gbọ́dọ̀ pe nọ́mbà fóònù tó wà lẹ́yìn káàdì ìdánimọ̀ wọn. Àwọn míràn le pe 855-258-6518 kí o sì dúró nípasẹ̀ ìjíròrò tití a ó fi sọ fún ọ láti tẹ 0. Nígbàtí aṣojú kan bá dáhùn, sọ èdè tí o fẹ́ a ó sì so ọ́ pọ̀ mọ́ ògbufọ̀ 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.

CareFirst
Family of health care plans

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।

Bǎsɔ́ɔ̀-wùdù (Bassa) Tò Đùǔ Cáo! Bɔ̌ nìà kɛ ɓá nyɔ ɓě ké m̀ gbo kpá ɓó nì fǔà-fǔá-tìǐn nyɛɛ jè dyí. Bɔ̌ nìà kɛ ɓédé wé jɛ́ɛ́ ɓě ɓɛ́ m̀ ké dɛ wa mó m̀ ké nyuɛɛ nyu hwè ɓɛ́ wé ɓěa ké zi. Ɔ mò nì kpé ɓɛ́ m̀ ké bɔ̌ nìà kɛ kè gbo-kpá-kpá m̀ mɔ́ɛɛ dyé dé nì ɓídí-wùdù mú ɓɛ́ m̀ ké se wídí dò péè. Kpooɔ nyɔ ɓě mɛ dá fǔùn-nɔ̀ɓà nìà dé waà I.D. káàɔ̀ dɛín nyɛ. Nyɔ tɔ̀ɔ̀ séín mɛ dá nɔ̀ɓà nìà kɛ: 855-258-6518, ké m̀ mɛ fò tee ɓɛ́ wa kéɛ m̀ gbo cɛ̃ ɓɛ́ m̀ ké nɔ̀ɓà mɔà 0 kɛɛ dyi pàdàìn hwè. Ɔ jǔ ké nyɔ dò dyi m̀ gɔ̌ jǔǐn, po wudu m̀ mɔ́ poɛ dyiɛ, ké nyɔ dò mu ɓó nììn ɓɛ́ ɔ ké nì wuduɔ̀ 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 855-258-6518پر 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 شناسایی‌شان تماس بگیرند. سایر افراد می توانند با شماره 855-258-6518تماس 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 للآخرين 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) Nrụbama: Ọkwa a nwere ozi gbasara mkpuchi nchekwa onwe gị. Ọ nwere ike ịnwe ụbọchị ndị dị mkpa, ị nwere ike ịme ihe tupu ụfọdụ ụbọchị njedebe. Ị nwere ikike ịnweta ozi na enyemaka a n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ndị otu kwesịrị ịkpọ akara ekwentị dị n'azụ nke kaadị njirimara ha. Ndị ọzọ niile nwere ike ịkpọ 855-258-6518 wee chere ụbụbọ ahụ ruo mgbe amanyere ịpị 0. Mgbe onye nnọchite anya zara, kwuo asụsụ ị chọrọ, a ga-ejikọ gị na onye ọkọwa 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 아니신 경우 855-258-6518 번으로 전화하여 0을 누르라는 메시지가 들릴 때까지 기다리십시오. 연결된 상담원에게 필요한 언어를 말씀하시면 통역 서비스에 연결해 드립니다.