Blue Shield of California
Blue Shield of California Life & Health Insurance Company
Dental plan, vision plan, and dental + vision package application

blue of california

This form is to be used by applicants applying for a Blue Shield dental plan, vision plan or IFP Specialty Duo℠ dental + vision package. Please include first month's dues/premiums to avoid return of application.

You are eligible for any Individual and Family Plan (IFP) dental plan, vision plan or the Specialty Duo dental + vision package if you are a California resident at the time of enrollment. If you had any Blue Shield IFP dental or vision plan cancelled for any reason (by yourself or by Blue Shield), you must wait six months from date of cancellation before reapplying.

Part 1 – Coverage, plan, and applicant information

Reason for application: ☐ New enrollment ☐ Plan transfer ☐ Add dependent family member to existing coverage
Requested effective date:

Dental plan, vision plan or dental + vision package options:

Dental plans:		**Vision plans:**	**Vision + dental package:**
☐ Dental HMO Plan ☐ Enhanced Dental HMO $0 ☐ Dental PPO Plan	☐ Enhanced Dental PPO 25/500 ☐ Enhanced Dental PPO 50/1250	☐ Ultimate Vision 15/25/120* ☐ Ultimate Vision 15/25/150*	☐ Specialty Duo (dental + vision) package*

Dental HMO applicants only – please choose a dentist from the Provider Directory at **blueshieldca.com**, or call **(888) 256-3650** for assistance.

Dental HMO provider name: _____ Dental HMO provider number: _____

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

Part 2 – Primary applicant information

Applicant's Social Security number/Tax ID number	Sex: ☐ Male ☐ Female	Date of birth (month/day/year)	Married: ☐ Yes ☐ No Domestic partnership: ☐ Yes ☐ No

First name	MI	Last name

Do you currently have dental coverage through Blue Shield? ☐ Yes ☐ No	If yes, please indicate plan	Dental subscriber number (if applicable)
Do you currently have medical coverage through Blue Shield? ☐ Yes ☐ No	If yes, please indicate plan	Medical subscriber number (if applicable)
Do you currently have vision coverage through Blue Shield? ☐ Yes ☐ No	If yes, please indicate plan	Vision subscriber number (if applicable)

Applicant's business phone number	Applicant's home phone number	Applicant's fax number	Applicant's cell number

I understand and agree that any phone number(s) I provide on this Application will be used by Blue Shield to contact me about my Blue Shield contract/policy. Subject to HIPAA, I understand that information may be provided in a pre-recorded telephone message with important information about my coverage, renewal options and other information Blue Shield determines is relevant to my coverage. I consent to allow Blue Shield to contact me and/or any dependents covered on my contract/policy at the phone number(s) I provided, including any number I provide that connects to a cell or mobile phone. Initial _____

Home address (**NO** P.O. box)		Apt No.
City	State	ZIP code
Billing address (if different from home address)		Apt No.
City	State	ZIP code
Applicant's mailing address (if different from home address)		Apt No.
City	State	ZIP code

List other name(s) used in past

Applicant's Email address	Best time to contact ☐ AM ☐ PM

I understand and agree that the email address I provide on this Application may be used by Blue Shield to contact me about my Blue Shield contract/policy. I understand that information sent to me by email could include important information about my coverage, renewal options, and any other information Blue Shield determines is relevant to my coverage. I consent to allow Blue Shield to contact me and/or any dependents covered on my contract/policy at the email I provide on this Application. Initial _____

Preferred method of contact (check one): ☐ Home phone ☐ Work phone ☐ Cell phone ☐ Email ☐ Standard mail

Indicate language preference: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Korean ☐ Other

Part 3(a) – Spouse/domestic partner dependent applicant information

☐ Spouse ☐ Domestic partner Sex: ☐ Male ☐ Female

First name	MI	Last name

Applicant's Social Security number/Tax ID number	Date of birth (month/day/year)

Is the spouse/domestic partner applicant's residence the same as the primary applicant? ☐ Yes ☐ No
If no, where does the applicant reside? (address, including ZIP code and state)

Part 3(b) – Child dependent applicant information

Dependent children must be under age 26. If more than eight child dependents are applying for coverage, please attach a supplemental page providing all information listed below, your signature, and date. Check here if a supplemental page is attached. ☐

1. ☐ Male ☐ Female | Relationship _____ (e.g. son/daughter)

First name | MI | Last name (if different from above)

Applicant's Social Security number/Tax ID number | Date of birth (month/day/year) _____

Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No
If no, where does the applicant reside? (address, including ZIP code and state)

2. ☐ Male ☐ Female | Relationship _____ (e.g. son/daughter)

First name | MI | Last name (if different from above)

Applicant's Social Security number/Tax ID number | Date of birth (month/day/year) _____

Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No
If no, where does the applicant reside? (address, including ZIP code and state)

3. ☐ Male ☐ Female | Relationship _____ (e.g. son/daughter)

First name | MI | Last name (if different from above)

Applicant's Social Security number/Tax ID number | Date of birth (month/day/year) _____

Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No
If no, where does the applicant reside? (address, including ZIP code and state)

4. ☐ Male ☐ Female | Relationship _____ (e.g. son/daughter)

First name | MI | Last name (if different from above)

Applicant's Social Security number/Tax ID number | Date of birth (month/day/year) _____

Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No
If no, where does the applicant reside? (address, including ZIP code and state)

5. ☐ Male ☐ Female | Relationship _____ (e.g. son/daughter)

First name | MI | Last name (if different from above)

Applicant's Social Security number/Tax ID number | Date of birth (month/day/year) _____

Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No
If no, where does the applicant reside? (address, including ZIP code and state)

6. ☐ Male ☐ Female | Relationship _____ (e.g. son/daughter)

First name | MI | Last name (if different from above)

Applicant's Social Security number/Tax ID number | Date of birth (month/day/year) _____

Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No
If no, where does the applicant reside? (address, including ZIP code and state)

7. ☐ Male ☐ Female | Relationship _____ (e.g. son/daughter)

First name | MI | Last name (if different from above)

Applicant's Social Security number/Tax ID number | Date of birth (month/day/year) _____

Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No
If no, where does the applicant reside? (address, including ZIP code and state)

8. ☐ Male ☐ Female | Relationship _____ (e.g. son/daughter)

First name | MI | Last name (if different from above)

Applicant's Social Security number/Tax ID number | Date of birth (month/day/year) _____

Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No
If no, where does the applicant reside? (address, including ZIP code and state)

Part 4 – Authorizations, terms, and conditions

Please read the following terms and conditions carefully. Each applicant age 18 and older is required to review the completed application and provide their own authorization and signature. Keep a copy of this application for your records.

1. **Application for coverage:** I understand that Blue Shield has the right to decline my application for coverage. I also understand that I must be residing in California in order to be eligible for enrollment in this plan/package. I will notify Blue Shield upon any change regarding my eligibility for the dental plan, vision plan, or Specialty Duo dental + vision package. I also agree to provide information requested by Blue Shield to verify my eligibility or continued eligibility for coverage, and understand that failure to cooperate could result in cancellation of coverage.

2. **First month's dues/premiums:** Blue Shield requires first month's dues/premiums at the time of application submission. Find your estimated monthly dues/premiums by going to **blueshieldca.com** or contact your agent. Refer to Part 6 for payment options. Failure to submit full payment of dues/premiums will result in a return of your application. Please note that processing of your payment does not constitute approval of your application with Blue Shield or Blue Shield Life. If you do not currently qualify for coverage, the dues/premiums you submit with your application will not be processed. If you include a check, it will be destroyed. If you complete the payment authorization form, your credit card or checking account will not be debited.

3. **Dues/premiums:** Dues/premiums are to be paid by the due date. Coverage will be terminated for failure to pay dues/premiums in a timely manner as set forth in the *Evidence of Coverage* and health service agreement/policy as allowed by law.

4. **Effective date of coverage:** If you qualify for coverage, Blue Shield will notify you of your effective date of coverage. If Blue Shield cannot honor your requested effective date or is unable to issue coverage before the requested date, coverage will begin as soon as possible. If additional dues/premiums are owed, payment must be received before coverage becomes effective. Any charges incurred for services received prior to your effective date or after termination of coverage are not covered.

5. **Acceptance of application:** You understand that only Blue Shield can accept your application and issue coverage for an IFP plan requested on this form. Your agent or broker cannot enroll you for coverage or change any terms or conditions of coverage.

6. **Parents/guardians:** If you are the parent or legal guardian of an applicant who is a minor, please sign on behalf of the applicant at the bottom of this Part 4. As the parent or legal guardian, you are identified as the person who may make inquiries and act on behalf of the applicant regarding this coverage (as allowed by law). In addition, you are agreeing to assume all responsibility for dues/premiums payments and for following the terms and conditions for coverage. If you are not the parent of the applicant, please attach court documents that appoint you as the guardian of this minor. Mark one of the following boxes and identify the individual authorized to act on behalf of the minor (applicant):
   - ☐ Parent or legal guardian _____ (include name and relationship); or
   - ☐ My designee _____ (include name and relationship); or
   - ☐ Qualified medical child support order designee _____ (include name and relationship).
   - ☐ Mark this box if Blue Shield is to only make changes to the contract upon written request by the person identified above.

7. **Authorization for spouse/domestic partner to make changes:** If you are an applicant whose spouse/domestic partner is also applying for coverage, please specify if you authorize your spouse/domestic partner to make changes to the contract/policy on your behalf. You may discontinue this authorization at any time by sending a written request to Blue Shield. ☐ **Yes** ☐ **No**

8. **Authorization for your agent to provide/obtain information:** Check here if you do **not** authorize your insurance agent, broker, or producer (referred to as "your agent") to access all information on this application. ☐

9. **Process to authorize Blue Shield to release personal and health information to a third party:** If you would like to authorize your spouse, domestic partner, or a third party to access your personal health information, please complete the form titled Authorization for Blue Shield to Disclose Personal & Health Information to a Third Party. To obtain this form, go to **blueshieldca.com** and click on the *Privacy* link at the bottom of the page, or call **(888) 256-3650**.

10. **Response to requested information:** You agree to cooperate with Blue Shield (or Blue Shield Life, as applicable) by providing, or by providing access to, documents and other information requested (such as court orders to provide dependent coverage, etc.) to corroborate information provided in this application for coverage. You acknowledge and agree that failure or refusal to provide these documents or the information requested may be cause to rescind or cancel your coverage.

11. **Receiving materials and communications electronically versus print:** Check here if you agree to receive required benefit plan and coverage-related materials and communications via email and/or the Blue Shield website **blueshieldca.com**, as applicable. Documents that are made available to you via **blueshieldca.com** are as follows:
    - *Evidence of Coverage* (EOC) and health service agreement/policy
    - Statement of Benefits (SOB)
    - Summary of Benefits and Coverage (SBC)
    - Endorsements to your EOC or policy

    Obtaining a document electronically will confirm your consent to electronic delivery. You also have the right to obtain printed, mailed materials at any time and at no expense to you.
    To receive printed materials in the mail, to opt out of email communications, or if you have questions, please call **(888) 256-3650**.

I have reviewed all responses pertaining to me in this application. I have read the summary of benefits and the terms and conditions of coverage and authorizations set forth above. With my own signature below, I represent that the information provided in this application is complete and accurate to the best of my knowledge, and I understand and agree to the terms and conditions of coverage and the authorizations I have provided. (Important: Each adult applicant must provide their own signature.) I understand that I must inform Blue Shield if anything changes or is different from what I listed on this application before my enrollment with Blue Shield begins.

Signature of applicant/parent or legal guardian	Today's date	Print name (and your relationship if applicant is a minor)
Signature of applicant's spouse/domestic partner (if applying)	Today's date	Print name
Signature of family member age 18 or over (if applying)	Today's date	Print name
Signature of family member age 18 or over (if applying)	Today's date	Print name
Signature of family member age 18 or over (if applying)	Today's date	Print name
Signature of family member age 18 or over (if applying)	Today's date	Print name
Signature of family member age 18 or over (if applying)	Today's date	Print name

Important: Return the application within 30 days of your date(s) and signature(s).

Part 5 – Producer information: To be completed by an authorized Blue Shield agent

1. Did you complete this application? ☐ Yes ☐ No

2. If yes, did you ask each question in this application exactly as set forth? ☐ Yes ☐ No

3. Are the answers recorded exactly as given to you? ☐ Yes ☐ No, attach explanation.

4. Do you want the health service agreement/policy sent directly to the subscriber? ☐ Yes ☐ No

Producer name (the entity/individual to whom commissions will be issued) Nevin & Witt Insurance			
Email address info@nevinandwitt.com	☐ Update email	Producer number 680462135	
Telephone number (530) 894-0111	☐ Update phone	Fax number (530) 894-0122	☐ Update fax
Producer address 1600 Mangrove Avenue #190			☐ Update address
City Chico	State CA	ZIP code 95926	
Super producer name	Super producer number		

		Mark Maidenburg
Producer signature (required)	Today's date (required)	Print name

Producers: Please ensure each part of the application is complete. In the event of missing or incomplete information, Blue Shield may contact your applicant directly to obtain complete information.

Please fax or mail the completed and signed application to:

Installation and Billing
Blue Shield of California
P.O. Box 3008
Lodi, CA 95241-1912
Fax: **(888) 386-3420**

For internal use only
DSA name: _____
DSA number: _____
Producer number: _____

Part 6 – Billing and payment information

Calculate estimate monthly dues/premiums

- Go to **blueshieldca.com** to get your estimated dues/premiums or talk to your agent to get estimated dues/premiums.
- First month's dues/premiums is required at the time of application submission.
- Blue Shield will issue final dues/premium before any effective date of coverage. If the final amount differs from the estimated dues/premium and additional amounts are owed, payment must be received before coverage will take effect.

Payment options

Your first month's dues/premium can be paid through the following options:

- Electronic funds transfer through your checking or savings account.
- Payment card – payments are handled via debit or credit to your debit or credit card.
- Submitting a check or money order.

Payment options: (Dues/premiums payment is required with your application.)
Please choose one of the following options below for payment:

☐ Electronic funds transfer through checking or savings account – (complete section A below)
☐ Payment card (debit or credit card) - (complete section B below)
☐ By check* or money order (Only if application is mailed)

* When you provide a check as payment, you authorize Blue Shield either to use information from your check to make a one-time electronic funds transfer from your account or to process the payment as a check transaction. When we use this information from your check to make an electronic funds transfer, funds will be withdrawn from your account as soon as the date we approve your application and you will not receive your check back from your financial institution.

Part 6 (cont'd) – Payment authorization form

Applicant information		
Applicant name		
Mailing address		Apt. No.
City	State	ZIP code
Applicant's daytime phone number		
Method of payment		
A. Payment by checking or savings account: ☐ Checking account ☐ Savings account		
Bank routing/transit number		
Bank account number		
Name(s) on bank account		
Name of financial institution		
Branch address		
City	State	ZIP code
Branch telephone number		
B. Payment card (Visa or MasterCard only)		
Cardholder name		
Cardholder billing address		Apt. No.
City	State	ZIP code
Payment card number		
Card type: ☐ Visa ☐ MasterCard	Expiration date (mm/yyyy)	

Authorization and signature(s)

One of the following provisions will apply, depending on the payment method I selected above:

Dues/premium by payment card (credit card or debit card):
I authorize my plan, Blue Shield of California or Blue Shield of California Life & Health Insurance Company ("Blue Shield"), to charge or debit the first month's dues/premium to my credit card or debit card ("payment card") identified above, and that this authorization is only valid to charge or debit the first month's dues/premium owed to Blue Shield. I understand my payment card will be charged or debited for the first month's dues/premium if my application is approved. I also understand that a different rate may apply for the coverage approved. If I am accepted at a different rate, Blue Shield will provide notice of actual monthly dues/premium, prior to the original effective date of coverage, and that amount will be paid pursuant to this authorization.

Dues/premium by debit from checking/savings account:
I authorize my plan, Blue Shield of California or Blue Shield of California Life & Health Insurance Company ("Blue Shield"), to debit the first month's dues/premium from my bank account identified above, and that this authorization is only valid to debit the first month's dues/premium owed to Blue Shield. I understand my bank account will be debited for the first month's dues/premium if my application is approved. I also understand that a different rate may apply for the coverage approved. If I am accepted at a different rate, Blue Shield will provide notice of actual monthly dues/premium, prior to the original effective date of coverage, and that amount will be paid pursuant to this authorization.

By signing below, I agree to the terms and conditions of this authorization form and I acknowledge that I have received a copy of this form. I acknowledge that all payment transactions must comply with the provisions of U.S. law.

Payments may be processed by a third-party vendor on behalf of Blue Shield.

Cardholder/account holder signature	Print name
Social Security number	Date
Cardholder/account holder signature	Print name
Social Security number	Date

Part 6 – Billing and payment information

KEEP THIS COPY FOR YOUR RECORDS

Calculate estimate monthly dues/premiums

- Go to **blueshieldca.com** to get your estimated dues/premiums or talk to your agent to get estimated dues/premiums.
- First month's dues/premiums is required at the time of application submission.
- Blue Shield will issue final dues/premium before any effective date of coverage. If the final amount differs from the estimated dues/premium and additional amounts are owed, payment must be received before coverage will take effect.

Payment options

Your first month's dues/premium can be paid through the following options:

- Electronic funds transfer through your checking or savings account.
- Payment card – payments are handled via debit or credit to your debit or credit card.
- Submitting a check or money order.

Payment options: (Dues/premiums payment is required with your application.)

Please choose one of the following options below for payment:

☐ Electronic funds transfer through checking or savings account – (complete section A below)
☐ Payment card (debit or credit card) - (complete section B below)
☐ By check* or money order (Only if application is mailed)

* When you provide a check as payment, you authorize Blue Shield either to use information from your check to make a one-time electronic funds transfer from your account or to process the payment as a check transaction. When we use this information from your check to make an electronic funds transfer, funds will be withdrawn from your account as soon as the date we approve your application and you will not receive your check back from your financial institution.

Applicant information		
Applicant name		
Mailing address		Apt. No.
City	State	ZIP code
Applicant's daytime phone number		
Method of payment		
A. Payment by checking or savings account: ☐ Checking account ☐ Savings account		
Bank routing/transit number		
Bank account number		
Name(s) on bank account		
Name of financial institution		
Branch address		
City	State	ZIP code
Branch telephone number		
B. Payment card (Visa or MasterCard only)		
Cardholder name		
Cardholder billing address		Apt. No.
City	State	ZIP code
Payment card number		
Card type: ☐ Visa ☐ MasterCard	Expiration date (mm/yyyy)	

Authorization and signature(s)

KEEP THIS COPY FOR YOUR RECORDS

One of the following provisions will apply, depending on the payment method I selected above:

Dues/premium by payment card (credit card or debit card):
I authorize my plan, Blue Shield of California or Blue Shield of California Life & Health Insurance Company ("Blue Shield"), to charge or debit the first month's dues/premium to my credit card or debit card ("payment card") identified above, and that this authorization is only valid to charge or debit the first month's dues/premium owed to Blue Shield. I understand my payment card will be charged or debited for the first month's dues/premium if my application is approved. I also understand that a different rate may apply for the coverage approved. If I am accepted at a different rate, Blue Shield will provide notice of actual monthly dues/premium, prior to the original effective date of coverage, and that amount will be paid pursuant to this authorization.

Dues/premium by debit from checking/savings account:
I authorize my plan, Blue Shield of California or Blue Shield of California Life & Health Insurance Company ("Blue Shield"), to debit the first month's dues/premium from my bank account identified above, and that this authorization is only valid to debit the first month's dues/premium owed to Blue Shield. I understand my bank account will be debited for the first month's dues/premium if my application is approved. I also understand that a different rate may apply for the coverage approved. If I am accepted at a different rate, Blue Shield will provide notice of actual monthly dues/premium, prior to the original effective date of coverage, and that amount will be paid pursuant to this authorization.

By signing below, I agree to the terms and conditions of this authorization form and I acknowledge that I have received a copy of this form. I acknowledge that all payment transactions must comply with the provisions of U.S. law.

Payments may be processed by a third-party vendor on behalf of Blue Shield.

Cardholder/account holder signature	Print name
Social Security number	Date
Cardholder/account holder signature	Print name
Social Security number	Date

blue of california

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

Blue Shield of California complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Blue Shield of California:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California 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:

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711)
Fax: (916) 350-7405
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our 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, DC 20201
(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For help at no cost, please call right away at the Member/Customer Service telephone number on the back of your Blue Shield ID card, or (866) 346-7198.

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda sin cargo, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Blue Shield o al (866) 346-7198. (Spanish)

重要通知：您能讀懂這封信嗎？如果不能，我們可以請人幫您閱讀。這封信也可以 用您所講的語言書寫。如需免费幫助，請立即撥打登列在您的Blue Shield ID卡背面上的 會員/客戶服務部的電話，或者撥打電話 (866) 346-7198。(Chinese)

QUAN TRỌNG: Quý vị có thể đọc lá thư này không? Nếu không, chúng tôi có thể nhờ người giúp quý vị đọc thư. Quý vị cũng có thể nhận lá thư này được viết bằng ngôn ngữ của quý vị. Để được hỗ trợ miễn phí, vui lòng gọi ngay đến Ban Dịch vụ Hội viên/Khách hàng theo số ở mặt sau thẻ ID Blue Shield của quý vị hoặc theo số (866) 346-7198. (Vietnamese)

MAHALAGA: Nababasa mo ba ang sulat na ito? Kung hindi, maari kaming kumuha ng isang tao upang matulungan ka upang mabasa ito. Maari ka ring makakuha ng sulat na ito na nakasulat sa iyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa numerong telepono ng Miyembro/Customer Service sa likod ng iyong Blue Shield ID kard, o (866) 346-7198. (Tagalog)

Baa' ákohwiindzindooígí: Díí naaltsoosísh yíiníłta'go bíníghah? Doo bíníghahgóó éí, naaltsoos nich'į' yiidóołtahígíí ła' nihee hóló. Díí naaltsoos ałdó' t'áá Diné k'ehjí ádoolníił nínízingo bíighah. Doo bąąh ílínígó shíká' adoowoł nínízingó nihich'į' béésh bee hodíilnih dóó námboo éí díí Blue Shield bee néího'dílzinígí bine'déé' bikáá' éí doodagó éí (866) 346-7198 jį' hodíílnih. (Navajo)

중요: 이 서신을 읽을 수 있으세요? 읽으실 수 경우, 도움을 드릴 수 있는 사람이 있습니다. 또한 다른 언어로 작성된 이 서신을 받으실 수도 있습니다. 무료로 도움을 받으시려면 Blue Shield ID 카드 뒷면의 회원/고객 서비스 전화번호 또는 (866) 346-7198로 지금 전환하세요. (Korean)

ԿԱՐԵՎՈՐ Է. Կարողանում ե՞ք կարդալ այս նամակը: Եթե ոչ, ապա մենք կօգնենք ձեզ: Դուք պետք է նաև կարողանաք ստանալ այս նամակը ձեր լեզվով: Ծառայությունն անվճար է: Խնդրում ենք անմիջապես զանգահարել Հաճախորդների սպասարկման բաժնի հեռախոսահամարով, որը նշված է ձեր Blue Shield ID քարտի ետևի մասում, կամ (866) 346-7198 համարով: (Armenian)

ВАЖНО: Не можете прочесть данное письмо? Мы поможем вам, если необходимо. Вы также можете получить это письмо написанное на вашем родном языке. Позвоните в Службу клиентской/членской поддержки прямо сейчас по телефону, указанному сзади идентификационной карты Blue Shield, или по телефону (866) 346-7198, и вам помогут совершенно бесплатно. (Russian)

重要：お客様は、この手紙を読むことができますか？ もし読むことができない場合、弊社が、お客様をサポートする人物を手配いたします。 また、お客様の母国語で書かれた手紙をお送りすることも可能です。 無料のサポートを希望される場合は、Blue Shield IDカードの裏面に記載されている会員/お客様サービスの電話番号、または、(866) 346-7198にお電話をおかけください。 (Japanese)

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر پاسختان منفی است، می‌توانیم کسی را برای کمک به شما در اختیارتان قرار دهیم. حتی می‌توانید نسخه مکتوب این نامه را به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، لطفاً بدون فوت وقت از طریق شماره تلفنی که در پشت کارت شناسی Blue Shield تان درج شده است و یا از طریق شماره تلفن 346-7198 (866) با خدمات اعضا/مشتری تماس بگیرید. (Persian)

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ ਤਾਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿਚ ਮਦਦ ਲਈ ਅਸੀਂ ਕਿਸੇ ਵਿਅਕਤੀ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਵਿਚ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਤੁਹਾਡੇ Blue Shield ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਮੈਂਬਰ/ਕਸਟਮਰ ਸਰਵਿਸ ਟੈਲੀਫ਼ੋਨ ਨੰਬਰ ਤੇ, ਜਾਂ (866) 346-7198 ਤੇ ਕਾੱਲ ਕਰੋ। (Punjabi)

ប្រការសំខាន់ៈ តើអ្នកអាចលិខិតនេះ បានដែរឬទេ? បើមិនអាចទេ យើងអាចឲ្យគេជួយអ្នកក្នុងការអានលិខិតនេះ។ អ្នកក៏អាចទទួលបានលិខិតនេះជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅកាន់លេខទូរស័ព្ទសេវាសមាជិក/អតិថិជនដែលមាននៅលើខ្នងប័ណ្ណសម្គាល់ Blue Shield របស់អ្នក ឬតាមរយៈលេខ (866) 346-7198។ (Khmer)

المهم: هل تستطيع قراءة هذا الخطاب؟ أن لم تستطع قراءته، يمكننا إحضار شخص ما ليساعدك في قراءته. قد تحتاج أيضاً إلى الحصول على هذا الخطاب مكتوباً بلغتك. للحصول على المساعدة بدون تكلفة، يرجى الاتصال الآن على رقم هاتف خدمة العملاء/أحد الأعضاء المدون على الجانب الخلفي من بطاقة الهوية Blue Shield أو على الرقم 346-7198 (866).(Arabic)

TSEEM CEEB: Koj pos tuaj yeem nyeem tau tsab ntawv no? Yog hais tias nyeem tsis tau, peb tuaj yeem nrhiav ib tug neeg los pab nyeem nws rau koj. Tej zaum koj kuj yuav tau txais muab tsab ntawv no sau ua koj hom lus. Rau kev pab txhais dawb, thov hu kiag rau tus xov tooj Kev Pab Cuam Tub Koom Xeeb/Tub Lag Luam uas nyob rau sab nraum nrob qaum ntawm koj daim npav Blue Shield ID, los yog hu rau tus xov tooj (866) 346-7198. (Hmong)

สำคัญ: คุณอ่านจดหมายฉบับนี้ได้หรือไม่ หากไม่ได้ โปรดขอคงามช่วยจากผู้อ่านได้ คุณอาจได้รับจดหมายฉบับนี้เป็นภาษาของคุณ หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดติดต่อฝ่ายบริการลูกค้า/สมาชิกทางเบอร์โทรศัพท์ในบัตรประจำตัว Blue Shield ของคุณ หรือโทร (866) 346-7198 (Thai)

महत्वपूर्ण: क्या आप इस पत्र को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी मदद के लिए किसी व्यक्ति का प्रबंध कर सकते हैं। आप इस पत्र को अपनी भाषा में भी प्राप्त कर सकते हैं। नि:शुल्क मदद प्राप्त करने के लिए अपने Blue Shield ID कार्ड के पीछे दिए गये मेंबर/कस्टमर सर्विस टेलीफोन नंबर, या (866) 346-7198 पर कॉल करें। (Hindi)

Notice of the Availability of Language Assistance Services

Blue Shield of California Life & Health Insurance Company

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-866-346-7198. For more help call the CA Dept. of Insurance at 1-800-927-4357. English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-866-346-7198. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

免費語言服務。您可獲得口譯員服務。可以用中文把文件唸給您聽，有些文件有中文的版本，也可以把這些文件寄給您。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打 1-866-346-7198 與我們聯絡。欲取得其他協助，請致電 1-800-927-4357 與加州保險部聯絡。Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch. Quý vị có thể được người khác đọc giúp các tài liệu và nhận một số tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-866-346-7198. Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-866-346-7198번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-866-346-7198. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-866-346-7198 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-866-346-7198. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance), по телефону 1-800-927-4357. Russian

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、ＩＤカード記載の番号または1-866-346-7198 までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357 までご連絡ください。Japanese

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند.برای دریافت کمک،با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره 1-866-346-7198 تماس بگیرید.برای دریافت کمک بیشتر، به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تلفن کنید. Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-866-346-7198 'ਤੇ ' ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

សេវាកម្មភាសាឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ
សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-866-346-7198 ។ សម្រាប់ជំនួយបន្ថែមទៀត
សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول علي مترجم و قراءة الوثائق لك باللغة العربية. للحصول علي المساعدة، اتصل بنا علي الرقم المبين علي بطاقة عضويتك أو علي الرقم 1-866-346-7198.للحصول علي المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا علي الرقم 1-800-927-4357. Arabic

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-866-346-7198. Yog xav tau kev pab ntxiv hu rau CA Iub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

บริการทางภาษาอย่างไม่เสียค่าใช้จ่าย คุณสามารถรับบริการจากล่าม รวมถึงให้เจ้าหน้าที่อ่านเอกสารให้คุณฟัง หรือส่งเอกสารบางส่วนในภาษาของคุณไปหาคุณได้ หากต้องการความช่วยเหลือ กรุณาโทรศัพท์ตามหมายเลขที่ระบุอยู่ด้านหลังบัตรประจำตัวของคุณ หรือ ที่หมายเลข 1-866-346-7198 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรมาที่ กรมการประกันภัยแห่งมลรัฐแคลิฟอร์เนียที่หมายเลข 1-800-927-4357 Thai

निःशुल्क भाषा सेवाएँ। आप एक दुभाषिया की सेवा प्राप्त कर सकते हैं। आप दस्तावेजों को पढ़वा के सुन सकते हैं और कुछ को अपनी भाषा में स्वयं को भिजवा सकते हैं। सहायता के लिए, अपने ID कार्ड पर दिए गए नंबर पर, या 1-866-346-7198 पर हमें फ़ोन करें। अधिक सहायता के लिए कैलीफोर्निया बीमा विभाग (CA Dept. of Insurance) को 1-800-927-4357 पर फ़ोन करें। Hindi

Doo bááh ílínígó saad bee yát'i' bee aná'áwo'. Díí shá ata'halne'dooígí hóló̧ǫdoo nínízingo éí bíighah. Naaltsoos naaninádájeehígí shich'į' yíídooltah éí doodagó ła' shich'į' ádoolníił nínízingo bíighah. Shíká a'doowoł nínízingo nihich'į' béésh bee hodíilnih dóó námboo éí díí ninaaltsoos doot'ízhígí bee néího'dílzinígí bine'déé' bikáá' éí doodagó éí (866) 346-7198jį' hodíilnih. Hózhǫ́ shíká anáá'doowoł nínízingo éí díí Akéédáshtíįh Béeso Ách'ą́ąh Naa'nil bił haz'ą́ąjį' 1-800-927-4357jį' hodíilnih. Navajo