Primary applicant name: _____

Anthem®

And Its Affiliate HealthKeepers, Inc.

Welcome

Virginia Individual Application

Thanks for choosing us. We're glad you're here.

Medical coverage plans made available under this application are health maintenance organization products offered by HealthKeepers, Inc. Supplemental Dental and Vision Plans are offered by Anthem Blue Cross and Blue Shield (Anthem).

If you have any questions while filling out this form, give us a call at 1 (877) 212-1793. But if you've worked with an agent or broker, contact them first.

About this form

Use this form to apply for **new** dental or vision coverage or to **change** existing coverage with Anthem.

You can add dependents or change coverage:

1. **During the annual Open Enrollment period**
   Your coverage will start based on when we receive your complete application. The earliest date coverage can start is January 1st.
2. **When you have a Special Enrollment period due to a qualifying event**
   When you're done with this form, fill out **Appendix A: Special Enrollment,** which includes information about qualifying events, when coverage starts, and limits on the plans you may select for certain qualifying events.

For new dental and vision:

- You can apply any time of year.
- Your coverage will start based on when we receive your complete application. Coverage starts the 1st day of the month after the date we receive your complete application.

Tips for filling out this form

- Answer all questions. Please print clearly using blue or black ink only.
- Please submit all pages.
- You can also apply online at anthem.com.

Some frequently asked questions

1. **Do I need to include a payment?**
   Yes. We can't process your application without your first month's premium payment. Without it, your enrollment will be delayed. We won't charge your card or cash your check or money order until you've been enrolled.
2. **Why do you need my Social Security Number (SSN)?**
   The IRS requires us to collect it. It won't be shared unless required by law.

Virginia Individual Application

Please indicate the reason for this application:
☐ Open Enrollment
☐ Special Enrollment Period (also complete Appendix A)

Step 1: Who is applying?

☐ New coverage
☐ Change coverage
☐ Add dependent to existing coverage
Subscriber ID no. _____

Primary Applicant

Last name (legal name)	**First name** (legal name)	**M.I.**	**Social Security Number** - -

Marital status ☐ Single ☐ Married ☐ Domestic Partner	**Sex** ☐ M ☐ F	**Date of birth** (mm/dd/yyyy) / /	**Legal resident of VA** ☐ Yes ☐ No	**County** (for home address)

Home address (not a P.O. Box)	**City**	**State**	**ZIP**
Billing address (optional - if different than home address)	**City**	**State**	**ZIP**
Mailing address (optional - if different than home address)	**City**	**State**	**ZIP**

Email address: _____
For myself and any dependents, I'm providing my email address because I agree to get my policy, certificate, or evidence of coverage electronically. I know I can change my mind at any time and request a free copy of specific materials by mail. I also understand that by providing my email address, information about my dependents may also be sent by email or electronically. To do either, I (or my enrolled dependents) will update communication preferences by going to anthem.com or calling Member Services.

Primary phone	**Secondary phone**	**Preferred written language** ☐ English (ENG) ☐ Spanish (SPA)	**Preferred spoken language** ☐ English (ENG) ☐ Spanish (SPA)

Coverage(s) selected ☐ Dental ☐ Vision
To enroll a Spouse or Domestic Partner and/or dependent, the primary applicant also must be enrolled.

Spouse or Domestic Partner

Last name (legal name)	**First name** (legal name)	**M.I.**	**Social Security Number** - -

Relationship to applicant ☐ Spouse ☐ Domestic Partner	**Sex** ☐ M ☐ F	**Date of birth** (mm/dd/yyyy) / /	**Legal resident of VA** ☐ Yes ☐ No

Coverage(s) selected ☐ Dental ☐ Vision
To enroll a Spouse or Domestic Partner and/or dependent, the primary applicant also must be enrolled.

Child dependent

Children must be under age 26.

Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves by reason of intellectual or physical disability. These Dependents must be allowed as a federal tax exemption by the subscriber or subscriber's Spouse or Domestic Partner.

Last name (legal name)	**First name** (legal name)	**M.I.**	**Social Security Number** - -

Relationship to applicant ☐ Child ☐ Other _____	**Sex** ☐ M ☐ F	**Date of birth** (mm/dd/yyyy) / /	**Legal resident of VA** ☐ Yes ☐ No

Coverage(s) selected ☐ Dental ☐ Vision
To enroll a Spouse or Domestic Partner and/or dependent, the primary applicant also must be enrolled.

Child dependent

Last name (legal name)	**First name** (legal name)		**M.I.**	**Social Security Number** - -
Relationship to applicant ☐ Child ☐ Other _____	**Sex** ☐ M ☐ F	**Date of birth** (mm/dd/yyyy) / /	**Legal resident of VA** ☐ Yes ☐ No	
Coverage(s) selected ☐ Dental ☐ Vision To enroll a Spouse or Domestic Partner and/or dependent, the primary applicant also must be enrolled.				

Child dependent ☐ **Check here if you have more dependents**. Print an extra copy of this page and attach to your application.

Last name (legal name)	**First name** (legal name)		**M.I.**	**Social Security Number** - -
Relationship to applicant ☐ Child ☐ Other _____	**Sex** ☐ M ☐ F	**Date of birth** (mm/dd/yyyy) / /	**Legal resident of VA** ☐ Yes ☐ No	
Coverage(s) selected ☐ Dental ☐ Vision To enroll a Spouse or Domestic Partner and/or dependent, the primary applicant also must be enrolled.				

Eligibility The answer to this question is needed to determine your eligibility.

Are any applicants currently incarcerated (with more than 60 days left to serve before release) as a result of a conviction? (not just pending disposition of charges) ☐ No ☐ Yes **If yes, who?**

Step 2: What coverage would you like?

Dental Plans

Dental coverage for children under age 19 is already included in all our medical plans (Also known as Pediatric Essential Health Benefits).
Choose a dental plan if you want to buy coverage for more than these Pediatric Dental Essential Health Benefits.
Our plans are available in all of Virginia, excluding the City of Fairfax, the Town of Vienna and the area east of State Route 123.

Dental plan options

☐ Anthem Dental Family Value (2J5G)
☐ Anthem Dental Family (1FVK)
☐ Anthem Dental Family Enhanced (1FVL)
☐ Dental Prime A (1RCJ)
☐ Dental Prime B (1RCK)
☐ Dental Prime C (1RCL)

Prior & other dental coverage

Name of person covered (Last, First, M.I.)	**Coverage (check all that apply)**	**Insurer name**	**Insurer phone no.**	**Policy ID no.**	**Dates (if applicable) (mm/dd/yyyy)**
	☐ Dental ☐ Orthodontia				**Start:** **End:**
	☐ Dental ☐ Orthodontia				**Start:** **End:**
	☐ Dental ☐ Orthodontia				**Start:** **End:**
	☐ Dental ☐ Orthodontia				**Start:** **End:**
	☐ Dental ☐ Orthodontia				**Start:** **End:**

Will you be replacing this dental coverage if approved for Anthem's coverage? ☐ Yes ☐ No

If **Yes**, what is the termination date? (mm/dd/yyyy) / /

Note: You cannot be covered by more than one Anthem individual dental policy at the same time.

Vision Plan

Vision coverage for children under age 19 is already included in all our medical plans (Also known as Pediatric Essential Health Benefits).
Choose a vision plan if you want to buy coverage for more than these Pediatric Vision Essential Health Benefits.
Our plans are available in all of Virginia, excluding the City of Fairfax, the Town of Vienna and the area east of State Route 123.

Vision plan options

☐ Blue View Vision Bundled (1RYB)
☐ Blue View Vision Enhanced (2SV5)
☐ Blue View Vision Plus (2SV6)
☐ Blue Vision Value (2SV7)

Step 3: Please read and sign

Important legal information

I understand that:

- I must include my first premium payment with this application, but that does not mean coverage has been processed. I'm applying for the coverage I chose in Step 2. Anthem has the right to accept or decline this application. If my application is denied, my bank account or credit card will not be charged, and if I paid with a money order, it will be returned to me.
- I'm responsible to let Anthem know, in a timely manner, of any change that would make me or any dependent ineligible for coverage.
- Check payments may be handled as Automated Clearinghouse (ACH) debit transactions. That means if I pay by check, the paper check will be destroyed and the debit payment will appear on my bank statement. My check won't be given to my financial institution or sent back to me. This does not mean I will be enrolled in an automatic debit process to pay my premium. Any resubmissions due to insufficient funds may also be electronic. All checking transactions will remain secure, and my payment by check means I agree to these terms.
- I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and me.
- I'm applying for individual dental and/or vision coverage which is not part of any employer sponsored plan and I'm responsible for all of the premium payments and making sure that all premiums are paid on time.
- I certify that each Social Security number listed on this application is correct.
- My domestic partner, if applicable, is only eligible for coverage if: he or she has been my sole domestic partner for 12 months or more; he or she is at least 18 years of age; he or she is mentally competent; he or she is not related to me in any way (including by blood or adoption) that would prohibit us from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with me.
- I certify to the best of my knowledge and belief, the responses herein are accurate. I certify that I have read, or had read to me, the completed application and that I realize that any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact in the application may result in the denial of benefits or cancellation of coverage(s).

I sign this application for and on behalf of any eligible dependents and myself if covered by Anthem. I am acting as their agent and representative.

This application cannot be altered by the applicant after submission to Anthem absent the acknowledgement and consent of Anthem.

By signing this application, I certify that the premium for my coverage will not be paid by a provider of health care services, hospital, non-profit organizations (including religious organizations) that have or whose primary donors have a financial interest in the benefits of the Evidence of Coverage, commercial entity with a direct or indirect financial interest in the benefits of the Evidence of Coverage or an employer that offers coverage under an employer health plan. I understand that if a third party is paying my premium, Anthem may decline to accept such premium payment if it is made by a person or entity from which it is not required by law to accept.
The undersigned applicant and the agent certify that the applicant has read, or had read to him, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in the loss of coverage under the policy.
Dental plans may contain waiting periods for certain types of services as disclosed in marketing materials and your policy. A waiting period is the length of time you must be covered under your dental policy and pay premiums before we will pay for covered services. You are eligible for payment of covered services once your waiting period has been met.

Please sign below

Primary Applicant (or legal representative)	Date
Spouse or Domestic Partner (or legal representative)	Date
Dependent Child (age 18 or over)	Date
Dependent Child (age 18 or over)	Date
Dependent Child (age 18 or over)	Date

Did an agent or broker help you?

☐ Yes ☐ No If yes, make sure they fill out this section.

Agent (or Broker) Certification All fields required

I certify to the best of my knowledge and belief, the responses herein are accurate. I certify that the applicant has read, or had read to him/her, the completed application and that the applicant realizes that any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact in the application may result in the denial of benefits, rescission or cancellation of coverage(s).			
Agent/Broker Signature			**Date**
Agent Name (Please print clearly)			
***(A) Writing Agent TIN/SSN** (Encrypted TIN is ok)	****(B) Writing Agent/Agency/General Agency TIN** (Encrypted TIN is ok)		
Agent Address		**City**	**State** / **ZIP**
Agent Phone No.	**Agent Fax No.**	**Agent Email**	

***Field (A)** - Always provide your Writing Agent TIN/SSN. ****Field (B)** - If you are a Direct Agent, with no relationship to an Agency, also enter your Agent TIN/SSN in Field (B). If this policy is sold through an Agency without a General Agency, enter the selling Agency TIN in Field (B); if this policy is sold through a General Agency, enter the General Agency TIN in Field (B).

Here's what's next.

1) Can you check a few items? When incorrect, they can cause enrollment delays.
   - Your name and address is clear and complete
   - You've included your first month's premium payment
   - Everyone 18 and older applying for coverage signed this form
   - Please make sure you submit all the pages of the application, including this page, even if you don't have an agent
   - If enrolling due to a qualifying event, you've completed Appendix A: Special Enrollment

2) All good? Send this to us by mail to Anthem Blue Cross and Blue Shield, P.O. Box 659960, San Antonio, TX 78265-9146 or by fax to 1 (800) 848-2512.

3) We'll be in touch in the next few weeks (or sooner). If you have questions before then, call us at 1 (855) 330-1108.

Thank you!

Appendix A: Special Enrollment

If you're applying for coverage due to a qualifying event, please fill out this section along with your application.

Qualifying event date	
Date of qualifying event / /	For Loss of Coverage, this is the last date of existing or prior coverage. For all other events, please enter the date based on the qualifying event.

You must apply for coverage within 60 days after your qualifying event for the following events (except in cases of domestic violence or spousal abandonment). If you have existing coverage and are adding one or more dependents due to marriage, birth, or adoption, you may add the new dependent(s) to your existing plan or apply for another plan for the dependent(s) who doesn't have current coverage.

Qualifying events	Coverage effective date
☐ **1. Marriage or Domestic Partnership** Got married or in a domestic partnership that becomes eligible for coverage (see step 3 for description of eligibility). One or both of the spouse(s) or domestic partner(s) must have had Minimum Essential Coverage for one or more days in the 60 days prior to the marriage or domestic partnership, unless one or both of the individuals has moved from a foreign country or U.S. territory within the 60 day period before the marriage/domestic partnership.	First day of the month after we receive your complete application.
☐ **2. Birth or adoption** Had a baby, adoption of a child or placement of a child with you for adoption.	**Select an effective date:** ☐ Same as the event date ☐ First day of the month after we receive your complete application ☐ Based on when we receive your complete application* ☐ First day of month after the event date
☐ **3. Court order or guardianship** Required by a court order to provide an eligible child(ren) coverage, including a child support order, appointment of guardianship of a child or a child in foster care is placed with you	**Select an effective date:** ☐ Same as the event date ☐ Based on when we receive your complete application*
☐ **4. Death** Death of a family member enrolled under current coverage	**Select an effective date:** ☐ First day of the month after we receive your complete application ☐ Based on when we receive your complete application*
☐ **5. Immigration** Immigration status changed ☐ **6. Domestic violence** I attest that I have been a victim of domestic violence that qualifies me for a special enrollment period. (The special enrollment period is available for 60 days following your request) ☐ **7. Spousal abandonment** I attest that I have been unable to locate my spouse after reasonable diligence. (The special enrollment period is available for 60 days following your request)	Based on when we receive your complete application*

* If the coverage date is based on when we receive your complete application, then if we receive it:

- Between the 1st and 15th day of the month, coverage starts the 1st day of the following month.
- Between the 16th and the last day of the month, coverage starts the 1st day of the second following month.

You must apply for coverage within 60 days before or 60 days after your qualifying event for the following events.

Qualifying events	Coverage effective date
8. Other qualifying event ☐ Material error on exchange ☐ Unintentional enrollment or non-enrollment in an exchange plan because of material error ☐ Violation by plan of material contract provision ☐ Newly ineligible for premium tax credit/subsidies ☐ Medicaid/FAMIS eligibility determination delay ☐ If you can't find your situation, contact your agent/broker or call us. We can only enroll based on events defined by state and/or federal law	Based on when we receive your complete application*
9. Loss of coverage: Lost or will lose Minimum Essential Coverage: ☐ Involuntary loss of coverage (for any reason except non-payment of premium or fraud) ☐ A legal separation or divorce ☐ Moved to a new service area. Minimum Essential Coverage must have been in effect for one or more days of the 60 days prior to the move.	First day of the month after we receive your complete application
10. Permanent move ☐ Moved to U.S. from a foreign country or a U.S. territory ☐ Permanent move to a new service area (within the U.S.). Minimum Essential Coverage must have been in effect for one or more days of the 60 days prior to the move. ☐ **11. Non-calendar renewal** Current policy does not renew on a calendar year basis (renews on a date other than January 1) ☐ **12. Jail or prison** Released from jail or prison (incarceration)	Based on when we receive your complete application.*

* If the coverage date is based on when we receive your complete application, then if we receive it:

- Between the 1st and 15th day of the month, coverage starts the 1st day of the following month.
- Between the 16th and the last day of the month, coverage starts the 1st day of the second following month.

Almost there! We may need a bit more info.

We need supporting documentation for most qualifying events, such as a letter or official form from the source (employer, state or federal agency, for example) to confirm the qualifying event occurred. It should also include the date the event happened, and the names of all applicants affected. If you're applying because you've lost coverage, we need to know the reason why coverage was lost in the supporting documentation. In all cases, we might need additional documentation to confirm eligibility.

Give us or your agent a call if you have any questions.

Payment Methods for Individual Applications

Anthem
And Its Affiliate HealthKeepers, Inc.

Applicant/Member name	Primary applicant's Social Security number

Anthem Blue Cross and Blue Shield (Anthem) and/or HealthKeepers, Inc. (HealthKeepers) will accept monthly payments on behalf of applicants/members **if the payment is made by the following persons or entities:** The Ryan White HIV/AIDS Program; other federal and state government programs that provide monthly payments and cost-sharing support for specific individuals; Indian tribes, tribal organizations and urban Indian organizations; or a relative or legal guardian on behalf of an applicant/member.

Unless required by law, Anthem and/or HealthKeepers does not accept monthly payments from third parties that are not listed above. Examples of third parties from whom Anthem and/or HealthKeepers will not accept monthly payments include, but are not limited to, insurance brokers and/or agents, doctors, hospitals, not-for-profit organizations (including religious organizations) that have or whose primary donors have a financial interest in the benefits of the contract/policy, commercial entities with a direct or indirect financial interest in the benefits of the contract/policy and employers that offer coverage under an employer health plan. Note: As allowed by law, Anthem and/or HealthKeepers reserves the right to decline monthly payments from third parties.

I authorize Anthem and/or HealthKeepers to debit the bank account listed or charge the credit/debit card listed for my first monthly payment on or after the day that my coverage is approved. By signing this form, I understand that the amount of the first payment may change from what I was told because my coverage has not been approved yet. In addition if I select Option 1 or Option 2 below, I understand that my future payments may vary as a result of changes(s) I make once enrolled, including but not limited to, adding and deleting dependents, moving my residence, changing coverage and/or changes made by Anthem and/or HealthKeepers of which I am notified according to my plan/policy. In addition, I understand if changes I make are close to the auto withdrawal date, Anthem and/or HealthKeepers may not be able to notify me before the withdrawal is made. **I agree to pay any service charge that Anthem and/or HealthKeepers may bill me because the debit/charge was not honored.** I understand if my monthly payment increases based on a certain percentage, Anthem and/or HealthKeepers will stop my automatic payments and send notification to me. I will have the option to restart the automatic monthly payments.

Please choose how you want to pay your monthly payments for all of your plans. Put a check in the box for either Option 1, Option 2 or Option 3.

☐ **Option 1 Bank Account Authorization: Have your first and future monthly payments automatically deducted from your bank account.**

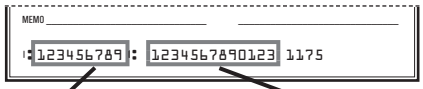
All of your monthly payments will be taken out of the **bank account** you check below.

Checking account: ☐ Business ☐ Personal

Savings account: ☐ Business ☐ Personal

Enter the requested debit date from your bank account ___ (1st to 6th of each month). If no date is requested your monthly payments will be debited on the first of each month.

Write the routing and account numbers that are on your check here: →



9-digit bank routing number	Bank account number

I authorize Anthem and/or HealthKeepers to automatically debit the **bank account** listed above each month to make my monthly payments. I agree that **Anthem and/or HealthKeepers' rights with each debit are the same as if the debit was a check that I signed.** I understand monthly payments will be made on the day I've indicated or within 3 business days thereafter. I authorize Anthem and/or HealthKeepers to automatically debit my account (and to make corrections to previous debits). This authority stays in effect until I let Anthem and/or HealthKeepers know that I no longer want them to debit my account by giving them a 30-day advance written notice. I understand that if my bank does not allow Anthem and/or HealthKeepers to debit my account for any reason, I will automatically be removed from automatic monthly payments and will be billed by mail. I understand if my monthly payment increases based on a certain percentage, Anthem and/or HealthKeepers will stop my automatic payments and send notification to me. I will have the option to restart the automatic monthly payments.

Authorized signature (as it appears on bank's records)	Printed bank account holder's name (as it appears on account)	Date (MM/DD/YY)
X		

☐ **Option 2 Credit/Debit Card Authorization: Have your first and future monthly payments automatically charged to your credit/debit card.**

Complete the information below

Enter the requested charge date for your credit/debit card ___ (1st to 6th of each month).

I authorize Anthem and/or HealthKeepers to automatically charge my **credit/debit card** listed below each month to make my monthly payments. I understand monthly payments will be made on the day I've indicated or within 3 business days thereafter. I authorize Anthem and/or HealthKeepers to charge my credit/debit card until I let them know that I no longer want them to charge my credit/debit card by giving them a 30-day advance written notice. I agree that Anthem and/or HealthKeepers, in honoring the monthly payments charged to my credit/debit card, is not responsible for any fees charged by my bank. I understand if that if any Anthem and/or HealthKeepers credit/debit transaction is not honored, I will automatically be removed from automatic monthly payments and will be billed by mail. I understand if my monthly payment increases based on a certain percentage, Anthem and/or HealthKeepers will stop my automatic payments and send notification to me. I will have the option to restart the automatic monthly payments.

Anthem and/or HealthKeepers accepts ☐ **Visa or** ☐ **Mastercard (Note to applicant: Please check one.)**

Card number	Expiration date ___ (MM/YY)

Billing address for this credit/debit card	City	Zip code

Authorized signature (as it appears on card)	Printed card holder's name (as it appears on card)	Date (MM/DD/YY)
X		

See page two for *Option 3 First Monthly Payment Only: Send us your first monthly payment now and receive a bill each month for your future monthly payments.*

Payment Methods for Individual Applications

Anthem
And Its Affiliate HealthKeepers, Inc.

Applicant/Member name	Primary applicant's Social Security number

☐ **Option 3 First Monthly Payment Only: Send us your first monthly payment now and receive a bill each month for your future monthly payments.**

Choose one of the ways below that you would like to pay only your first monthly payment.

☐ Check (enclose your paper check with application) ☐ Electronic check (fill out section A below) ☐ Credit/Debit card (fill out section B below)

A. **Electronic check:** Instead of sending us a paper check, you can use an electronic check that allows Anthem and/or HealthKeepers to take the money right from your bank account to make your first payment on the day that your coverage is approved. You will not get the check back from your bank. (We will not keep this information on file or use it for any future payments.) Please fill out this information.

Printed account holder name	Routing number	Account Number	Amount of first payment
			$

B. **Credit/Debit card:** I allow Anthem and/or HealthKeepers to charge the credit or debit card I listed below one time for my first monthly payment. This payment will cover the first monthly payment for all of the plans I have with Anthem and/or HealthKeepers.

Anthem and/or HealthKeepers accepts ☐ Visa or ☐ Mastercard (Note to applicant: Please check one.)

Card number	Expiration date (MM/YY)

Billing address for this credit/debit card	City	Zip code

I authorize Anthem and/or HealthKeepers to debit/charge the bank account or credit/debit card listed above **to make my first monthly payment only.**

I agree that Anthem and/or HealthKeepers will not have to pay any fees that my bank may charge because my electronic check or credit/debit card was rejected even if I can no longer continue coverage. I understand that **this is a one-time payment and that I am responsible for making sure Anthem and/or HealthKeepers receives my future monthly payments after this first payment.**

Authorized signature (as it appears on bank account/card)	Printed bank account/card holder's name (as it appears on account/card)	Date (MM/DD/YY)
X		

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

Spanish
Usted tiene derecho a recibir ayuda en su idioma en forma gratuita. Simplemente llame al número de Servicios para Miembros que figura en su tarjeta de identificación.

Chinese
您有權免費獲得透過您使用的語言提供的幫助。請撥打您的 ID 卡片上的會員服務電話號碼。若您是視障人士，還可索取本文件的其他格式版本。

Vietnamese
Quý vị có quyền nhận miễn phí trợ giúp bằng ngôn ngữ của mình. Chỉ cần gọi số Dịch vụ dành cho thành viên trên thẻ ID của quý vị. Bị khiếm thị? Quý vị cũng có thể hỏi xin định dạng khác của tài liệu này."

Korean
귀하는 자국어로 무료지원을 받을 권리가 있습니다. ID 카드에 있는 멤버 서비스번호로 연락하십시오.

Tagalog
May karapatan ka na makakuha ng tulong sa iyong wika nang libre. Tawagan lamang ang numero ng Member Services sa iyong ID card. May kapansanan ka ba sa paningin? Maaari ka ring humiling ng iba pang format ng dokumentong ito.

Russian
Вы имеете право на получение бесплатной помощи на вашем языке. Просто позвоните по номеру обслуживания клиентов, указанному на вашей идентификационной карте. Пациенты с нарушением зрения могут заказать документ в другом формате.

Armenian
Դուք իրավունք ունեք ստանալ անվճար օգնություն ձեր լեզվով: Պարզապես զանգահարեք Անդամների սպասարկման կենտրոն, որի հեռախոսահամարը նշված է ձեր ID քարտի վրա:

Farsi
"شما این حق را دارید تا به صورت رایگان به زبان مادری تان کمک دریافت کنید. کافی است با شماره خدمات اعضا (Member Services) درج شده روی کارت شناسایی خود تماس بگیرید." دچار اختلال بینایی هستید؟ می توانید این سند را به فرمت های دیگری نیز درخواست دهید.

French
Vous pouvez obtenir gratuitement de l'aide dans votre langue. Il vous suffit d'appeler le numéro réservé aux membres qui figure sur votre carte d'identification. Si vous êtes malvoyant, vous pouvez également demander à obtenir ce document sous d'autres formats.

Arabic
لك الحق في الحصول على مساعدة بلغتك مجانًا. ما عليك سوى الاتصال برقم خدمة الأعضاء الموجود على بطاقة الهوية. هل أنت ضعيف البصر؟ يمكنك طلب أشكال أخرى من هذا المستند.

Japanese
お客様の言語で無償サポートを受けることができます。IDカードに記載されているメンバーサービス番号までご連絡ください。

Haitian
Se dwa ou pou w jwenn èd nan lang ou gratis. Annik rele nimewo Sèvis Manm ki sou kat ID ou a. Èske ou gen pwoblèm pou wè? Ou ka mande dokiman sa a nan lòt fòma tou.

Italian
Ricevere assistenza nella tua lingua è un tuo diritto. Chiama il numero dei Servizi per i membri riportato sul tuo tesserino. Sei ipovedente? È possibile richiedere questo documento anche in formati diversi

Polish
Masz prawo do uzyskania darmowej pomocy udzielonej w Twoim języku. Wystarczy zadzwonić na numer działu pomocy znajdujący się na Twojej karcie identyfikacyjnej.

Punjabi
ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮੁਫ਼ਤ ਵਿੱਚ ਮਦਦ ਹਾਸਲ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਬਸ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਸਿਰਵਸ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। ਨਜ਼ਰ ਕਮਜ਼ੋਰ ਹੈ? ਤੁਸ ਇਸ ਦਸਤਾਵੇਜ਼ ਦੇ ਹੋਰ ਰੂਪਾਂਤਰ ਮੰਗ ਸਕਦੇ ਹੋ।

TTY/TTD:711

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