PREMERA BLUE CROSS

P.O. Box 327, MS 295
Seattle, WA 98111-9220

B

Group Medicare Supplement Enrollment Application
Washington State Health Care Authority

You can become a Washington State Health Care Authority Medicare Supplement member if you:

- Are eligible for the group's Medicare supplement plan
- Currently have both Medicare Part A and Part B, **and**
- Don't receive Medicaid assistance other than payment of your Medicare Part B premium.

For Office Use Only
Group Number: _____
Effective Date of Coverage: _____
Enrollee Class (if applicable): _____

Please PRINT, sign and date in blue or black ink. Applications that contain correction fluid or tape will not be accepted. PLEASE RETURN ALL THE PAGES OF THE APPLICATION EVEN IF THEY ARE BLANK.

A Your Information

Applicant

I am eligible for Medicare Part A and B because: ☐ Age 65+ ☐ Under Age 65
I have Medicare due to: ☐ Kidney Dialysis or Kidney Transplant

Last Name First Name Middle Initial		Social Security Number (required)		
Home Address (cannot be a P.O. Box)	City	County	State	ZIP
Mailing Address (if different from above)	City	County	State	ZIP
Daytime Phone Number	Email Address			
Birthdate *Month* *Day* *Year*	Gender ☐ Male ☐ Female			

Dependent

I am eligible for Medicare Part A and B because: ☐ Age 65+ ☐ Under Age 65
I have Medicare due to: ☐ Kidney Dialysis or Kidney Transplant

Relationship to Applicant: _____

Last Name First Name Middle Initial		Social Security Number (required)		
Home Address (cannot be a P.O. Box)	City	County	State	ZIP
Mailing Address (if different from above)	City	County	State	ZIP
Daytime Phone Number	Email Address			
Birthdate *Month* *Day* *Year*	Gender ☐ Male ☐ Female			

B What Plan Do You Want?

Which Medicare supplement plan do you want to enroll in? ☒ Plan G

Did you receive a copy of the Premera Blue Cross "Outline of Coverage"? ☐ Yes ☐ No

Did you receive a copy of Medicare's "Choosing A Medigap Policy" guide? ☐ Yes ☐ No

C Your Other Health Coverage

Please answer all the questions below as best you know how.

Applicant

Tell Us About Your Medicare Coverage (You have to have Medicare Parts A and B to Enroll)

1. a. Did you turn age 65 in the last 6 months? ☐Yes ☐No

b. Did you enroll in Medicare Part B in the last 6 months? ☐Yes ☐No

c. If **Yes**, what is the effective date? (month and year) _____ / 01 / _____

(See your Medicare card to find this date.)

Please fill in your Medicare number and effective dates in the box to the right. You can copy from your Medicare card. Or, it's OK to include a copy of your Medicare card instead. We need these numbers to enroll you.

Your Medicare Information Here

MEDICARE HEALTH INSURANCE

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY

MEDICARE CLAIM NUMBER

_____ - ____ - _____ - ____

IS ENTITLED TO	EFFECTIVE DATE
Part A Hospital Insurance	_____ / 01 / _____
Part B Medical Insurance	_____ / 01 / _____

Tell Us About Your Medicare Advantage Coverage, If Any

If you didn't have this kind of coverage, just check "No" to 2.a., b., c. and d.

2. a. Have you had coverage from any Medicare plan other than original Medicare within the last 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO)? ☐Yes ☐No

If Yes, fill in your **start** and **end** dates below. (OK to put in just the month and year.)

If you are still covered under this plan, leave "End" blank.

Start: _____ / _____ / _____ End: _____ / _____ / _____

b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement plan? (You can't keep both.) ☐Yes ☐No

c. Was this your first time in this type of Medicare plan? ☐Yes ☐No

d. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ☐Yes ☐No

Tell Us About Your Medicare Supplement Coverage, If Any

If you didn't have this kind of coverage, just check "No" to 3.a. and c. Leave 3.b. blank.

3. a. Do you have another Medicare Supplement policy in force? (These plans are called Plan A, B, C, D, F, G, K, L, M or N) ☐Yes ☐No

b. If Yes, with what company, and what plan do you have? (If you know, put the insurance company name and the plan name (such as Plan F) in the blanks.)

Company: _____ Plan: _____

c. If Yes, do you intend to replace your current Medicare Supplement policy with this plan? (You can't keep both.) ☐Yes ☐No

Tell Us About Any Other Individual Or Group Health Insurance Coverage, If Any

If you didn't have this kind of coverage, just check "No" to 4.a., and leave b. and c. blank.

4. a. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan). ☐Yes ☐No

b. If Yes, with what company and what kind of policy? (If you know, put in the insurance company name and the type of policy, such as group coverage through your spouse or individual coverage.)

Company: _____ Policy: _____

c. What are your dates of coverage under the other policy? **If you are still covered under the same policy**, leave “End” blank. (It's OK to put just the month and year or just the year.)

Start: _____ / _____ / _____ End: _____ / _____ / _____

Tell Us About Any Help With Your Medical Bills You Receive From Your State's Medicaid Programs

This doesn't mean Social Security benefits or food stamps. It can include payment for nursing home care. If you didn't have this kind of help from State Medicaid, just check "No" to 5.a., b. and c.

5. a. Are you covered for any medical assistance through the state Medicaid program?
Note To Applicant: If you are participating in a “Spend-Down Program” and have not met your “Share of Cost,” please answer **No** to this question. ☐Yes ☐No

b. If **Yes**, will Medicaid pay your premiums for this Medicare Supplement plan? ☐Yes ☐No

c. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B Premium? ☐Yes ☐No

Dependent

Tell Us About Your Medicare Coverage
(You have to have Medicare Parts A and B to Enroll)

1. a. Did you turn age 65 in the last 6 months? ☐Yes ☐No

b. Did you enroll in Medicare Part B in the last 6 months? ☐Yes ☐No

c. If **Yes**, what is the effective date? (month and year) _____ / 01 / _____

(See your Medicare card to find this date.)

Dependent's Medicare Information Here

Please fill in your Medicare number and effective dates in the box to the right. You can copy from your Medicare card. Or, it's OK to include a copy of your Medicare card instead. We need these numbers to enroll you.

MEDICARE HEALTH INSURANCE

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY

MEDICARE CLAIM NUMBER

_____ - ____ - _____ - ____

IS ENTITLED TO	**EFFECTIVE DATE**
Part A Hospital Insurance	_____ / 01 / _____
Part B Medical Insurance	_____ / 01 / _____

Tell Us About Your Dependent's Medicare Advantage Coverage, If Any

If you didn't have this kind of coverage, just check "No" to 2.a., b., c. and d.

2. a. Have you had coverage from any Medicare plan other than original Medicare within the last 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO)? ☐Yes ☐No

If Yes, fill in your **start** and **end** dates below. (OK to put in just the month and year.)
If you are still covered under this plan, leave "End" blank.

Start: _____ / _____ / _____ End: _____ / _____ / _____

b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement plan? (You can't keep both.) ☐Yes ☐No

c. Was this your first time in this type of Medicare plan? ☐Yes ☐No

d. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ☐Yes ☐No

Tell Us About Your Dependent's Medicare Supplement Coverage, If Any

If you didn't have this kind of coverage, just check "No" to 3.a. and c. Leave b. blank.

3. a. Do you have another Medicare Supplement policy in force? (These plans are called Plan A, B, C, D, F, G, K, L, M or N) ☐Yes ☐No

b. If Yes, with what company, and what plan do you have? (If you know, put the insurance company name and the plan name (such as Plan F) in the blanks.)

Company: _____ Plan: _____

c. If Yes, do you intend to replace your current Medicare Supplement policy with this plan? (You can't keep both.) ☐Yes ☐No

Tell Us About Any Other Dependent Individual Or Group Health Insurance Coverage, If Any

If you didn't have this kind of coverage, just check "No" to 4.a., and leave b. and c. blank.

4. a. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan). ☐Yes ☐No

b. If Yes, with what company and what kind of policy? (If you know, put in the insurance company name and the type of policy, such as group coverage through your spouse or individual coverage.)

Company: _____ Policy: _____

c. What are your dates of coverage under the other policy? **If you are still covered under the same policy**, leave "End" blank. (It's OK to put just the month and year or just the year.)

Start: _____ / _____ / _____ End: _____ / _____ / _____

Tell Us About Any Help With Your Dependent's Medical Bills You Receive From Your State's Medicaid Programs

This doesn't mean Social Security benefits or food stamps. It can include payment for nursing home care. If you didn't have this kind of help from State Medicaid, just check "No" to 5.a., b. and c.

5. a. Are you covered for any medical assistance through the state Medicaid program? **Note To Applicant:** If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer **No** to this question. ☐Yes ☐No

b. If **Yes**, will Medicaid pay your premiums for this Medicare Supplement plan? ☐Yes ☐No

c. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B Premium? ☐Yes ☐No

Proceed to section D

D Conditions of Enrollment/Signatures

I, the undersigned, apply for enrollment with Premera Blue Cross (Premera). I represent that all statements and answers on this application are complete and true.

1. I am an eligible member of the group.
2. I have **both** Medicare Parts A and B in force today.
3. I understand that my coverage does not start until Premera accepts this application and assigns an effective date.
4. I authorize Premera, at its option, to pay doctors and other providers directly for health care I receive.
5. I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.
6. I also understand and agree that Premera may cancel this coverage back to its start date as if I never had coverage at all, if it is found that I have supplied false information, or any information was omitted by me or for me, on this application, and that information is material enough to affect my eligibility for coverage. (Please note: After coverage has been in force for two years, coverage may no longer be canceled for this reason.)
7. I understand that Premera may collect, use, and disclose personal information about me as required or permitted by law or to perform routine business functions. Examples are to determine my eligibility for enrollment or to pay claims. If Premera discloses my personal information for any other reason, Premera will first take out any data that can be used to easily identify me, or will get my signed permission.

Be sure to sign and date this application, include all pages of the application and provide any proof required for "yes" answers in section C, when submitting to Premera for processing.

Signature of Applicant	Today's Date
X	

Signature of Dependent	Today's Date
X	

Please Note: If you have a Medicare supplement or Medicare Advantage policy today (including a Medicare HMO or PPO), you cannot be enrolled unless you intend to replace your current coverage. Please complete the "Notice to Applicant Regarding Replacement of Medicare Supplement or Medicare Advantage Coverage" form.

If you have any questions, please contact your benefit department or Premera at 1-800-817-3049 or TDD for the Deaf or Hard of Hearing at 1-800-842-5357.

Important Notes

1. You do not need more than one Medicare Supplement policy. If you currently have a Medicare Supplement policy or Medicare Advantage policy (including a Medicare HMO or PPO), you cannot be enrolled unless you intend to replace your current coverage. Please complete a replacement form. If you purchase this contract, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
2. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy. Medicaid is a public aid program for people with low income. It is not the same as Medicare.
3. If, after purchasing this plan, you become entitled to Medicaid, the benefits and subscription charges under your Medicare Supplement contract can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement plan (or, if that is no longer available, a substantially equivalent plan) will be re-instituted if requested within 90 days of losing Medicaid eligibility.
4. Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement coverage and concerning medical assistance through the state Medicaid program, including benefits as a “Qualified Medicare Beneficiary” (QMB) or a “Specified Low-Income Medicare Beneficiary” (SLMB).
5. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted, if requested within 90 days of losing your employer or union based group health plan.

Who Is Eligible For Coverage?

Public Employees Benefit Board (PEBB) Program Retirees, Survivors, or PEBB Continuation Coverage (COBRA) Subscribers

To be eligible, you must be an eligible retiree, survivor, or PEBB continuation coverage (COBRA) subscriber and enroll during one of the periods listed below:

- Upon initial enrollment in PEBB insurance coverage.
- Within six months of initial enrollment in Medicare Part B.
- If you deferred PEBB retiree health plan coverage, you may enroll during any PEBB Program annual open enrollment or no later than 60 days after the date other qualified coverage ends.
- Existing PEBB subscribers may change their coverage by applying for another plan during a PEBB Program annual open enrollment or a special open enrollment period, established by the PEBB Program.
- During other enrollment periods, if any, established by the PEBB Program.

Dependents of PEBB Program Retirees or PEBB Continuation Coverage (COBRA) Subscribers

To be eligible, you must be an eligible spouse or state-registered domestic partner and enroll during one of the periods listed below:

- At the same time as the PEBB retiree or PEBB Continuation Coverage (COBRA) subscriber.
- Within six months of initial enrollment in Medicare Part B.
- During a PEBB Program annual open enrollment or a special open enrollment period established by the PEBB Program.

State Residents

To be eligible, you must be a current Washington State resident and enroll during one of the periods listed below:

- No earlier than 30 days before you become eligible for Part A and Part B of Medicare.
- Within six months of initial enrollment in Medicare Part B provided that you are replacing a health plan with no lapse in coverage of more than 63 days.
- Within six months of attaining age 65 or older and is enrolled in Medicare Part B.
- Within 63 days of establishing Washington State residency. Residency date: _____
- Within 63 days of losing coverage under a retiree group health plan, a Medicare Advantage plan, a health care prepayment plan, a Program of All-Inclusive Care for the Elderly, a Medicare supplement or Medicare SELECT plan, or a Medicare risk or cost plan for reasons that qualify under federal law. Your answers in section C of the application will determine if you qualify.
- When replacing coverage or enrolling during a guaranteed issue period, as allowed by law. Your answers in section C of the application will determine if you qualify.

Discrimination is Against the Law

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

Premera:

- Provides free aids 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, contact the Civil Rights Coordinator.

If you believe that Premera 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:
Civil Rights Coordinator — Complaints and Appeals
PO Box 91102, Seattle, WA 98111
Toll free 855-332-4535, Fax 425-918-5592,
TTY 800-842-5357
Email AppealsDepartmentInquiries@Premera.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the 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 Ave SW, Room 509F, HHH Building
Washington, D.C. 20201, 1-800-368-1019,
800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Getting Help in Other Languages

This Notice has Important Information. This notice may have important information about your application or coverage through Premera Blue Cross. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 800-722-1471 (TTY: 800-842-5357).

አማሪኛ (Amharic):
ይህ ማስታወቂያ አስፈላጊ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም የ Premera Blue Cross ሽፋን አስፈላጊ መረጃ ሊኖረው ይችላል። በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀኖች ሊኖሩ ይችላሉ። የጤናን ሽፋንዎን ለመጠበቅና በአከፋፈል እርዳታ ለማግኘት በተውሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ እንዲያገኙ እና ያለምንም ክፍያ በቋንቋዎ እርዳታ እንዲያገኙ መብት አለዎት።በስልክ ቁጥር 800-722-1471 (TTY: 800-842-5357) ይደውሉ።

العربية (Arabic):
يحوي هذا الإشعار معلومات هامة. قد يحوي هذا الإشعار معلومات مهمة بخصوص طلبك أو التغطية التي تريد الحصول عليها من خلال Premera Blue Cross. قد تكون هناك تواريخ مهمة في هذا الإشعار. وقد تحتاج لاتخاذ إجراء في تواريخ معينة للحفاظ على تغطيتك الصحية أو للمساعدة في دفع التكاليف. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك دون تكبد أية تكلفة. اتصل بـ800-722-1471 (TTY: 800-842-5357)

中文 (Chinese):
本通知有重要的訊息。本通知可能有關於您透過 Premera Blue Cross 提交的申請或保險的重要訊息。本通知內可能有重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 800-722-1471 (TTY: 800-842-5357)。

Oromoo (Cushite):
Beeksisni kun odeeffannoo barbaachisaa qaba. Beeksisti kun sagantaa yookan karaa Premera Blue Cross tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qabaachuu danda'a. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa 800-722-1471 (TTY: 800-842-5357) tii bilbilaa.

Français (French):
Cet avis a d'importantes informations. Cet avis peut avoir d'importantes informations sur votre demande ou la couverture par l'intermédiaire de Premera Blue Cross. Le présent avis peut contenir des dates clés. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez le 800-722-1471 (TTY: 800-842-5357).

Kreyòl ayisyen (Creole):
Avi sila a gen Enfòmasyon Enpòtan ladann. Avi sila a kapab genyen enfòmasyon enpòtan konsènan aplikasyon w lan oswa konsènan kouvèti asirans lan atravè Premera Blue Cross. Kapab genyen dat ki enpòtan nan avi sila a. Ou ka gen pou pran kèk aksyon avan sèten dat limit pou ka kenbe kouvèti asirans sante w la oswa pou yo ka ede w avèk depans yo. Se dwa w pou resevwa enfòmasyon sa a ak asistans nan lang ou pale a, san ou pa gen pou peye pou sa. Rele nan 800-722-1471 (TTY: 800-842-5357).

Deutsche (German):
Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält unter Umständen wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Premera Blue Cross. Suchen Sie nach eventuellen wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 800-722-1471 (TTY: 800-842-5357).

Hmoob (Hmong): Tsab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb. Tej zaum tsab ntawv tshaj xo no muaj cov ntsiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog koj qhov kev pab cuam los ntawm Premera Blue Cross. Tej zaum muaj cov hnub tseem ceeb uas sau rau hauv daim ntawv no. Tej zaum koj kuj yuav tau ua qee yam uas peb kom koj ua tsis pub dhau cov caij nyoog uas teev tseg rau hauv daim ntawv no mas koj thiaj yuav tau txais kev pab cuam kho mob los yog kev pab them tej nqi kho mob ntawd. Koj muaj cai kom lawv muab cov ntshiab lus no uas tau muab sau ua koj hom lus pub dawb rau koj. Hu rau 800-722-1471 (TTY: 800-842-5357).

Iloko (Ilocano): Daytoy a Pakdaar ket naglaon iti Napateg nga Impormasion. Daytoy a pakdaar mabalin nga adda ket naglaon iti napateg nga impormasion maipanggep iti apliksayonyo wenno coverage babaen iti Premera Blue Cross. Daytoy ket mabalin dagiti importante a petsa iti daytoy a pakdaar. Mabalin nga adda rumbeng nga aramidenyo nga addang sakbay dagiti partikular a naituding nga aldaw tapno mapagtalinaedyo ti coverage ti salun-atyo wenno tulong kadagiti gastos. Adda karbenganyo a mangala iti daytoy nga impormasion ken tulong iti bukodyo a pagsasao nga awan ti bayadanyo. Tumawag iti numero nga 800-722-1471 (TTY: 800-842-5357).

Italiano (Italian): Questo avviso contiene informazioni importanti. Questo avviso può contenere informazioni importanti sulla tua domanda o copertura attraverso Premera Blue Cross. Potrebbero esserci date chiave in questo avviso. Potrebbe essere necessario un tuo intervento entro una scadenza determinata per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere queste informazioni e assistenza nella tua lingua gratuitamente. Chiama 800-722-1471 (TTY: 800-842-5357).

日本語 (Japanese): この通知には重要な情報が含まれています。この通知には、Premera Blue Cross の申請または補償範囲に関する重要な情報が含まれている場合があります。この通知に記載されている可能性がある重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。800-722-1471 (TTY: 800-842-5357)までお電話ください。

한국어 (Korean):
본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 Premera Blue Cross 를 통한 커버리지에 관한 정보를 포함하고 있을 수 있습니다. 본 통지서에는 핵심이 되는 날짜들이 있을 수 있습니다. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 800-722-1471 (TTY: 800-842-5357) 로 전화하십시오.

ລາວ (Lao):
ແຈ້ງການນີ້ມີຂໍ້ມູນສຳຄັນ. ແຈ້ງການນີ້ອາດຈະມີຂໍ້ມູນສຳຄັນກ່ຽວກັບຄຳຮ້ອງສະໝັກ ຫຼື ຄວາມຄຸ້ມຄອງປະກັນໄພຂອງທ່ານຜ່ານ Premera Blue Cross. ອາດຈະມີວັນທີສຳຄັນໃນແຈ້ງການນີ້. ທ່ານອາດຈະຈຳເປັນຕ້ອງດຳເນີນການຕາມກຳນົດເວລາສະເພາະເພື່ອຮັກສາຄວາມຄຸ້ມຄອງປະກັນສຸຂະພາບ ຫຼື ຄວາມຊ່ວຍເຫຼືອເວື້ອງຄ່າໃຊ້ຈ່າຍຂອງທ່ານໄວ້. ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໃຫ້ໂທຫາ 800-722-1471 (TTY: 800-842-5357).

ภาสาไทย (Khmer):
សេចក្តីជូនដំណឹងនេះមានព័ត៌មានយ៉ាងសំខាន់។
សេចក្តីជូនដំណឹងនេះប្រហែលជាមានព័ត៌មានយ៉ាងសំខាន់អំពីទម្រង់បែបបទ ឬការកាន់កាប់របស់អ្នកកាមរយៈ Premera Blue Cross ។ ប្រហែលជាមានកាលបរិច្ឆេទសំខាន់នៅក្នុងសេចក្តីជូនដំណឹងនេះ។ អ្នកប្រហែលជាត្រូវការបញ្ជូនសមត្ថភាព ដល់កំណត់ថ្ងៃជាក់ច្បាស់នានា ដើម្បីនឹងរក្សាទុកការធានារ៉ាប់រងសុខភាពរបស់អ្នក ឬជ្រាក់ជំនួយចេញថ្លៃ។ អ្នកមានសិទ្ធិទទួលព័ត៌មាននេះ និងជំនួយនៅក្នុងភាសារបស់អ្នកដោយមិនអស់លុយឡើយ។ សូមទូរស័ព្ទ 800-722-1471 (TTY: 800-842-5357)។

ਪੰਜਾਬੀ (Punjabi):
ਇਸ ਨੋਟਿਸ ਵਿਚ ਖਾਸ ਜਾਣਕਾਰੀ ਹੈ. ਇਸ ਨੋਟਿਸ ਵਿਚ Premera Blue Cross ਵਲੋਂ ਤੁਹਾਡੀ ਕਵਰੇਜ ਅਤੇ ਅਰਜੀ ਬਾਰੇ ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ ਹੋ ਸਕਦੀ ਹੈ . ਇਸ ਨੋਜਿਸ ਜਵਚ ਖਾਸ ਤਾਰੀਖਾ ਹੋ ਸਕਦੀਆਂ ਹਨ. ਜੇਕਰ ਤੁਸੀ ਜਸਹਤ ਕਵਰੇਜ ਰਿੱਖਣੀ ਹੋਵੇ ਜਾ ਓਸ ਦੀ ਲਾਗਤ ਜਵਿੱਚ ਮਦਦ ਦੇ ਇਛੁੱਕ ਹੋ ਤਾਂ ਤੁਹਾਨੂੰ ਅੰਤਮ ਤਾਰੀਖ਼ ਤੋਂ ਪਹਿਲਾਂ ਕੁੱਝ ਖਾਸ ਕਦਮ ਚੁੱਕਣ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ .ਤੁਹਾਨੂੰ ਮੁਫ਼ਤ ਵਿੱਚ ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ .ਕਾਲ 800-722-1471 (TTY: 800-842-5357).

فارسی (Farsi):
این اعلامیه حاوی اطلاعات مهم میباشد .این اعلامیه ممکن است حاوی اطلاعات مهم درباره فرم تقاضا و یا پوشش بیمه ای شما از طریقPremera Blue Cross باشد. به تاریخ های مهم در این اعلامیه توجه نمایید .شما ممکن است برای حفظ پوشش بیمه تان یا کمک در پرداخت هزینه های درمانی تان، به تاریخ های مشخصی برای انجام کارهای خاصی احتیاج داشته باشید .شما حق این را دارید که این اطلاعات و کمک را به زبان خود به طور رایگان دریافت نمایید. برای کسب اطلاعات با شماره 800-722-1471 (کاربران TTY تماس باشماره 800-842-5357) تماس برقرار نمایید.

Polskie (Polish):
To ogłoszenie może zawierać ważne informacje. To ogłoszenie może zawierać ważne informacje odnośnie Państwa wniosku lub zakresu świadczeń poprzez Premera Blue Cross. Prosimy zwrócic uwagę na kluczowe daty, które mogą być zawarte w tym ogłoszeniu aby nie przekroczyć terminów w przypadku utrzymania polisy ubezpieczeniowej lub pomocy związanej z kosztami. Macie Państwo prawo do bezpłatnej informacji we własnym języku. Zadzwońcie pod 800-722-1471 (TTY: 800-842-5357).

Português (Portuguese):
Este aviso contém informações importantes. Este aviso poderá conter informações importantes a respeito de sua aplicação ou cobertura por meio do Premera Blue Cross. Poderão existir datas importantes neste aviso. Talvez seja necessário que você tome providências dentro de determinados prazos para manter sua cobertura de saúde ou ajuda de custos. Você tem o direito de obter esta informação e ajuda em seu idioma e sem custos. Ligue para 800-722-1471 (TTY: 800-842-5357).

Română (Romanian):
Prezenta notificare conține informații importante. Această notificare poate conține informații importante privind cererea sau acoperirea asigurării dumneavoastre de sănătate prin Premera Blue Cross. Pot exista date cheie în această notificare. Este posibil să fie nevoie să acționați până la anumite termene limită pentru a vă menține acoperirea asigurării de sănătate sau asistența privitoare la costuri. Aveți dreptul de a obține gratuit aceste informații și ajutor în limba dumneavoastră. Sunați la 800-722-1471 (TTY: 800-842-5357).

Русский (Russian):
Настоящее уведомление содержит важную информацию. Это уведомление может содержать важную информацию о вашем заявлении или страховом покрытии через Premera Blue Cross. В настоящем уведомлении могут быть указаны ключевые даты. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 800-722-1471 (TTY: 800-842-5357).

Fa'asamoa (Samoan):
Atonu ua iai i lenei fa'asilasilaga ni fa'amatalaga e sili ona taua e tatau ona e malamalama i ai. O lenei fa'asilasilaga o se fesoasoani e fa'amatala atili i ai i le tulaga o le polokalame, Premera Blue Cross, ua e tau fia maua atu i ai. Fa'amolemole, ia e iloilo fa'alelei i aso fa'apitoa olo'o iai i lenei fa'asilasilaga taua. Masalo o le'a iai ni feau e tatau ona e faia ao le'i aulia le aso ua ta'ua i lenei fa'asilasilaga ina ia e iai pea ma maua fesoasoani mai ai i le polokalame a le Malo olo'o e iai i ai. Olo'o iai iate oe le aia tatau e maua atu i lenei fa'asilasilaga ma lenei fa'matalaga i legagana e te malamalama i ai aunoa ma se togiga tupe. Vili atu i le telefoni 800-722-1471 (TTY: 800-842-5357).

Español (Spanish):
Este Aviso contiene información importante. Es posible que este aviso contenga información importante acerca de su solicitud o cobertura a través de Premera Blue Cross. Es posible que haya fechas clave en este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 800-722-1471 (TTY: 800-842-5357).

Tagalog (Tagalog):
Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay maaaring naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Premera Blue Cross. Maaaring may mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 800-722-1471 (TTY: 800-842-5357).

ไทย (Thai):
ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้อาจมีข้อมูลที่สำคัญเกี่ยวกับการการสมัครหรือขอบเขตประกันสุขภาพของคุณผ่าน Premera Blue Cross และอาจมีกำหนดการในประกาศนี้ คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร 800-722-1471 (TTY: 800-842-5357)

Український (Ukrainian):
Це повідомлення містить важливу інформацію. Це повідомлення може містити важливу інформацію про Ваше звернення щодо страхувального покриття через Premera Blue Cross. Зверніть увагу на ключові дати, які можуть бути вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону 800-722-1471 (TTY: 800-842-5357).

Tiếng Việt (Vietnamese):
Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn xin tham gia hoặc hợp đồng bảo hiểm của quý vị qua chương trình Premera Blue Cross. Xin xem ngày quan trọng trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 800-722-1471 (TTY: 800-842-5357).