BlueCross BlueShield of Texas

Dearborn National

Enrollment Application | Change Form

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

730197.1216

ENROLLMENT APPLICATION/CHANGE FORM INSTRUCTIONS

PLEASE READ THOROUGHLY BEFORE COMPLETING ENROLLMENT APPLICATION/CHANGE FORM

Use a black or blue ballpoint pen only. Print neatly. Do not abbreviate.

SECTION 1

Check all the boxes that apply to indicate if you are a new enrollee or if you are requesting a change to your coverage. Indicate the event and date, if applicable. Complete the additional sections that correspond to your selection.

New Enrollee: Complete all Sections where applicable.

Add Dependent: Complete all Sections where applicable.

- If you are enrolling a court-ordered dependent for coverage beyond the automatic 31-day period for coverage, you must submit a copy of the court order or decree.
- If student dependent coverage is part of your employer's plan and you are adding or enrolling a dependent child age 26 or over who is a student, you may be required to submit a completed Student Certification form.
- If you are applying for coverage for a disabled dependent over the age limit of your employer's plan, please provide the additional information requested in Section 6. Additional documentation may be required as addressed in that section.

Completion of Other Eligibility Requirements: Check this box only if your employer has eligibility requirements that you have met/completed prior to enrollment, such as measurement period or orientation period. **Effective Date of Benefits** field is mandatory.

Cancel Enrollee: Complete Sections 1, 2, 4 and 10. In Section 4 include name, social security number, and date of birth of individual(s) cancelling.

Cancel Dependent: Complete Sections 1, 2, 4 and 10. In Section 4 include name and date of birth of individual(s) cancelling.

Declining Coverage: Complete Sections 2, 9 and 10.

SECTIONS 2 & 3

Complete all portions related to the coverages for which you are applying.

If you work for an employer with 2-50 employees: Please list the seven-character plan ID for your selected benefit design (example: B634ADT) in the plan # field. If you are unsure of your group size or do not know your plan ID, please ask for guidance from your employer.

SECTION 4

Complete all areas that apply to you and each dependent.

For HMO only:

- Blue Premier℠ and Blue Essentials℠ are HMO plans that require a primary care physician/practitioner (PCP) selection. Blue Premier Access℠ and Blue Essentials Access℠ are HMO plans that do not require a PCP selection.
- Those applying for HMO coverage that require PCP selection should select a PCP for each individual to be covered. List the name of the physician/practitioner and the provider number from the provider directory or Provider Finder® at **bcbstx.com**. Be sure to check the appropriate box for a new patient.

ATTENTION FEMALE MEMBERS: If you select an HMO plan that requires PCP selection, remember that your PCP's network may affect your choice of an OB/GYN. You have the right to receive services from an OB/GYN without first obtaining a referral from your PCP. However, for HMO members, the OB/GYN from whom you receive services must belong to the same physician practice group or independent practice association (IPA) as your PCP. This is another reason to make certain that your PCP's network includes the specialists – particularly the OB/GYN – and hospitals that you prefer. You are not required to designate an OB/GYN. You may elect to receive OB/GYN services from your PCP.

Change Primary Care Physician/Practitioner: In Section 1, check the "Other Change(s)" box, then complete sections 2, 3, 4 and 10. In Section 4, please include enrollee's or dependent's name, social security number, date of birth, and name and number of the new PCP.

Change Address / Name: In Section 1, check the "Other Change(s)" box, then complete sections 1, 2 and 10.

SECTION 5

Complete this section if your employer is offering life insurance coverage.

SECTION 6

Complete this section if you are applying for coverage for a disabled dependent child over the dependent child age limit of your employer's plan. A disabled dependent must be certified by medical underwriting and a completed Dependent Child's Statement of Disability form must be submitted with this enrollment application.

SECTION 7

Complete this section if you or any dependent have other health care coverage through an employer (group coverage) that will not be cancelled when the coverage under this application becomes effective.

SECTION 8

Complete this section if you or any of your dependents are covered by Medicare.

SECTION 9

Complete this section if you are declining health coverage for yourself and your dependents. **Anyone** declining coverage for any reason should complete Section 9, not just those declining because of other coverage.

IMPORTANT NOTICE – DECLINATION OF HEALTH COVERAGE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health care coverage, you may, in the future, be able to enroll yourself or your dependents in the plan if you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of a marriage, birth, adoption, becoming a party in a suit for adoption, or placement of a foster child in your home, you may be able to enroll yourself and your dependents if you request enrollment within 31 days after the marriage, birth, adoption, suit for adoption, or placement of an eligible foster child in your home.

SECTION 10

Sign your name and date the enrollment application if you agree to the conditions set forth in this section. Your enrollment application should be submitted to your employer's **Enrollment Department**, which will then submit your form to: **Group Accounts Dept. • P. O. Box 655730 • Dallas, TX 75265-5730**

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

Forms referenced above may be obtained by accessing the Blue Cross and Blue Shield of Texas website at bcbstx.com, from your Marketing Service Representative, or from your employer. If you have any questions, please contact your Marketing Service Representative.

ENROLLMENT APPLICATION/CHANGE FORM

X X X X X X	X X X X	X X X	X X X X X X X X
Group #	Section #	Dept #	Social Security #
X X X X X X	X X X X	X X X	XXXXXXXX
Group #	Section #	Dept #	Category

BlueCross BlueShield of Texas   Dearborn National

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

SECTION 1 — ENROLLMENT EVENTS

PLEASE CHECK ALL THAT APPLY – IF YOU ARE DECLINING COVERAGE, COMPLETE SECTIONS 2, 9 AND 10 ONLY

☑ **New Enrollee** ☑ **Add Dependent** ☑ **Open Enrollment** ☑ **Other Change(s)**
Are you applying as a result of a Special Enrollment Event?
☑ **No** ☑ **Yes, Event Date:** xx / xx / 0000
Event: ☑ Marriage ☑ Birth
☑ Adoption or Suit for Adoption (Provide Legal Documents)
☑ Court Order (Provide Court Order or decree)
☑ Loss of Other Coverage
☑ Other (Explain): XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Effective Date of Benefits: 00 / 00 / 0000 ☑Completion of Other Eligibility Requirements **NOTE:** Declination of Coverage (Complete Sections 2, 9 and 10)

Add Coverage:
☑ Health
☑ Dental
☑ Term Life
☑ Dependent Life
☑ Short Term Disability (STD)
☑ Long Term Disability (LTD)

☑ **Cancel Enrollee** ☑ **Cancel Dependent**
Cancel Coverage: ☑ Health ☑ Dental
☑ Term Life ☑ Dependent Life ☑ STD ☑ LTD
List names of those cancelling in Section 4 below
Event: ☑ Divorce ☑ Death
☑ Terminated Employment ☑ Other
Indicate Event Date: 00 / 00 / 0000

SECTION 2 — PLEASE TELL US ABOUT YOURSELF

COMPLETE EVEN IF DECLINING COVERAGE

Last Name	First Name	MI (opt)	Suffix	Birth Date (MM/DD/YYYY)	Social Security #
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXX	X	XXXXXXX	03/03/2017	XXX – XX – XXXX

Mailing Address - Street - Apt #	City	State	ZIP code
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XX	XXXXXXXXXXXXXXX

Email Address		Home/Cell Phone #
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	☑ Male ☑ Female	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Name of Employer	Job Title	Business Phone #	Employment Date (MM/DD/YYYY)	Do you usually work at least 30 hours a week for this employer?
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX	03/08/2017	☑ Yes ☑ No

Eligibility Status: ☑ Active Employee ☑ Retired Employee - Date of Retirement: 04/07/2017 ☑ COBRA Continuation
☑ State Continuation of Group Coverage (insured plans only) ☑ Dependent State Continuation of Group Coverage (insured plans only)

SECTION 3 — SELECT YOUR COVERAGE

PLEASE CHECK ALL THAT APPLY

Small Group Plans (2-50 employees)

Health Coverage (select one)
☑ Blue Premier℠ ☑ Blue Choice PPO℠
☑ Blue Premier Access℠ ☑ Blue Advantage HMO℠
☑ Blue Essentials℠
☑ Blue Essentials Access℠
Plan # (required) XXXXXXXXXXXXXXXXXX

Who is covered? (select one)
☑ Employee Only
☑ Employee /Spouse
☑ Employee /Child(ren)
☑ Family
☑ I am not applying for Health coverage

BlueCare Dental℠ Coverage
☑ Yes
☑ No

Who is covered? (select one)
☑ Employee Only
☑ Employee /Spouse
☑ Employee /Child(ren)
☑ Family
☑ I am not applying for Dental coverage

Large Group Plans (more than 50 Employees)

Health Coverage (select one)
☑ Blue Choice PPO ☑ Blue Essentials
☑ Blue Premier ☑ Blue Essentials Access
☑ Blue Premier Access
☑ Other XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Plan # XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Who is covered? (select one)
☑ Employee Only
☑ Employee /Spouse
☑ Employee /Child(ren)
☑ Family
☑ I am not applying for Health coverage

Dental Coverage
☑ Yes
☑ No
Plan # (required)
XXXXXXXXXXXXXXXXX

Who is covered? (select one)
☑ Employee Only
☑ Employee /Spouse
☑ Employee /Child(ren)
☑ Family
☑ I am not applying for Dental coverage

Primary Language: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX ☑ Check here to request a Spanish HMO Member Handbook
Do you have a disability affecting your ability to communicate or read? ☑ Yes ☑ No
If "Yes", describe special communication materials needed: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

SECTION 4 — COVERAGE OPTIONS

PCP SELECTION IS REQUIRED FOR BLUE PREMIER AND BLUE ESSENTIALS PLANS.
PCP SELECTION IS NOT REQUIRED FOR BLUE PREMIER ACCESS AND BLUE ESSENTIALS ACCESS PLANS.

Employee/Enrollee's Name	PCP Name	PCP #	New Patient?	HMO OB/GYN Name (optional)	HMO OB/GYN #
XXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXX	☑ Y ☑ N	XXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXX

Dependent's Name ☑ Husband ☑ Wife	Dependent's PCP Name	PCP #	New Patient?	HMO OB/GYN Name (optional)	HMO OB/GYN #
XXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXX	☑ Y ☑ N	XXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXX

Dependent's Social Security #	Birth Date (MM/DD/YYYY)	Address (if different) - # and Street Address City State ZIP code
XXX – XX – XXXX	03/09/2017	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Dependent's Name ☑ Son ☑ Daughter ☑ Other Eligible Dependent	Dependent's Social Security #	Dependent's PCP Name	PCP #	New Patient	HMO OB/GYN Name (optional)	HMO OB/GYN #
XXXXXXXXXXXXXXXX	XXX – XX – XXXX	XXXXXXXXXXXXXXX	XXXXXXXXXX	☑ Y ☑ N	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXX

Birth Date (MM/DD/YYYY)	Home Address (If different) Street/City/State/ZIP code	Is this dependent a natural child, stepchild, eligible foster child, adopted child, or a child in Suit for Adoption?	If not your natural child, stepchild, eligible foster child, adopted child or child in Suit for Adoption, are you (or your spouse) responsible for this dependent?
04/14/2017	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	☑ Y ☑ N	☑ Y ☑ N

Dependent's Name ☑ Son ☑ Daughter ☑ Other Eligible Dependent	Dependent's Social Security #	Dependent's PCP Name	PCP #	New Patient	HMO OB/GYN Name (optional)	HMO OB/GYN #
XXXXXXXXXXXXXXXX	XXX – XX – XXXX	XXXXXXXXXXXXXXXX	XXXXXXXXXX	☑ Y ☑ N	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXX

Birth Date (MM/DD/YYYY)	Home Address (If different) Street/City/State/ZIP code	Is this dependent a natural child, stepchild, eligible foster child, adopted child, or a child in Suit for Adoption?	If not your natural child, stepchild, eligible foster child, adopted child or child in Suit for Adoption, are you (or your spouse) responsible for this dependent?
04/19/2017		☑ Y ☑ N	☑ Y ☑ N

Dependent's Name ☑ Son ☑ Daughter ☑ Other Eligible Dependent	Dependent's Social Security #	Dependent's PCP Name	PCP #	New Patient	HMO OB/GYN Name (optional)	HMO OB/GYN #
XXXXXXXXXXXXXXXX	XXX – XX – XXXX	XXXXXXXXXXXXXXXX	XXXXXXXXXX	☑ Y ☑ N	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXX

Birth Date (MM/DD/YYYY)	Home Address (If different) Street/City/State/ZIP code	Is this dependent a natural child, stepchild, eligible foster child, adopted child, or a child in Suit for Adoption?	If not your natural child, stepchild, eligible foster child, adopted child or child in Suit for Adoption, are you (or your spouse) responsible for this dependent?
04/07/2017	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXV	☑ Y ☑ N	☑ Y ☑ N

Last Name: XXXXXXXXXXXXXXXXXXXXXXXXXXXXX Social Security #: XXX – XX – XXXX Group # X X X X X X

SECTION 5 — GROUP TERM LIFE, ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D), AND DISABILITY INSURANCE COVERAGE

Employee Occupation/Job Title: XXXXXXXXXXXXXXXXXXXXXXX Wage Rate $ XXXXXXXXXXXXXX per ☑ hour ☑ week ☑ month ☑ year

Group Basic Term Life & AD&D ☑ I do not apply ☑ I do apply Amount $ XXXXXXXXXXXXXXXXXXXXXX

Group Dependents' Life ☑ I do not apply ☑ I do apply

Group Supplemental Life ☑ I do not apply ☑ I do apply

Employee Election: $ XXXXXXXXXXXXXX Spouse Election: $ XXXXXXXXXXXXXX Child Election: $ XXXXXXXXXXXXXX

Short Term Disability (STD) ☑ I do not apply ☑ I do apply

Long Term Disability (LTD) ☑ I do not apply ☑ I do apply

	First Name	Initial	Last Name	Relationship	Birth Date (MM/DD/YYYY)	Social Security #
Primary Beneficiary	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX				03/17/2017	XXX – XX – XXXX
Contingent Beneficiary	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX				03/16/2017	XXX – XX – XXXX

SECTION 6 — DISABLED DEPENDENT

Name of Disabled Dependent	Nature of Disability
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

If disabled child is over the dependent age limit of your employer's plan, please attach a completed Dependent Child's Statement of Disability form.

SECTION 7 — OTHER COVERAGE INFORMATION

Complete this section only if you or any of your dependents have other health and / or dental coverage **that will not be cancelled** when the coverage under this application becomes effective. **List names of each individual covered**:

Group Coverage	Name and Address of Other Insurance Carrier	Effective Date (MM/DD/YYYY)	Type of Policy
☑ Yes ☑ No	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	03/10/2017	☑ Employee Only ☑ Employee/Spouse ☑ Employee/Child(ren) ☑ Family

Name of Policyholder	Birth Date (MM/DD/YYYY)		Relationship to Applicant
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	03/16/2017	☑ Male ☑ Female	☑ Self ☑ Spouse ☑ Dependent

Employer's Name	Employment Date (MM/DD/YYYY)	Health Group #	Health ID #	Dental Group #	Dental ID #
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	03/15/2017	XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXX	XXXXXXXXXXXXXXX

SECTION 8 — MEDICARE COVERAGE INFORMATION

Name of person covered: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Medicare A (Hospital) Effective Date: 03/09/2017 End Date: 03/03/2017
Medicare B (Medical) Effective Date: 03/10/2017 End Date: 03/09/2017
Medicare D (Drug) Effective Date: 03/16/2017 End Date: 03/23/2017
Medicare D (Drug) Carrier: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Medicare HIC # (From Medicare Card) XXXXXXXXXXXXXXXXX

Please indicate reason for Medicare Eligibility: ☑ Entitled Age ☑ Entitled Disability ☑ End-Stage Renal Disease ☑ Disability and Current Renal Disease

Name of person covered: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Medicare A (Hospital) Effective Date: 03/08/2017 End Date: 03/02/2017
Medicare B (Medical) Effective Date: 03/15/2017 End Date: 03/17/2017
Medicare D (Drug) Effective Date: 03/17/2017 End Date: 03/23/2017
Medicare D (Drug) Carrier: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Medicare HIC # (From Medicare Card) XXXXXXXXXXXXXXXXX

Please indicate reason for Medicare Eligibility: ☑ Entitled Age ☑ Entitled Disability ☑ End-Stage Renal Disease ☑ Disability and Current Renal Disease

SECTION 9 — DECLINATION OF COVERAGE

This is to certify the available coverage has been explained to me. I have been given the opportunity to apply for the coverage offered to me and my eligible dependents and have voluntarily elected to decline the coverage as indicated below. If I desire to apply for coverage at a later date, I understand there may be a delay in the effective date of the coverage.

Name ☑ Employee XXXXXXXXXXXXXXXXXXXXXX
Reason for Declining **Health**: ☑ Other Group Health Coverage; Carrier: XXXXXXXXXXXXXXXXXXXXXXXXX ☑ Medicare ☑ Medicaid ☑ Other Individual Health Coverage; Carrier: XXXXXXXXXXXXXXXXXXXXXXXXX ☑ Other, Explain: XXXXXXXXXXXXXXXXXXXXXXXXX ☑ I am not enrolled in any Health insurance plan, but do not want this coverage.

Name ☑ Employee XXXXXXXXXXXXXXXXXXXXXX
Reason for Declining **Dental**: ☑ Other Group Dental Coverage ☑ Medicaid ☑ Individual Dental Coverage ☑ Other, Explain: XXXXXXXXXXXXXXXXXXXXXXXXX ☑ I am not enrolled in any Dental insurance plan, but do not want this coverage.

Name ☑ Spouse XXXXXXXXXXXXXXXXXXXXXX
Reason for declining: ☑ Other Group Health Coverage ☑ Medicare ☑ Medicaid ☑ Other Individual Health Coverage ☑ Other, Explain: XXXXXXXXXXXXXXXXXXXXXXXXX ☑ I am not enrolled in any Health insurance plan, but do not want this coverage.

Name ☑ Child XXXXXXXXXXXXXXXXXXXXXX
Reason for declining: ☑ Other Group Health Coverage ☑ Medicare ☑ Medicaid ☑ Other Individual Health Coverage ☑ Other, Explain: XXXXXXXXXXXXXXXXXXXXXXXXX ☑ I am not enrolled in any Health insurance plan, but do not want this coverage.

Name ☑ Child XXXXXXXXXXXXXXXXXXXXXX
Reason for declining: ☑ Other Group Health Coverage ☑ Medicare ☑ Medicaid ☑ Other Individual Health Coverage ☑ Other, Explain: XXXXXXXXXXXXXXXXXXXXXXXXX ☑ I am not enrolled in any Health insurance plan, but do not want this coverage.

SECTION 10 — COVERAGE CONDITIONS

- I am an employee of the Employer named in this Enrollment Application. I am eligible to participate in the coverage(s) afforded by my Employer's plan, which is either underwritten or administered by Blue Cross and Blue Shield of Texas (BCBSTX) or Dearborn National® Life Insurance Company. On behalf of myself and any dependents listed on this Enrollment Application, I apply for those coverage(s) for which I am eligible. I state that the information given on this Enrollment Application is true and correct. I understand and agree that any intentional misrepresentation of a material fact made by me will invalidate my coverage(s).
- Only those coverage(s) and amounts for which I am eligible will be available to me. I understand that if this Enrollment Application is accepted, the coverage(s) will become effective in accordance with the provisions of the Contracts(s)/Plan(s).
- I agree that my Employer acts as my agent. I authorize necessary payroll deduction by my Employer, if any, to cover the cost of my coverage(s). As applies to HMO coverage, I will accept an electronic copy of my coverage documents (whether certificate of coverage or benefit booklet) if my Employer requests that BCBSTX deliver the information electronically. I understand that a hard copy is available to me upon request.
- I understand that my participation in the coverage(s) is subject to any future amendment. I also understand that all notices given to my Employer are applicable to me.
- I understand that written communications that are required by law may be delivered to me electronically, with my consent. I understand that if I consent to receive my documents electronically, that I have a right to obtain a paper copy and to withdraw my consent.

Applicant's Signature ______________________ Date 03/24/2017

BlueCross BlueShield of Texas

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 888-697-0683

العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 888-697-0683.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。 洽詢一位翻譯員, 請撥電話 號碼 888-697-0683.
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 888-697-0683.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 888-697-0683 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવા કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 888-697-0683 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा मे निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 888-697-0683 पर कॉल करें ।
日本語 Japanese	ご本人様、またはお客様の身の回りの方でも、ご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したり することができます。料金はかかりません。通訳とお話される場合、888-697-0683 までお電話ください。
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 888-697-0683 로 전화하십시오.
ພາສາລາວ Laotian	ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກໍາລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄໍາຖາມ, ທ່ານມີສິດຂໍເອົາການຊ່ວຍເຫຼືອ ແລະ ຂໍ ມູນເປັນພາສາຂອງທ່ານໄດ້ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອລົມກັບນາຍແປພາສາ, ໃຫ້ໂທຫາເບີ 888-697-0683.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił hodoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 888-697-0683.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی،با شمار888-697-0683 تماس حاصل نمایید.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 888-697-0683.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 888-697-0683.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 888-697-0683.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 888-697-0683 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị đang giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 888-697-0683.

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300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

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

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

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

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