

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Retail Industry Health Trust Employee Enrollment and Change Form 2018** | | | | | | | | | | | | | | | |
| Employer Name | | | Effective Date      /     /Date of Hire      /     / **Hours Worked Per Week** | | | | **Qualifying Event Description Event Date:      /     /**  Hire/Rehire  Birth/Adoption  Marriage/DP Open Enrollment COBRA Loss of Coverage  Court Order Name Change  New Address  Beneficiary  Other \_\_\_\_\_\_\_\_\_\_\_\_  Termination | | | | | | | | | |
| **EMPLOYEE INFORMATION** ***(\*indicates required field)*** | | | | | | | | | | | | | | | | |
| \*First Name, Middle Initial, Last Name | | | | Marital Status  Married: Single: | | | | \*Date of Birth  **/****/** | | | | \*Gender | | \*Social Security # | | |
| M | F |
| \*Mailing Address: City, State, Zip | | | | \*Employee Email Address | | | | | | \*Phone Number | | | | Annual Salary | Employee Class | |
| DEPENDENT INFORMATION (*\*indicates required field)* | | | | | | | | | | | | | | | | |
| **\*Add or**  **Delete**  (Circle One) | **\*Name of Dependent**  (If dependent has different mailing address, please attach)  First name, Middle initial, Last name | | | | **\*Birth Date**  (Children age 26 or over require disability certification) | | | | **\*Gender**  (Circle One) | | **\*Social Security #** | | | | | |
|
| Add/Delete | Spouse/Registered Domestic Partner | | | | **/**     **/** | | | | M F | |  | | | | | |
| Add/Delete | Child | | | | **/**     **/** | | | | M F | |  | | | | | |
| Add/Delete | Child | | | | **/**     **/** | | | | M F | |  | | | | | |
| Add/Delete | Child | | | | **/**     **/** | | | | M F | |  | | | | | |
| Add/Delete | Child | | | | **/**     **/** | | | | M F | |  | | | | | |
| **For individuals who are eligible for enrollment in an employer group health plan:** If you are declining enrollment for yourself or your dependents (including your spouse/domestic partner) because of other health insurance or employer group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if, in the case of employer group health plan coverage, the employer stops contributing toward you or your dependents’ other coverage.) However, you should request enrollment within 60 days after you or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you gain a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you should request enrollment within 60 days of the marriage, birth, adoption, or date of assumption of total or partial legal obligation for support of a child in anticipation of adoption. | | | | | | | | | | | | | | | | |
| PLAN SELECTIONS | | |  | | | | | | | | | | | | | | |
| Medical and Prescription Drug (Rx) Plan Selection fromPremera Blue Cross | | | **Employee**  **Employee and Spouse/Domestic Partner**  **Employee and Child(ren)**  **Family**  Please see your employer for plan details. Common enrollment is required for all lines of coverage.  ***If no coverage selected, attach waiver form.*** | | | | | | | | | | | | | | |
| Dental Plan Selection fromDelta Dental of Washington | | | **Employee**  **Employee and Spouse/Domestic Partner**  **Employee and Child(ren)**  **Family**  Please see your employer for plan details. | | | | | | | | | | | | | | |
| **Vision Plan** from VSP Vision Care Inc. | | | **Employee**  **Employee and Spouse/Domestic Partner**  **Employee and Child(ren)**  **Family**  Please see your employer for plan details. | | | | | | | | | | | | | | |
| **Voluntary Life** from LifeMap Assurance Company  Please see your employer for plan details. | | | If offered by your Employer, you may elect $20,000 or $40,000 guarantee issue in voluntary life insurance for yourself. Additional amounts require evidence of insurability. Premium will be payroll deducted.  **Employee:**  $20,000  $40,000 $60,000\*  $80,000\*  $100,000\* \**Requires Evidence of Insurability*  **Use the rate table below to determine your monthly cost.**   |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Age | Under 30 | 30-34 | 35-39 | 40-44 | 45-49 | 50-54 | 55-59 | 60-64 | 65-69 | 70-74 | 75+ | | Rate for $20,000 | 2.00 | 2.20 | 2.60 | 4.80 | 8.40 | 14.20 | 24.40 | 28.20 | 49.60 | 87.00 | 133.00 | | Rate for $40,000 | 4.00 | 4.40 | 5.20 | 9.60 | 16.80 | 28.40 | 48.80 | 56.40 | 99.20 | 174.00 | 266.00 | | Rate for $60,000 | 6.00 | 6.60 | 7.80 | 14.40 | 25.20 | 42.60 | 73.20 | 84.60 | 148.80 | 261.00 | 399.00 | | Rate for $80,000 | 8.00 | 8.80 | 10.40 | 19.20 | 33.60 | 56.80 | 97.60 | 112.80 | 198.40 | 348.00 | 532.00 | | Rate for $100,000 | 10.00 | 11.00 | 13.00 | 24.00 | 42.00 | 71.00 | 122.00 | 141.00 | 248.00 | 435.00 | 665.00 | | | | | | | | | | | | | | | |
| **Voluntary Personal Accident**  National Union Fire Insurance Company of Pittsburgh, Pa. (an AIG Company) | | | Please see your employer for plan details | | | | | | | | | | | | | | |
| **Beneficiary Information** | | | | | | | | | | | | | | | | | |
| **Beneficiary Information: (Mandatory) Compulsory 15K Policy w/ Medical** | | | Primary Beneficiary Name and Relationship\* | | | | Primary Beneficiary Address | | | | | | | | | | |
| Contingent Beneficiary Name and Relationship\*\* | | | | Contingent Beneficiary Address | | | | | | | | | | |
| \* If more than one primary beneficiary is named, the primary beneficiaries shall share equally unless otherwise indicated above. \*\* Contingent Beneficiary (ies) will only receive proceeds if all Primary Beneficiaries have predeceased the Insured. If you are naming more than one Contingent Beneficiary at 100% each, please indicate them in order of precedence. | | | | | | | | | | | | | | | | | |

|  |  |
| --- | --- |
| **Employee and Employer Signature:**  I hereby apply for enrollment or change of enrollment as indicated on this application. I understand that the Trust and the Insurers may collect, use and disclose protected health information about each individual enrolled under this application in order to carry out their routine business functions, including but not limited to, determining eligibility for benefits, paying claims, coordinating benefits with other insurance carriers or payer, underwriting and conducting case management care management and quality reviews. The Trust and the Insurers may also disclose protected health information to state and federal agencies, or other third parties, as required by law. I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. 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.  I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are eligible for benefits coverage and are listed on the enrollment form) for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law.\* Health information requested or disclosed may be related to treatment or services performed by: a physician, dentist, pharmacist or other physical or behavioral health care practitioner; a clinic, hospital, long term care or other medical facility; any other institution providing care treatment, consultation, pharmaceuticals or supplies; or an insurance carrier or group health plan. Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). This acknowledgement does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes. I authorize my employer to deduct from my earnings the amount, if any, for the coverage selected.\*For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Notice of Privacy Practices. A copy is available from the appropriate Endorsed Carrier listed below. | |
| Employee Signature and Date (Required for all Adds/Changes to enrollment)    Employee email address (for electronic notifications): | Employer Signature and Date |
| Endorsed Carrier Contact Information | |
| Premera Blue Cross: 7001 220th St. SW, Mountlake Terrace, WA 98043, Customer Service 800.722.1471  Delta Dental of Washington: 400 Fairview Avenue North, Suite 800, Seattle, WA 98106; Customer Service - 800.554.1907  VSP Vision Care Inc.: 3333 Quality Drive Rancho Cordova, CA 95670; Customer Service - 800.877.7195  LifeMap Assurance Company™: 100 S.W. Market St., Portland, OR 97207-5702; Customer Service – 800.794.5390  Wellspring EAP: 1900 Rainier Ave. South, Seattle, WA 98020; Customer Service – 800.553.7798  National Union Fire Insurance Company of Pittsburgh, Pa. (an AIG Company): 175 Water St. 18th Floor; New York, NY 10038 Customer Service – 212.770.7000 | |
| **For Employer Use Only**  **Please send applications to: Business Solutions, Inc. BHT Admin. PO Box 6, Mukilteo, WA 98275 Email: bht@bsitpa.com**  **Premera Blue Cross:**  Titanium $200  Titanium $350  Titanium $500  Sterling $250  Sterling $500  Sterling $750  Sterling $1000  Sterling $1500  Sterling $2000  Sterling $2500  Sterling $3000  Sterling $4000  Sterling $5000  HSA $1500  HSA $2500  HSA $3500  HSA $5000  **Premera Network:**  Heritage Prime Network\* **OR**  Heritage Plus Network\* \***Dual network offerings ONLY available to groups with 51 or more enrolled**  **Delta Dental of Washington:**  Plan 1  Plan 2  Plan 3  Plan 4  Plan 5\*\*  Plan 6\*\*  Child Orthodontia Rider  Family Orthodontia Ride  \*\*Plan 5 & Plan 6 available only to new group enrollment  **VSP Vision Care Inc.:**  Choice Plan A  Choice Plan B  **LifeMap Assurance Company Voluntary Life:**   Yes  No  **National Union Fire Insurance Company of Pittsburgh, Pa. (an AIG Company) Voluntary Personal Accident:** Yes  No | |

* **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 Cross를 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):  
ແຈ້ງການນີ້​ມີ​ຂໍ້ມູນສໍາຄັນ**. ແຈ້ງການນີ້ອາດ​ຈະ​ມີ​ຂໍ້​ມູນ​ສຳຄັນ​ກ່ຽວ​ກັບຄໍາຮ້ອງສະໝັກ ຫຼື ຄວາມ​ຄຸ້ມ​ຄອງ​ປະກັນ​ໄພ​ຂອງ​ທ່ານ​ຜ່ານ Premera Blue Cross. ອາດ​ຈະ​ມີວັນ​ທີ​ສຳຄັນໃນແຈ້ງການນີ້. ທ່ານອາດຈະຈຳ​ເປັນ​ຕ້ອງ​ດຳ​ເນີນ​ການ​ຕາມ​ກຳນົດ​ເວລາ​ສະ​ເພາະ​ເພື່ອ​ຮັກສາ​ຄວາມ​ຄຸ້ມ​ຄອງ​ປະກັນ​ສຸຂະພາບ​ ຫຼື ຄວາ​ມຊ່ວຍ​ເຫຼືອ​ເລື່ອງ​ຄ່າ​ໃຊ້​ຈ່າຍ​ຂອງ​ທ່ານ​ໄວ້. ທ່ານ​ມີ​ສິດ​ໄດ້​ຮັບ​ຂໍ້​ມູນ​ນີ້ ​ແລະ ຄວາມ​ຊ່ວຍ​ເຫຼືອ​ເປັນ​ພາສາ​ຂອງ​ທ່ານ​ໂດຍບໍ່​ເສຍ​ຄ່າ. ​ໃຫ້​ໂທ​ຫາ 800-722-1471 (TTY: 800-842-5357).

**ភាសាខ្មែរ (Khmer):  
សេចក្តីជូនដំណឹងនេះមានព័ត៌មានយ៉ាងសំខាន់។** សេចក្តីជូនដំណឹងនេះប្រហែលជាមានព័ត៌មានយ៉ាងសំខាន់អំពីទម្រង់បែបបទ ឬការរ៉ាប់រងរបស់អ្នកតាមរយៈ Premera Blue Cross ។ ប្រហែលជាមាន កាលបរិច្ឆេទសំខាន់នៅក្នុងសេចក្តីជូនដំណឹងនេះ។ អ្នកប្រហែលជាត្រូវការបញ្ចេញសមត្ថភាព ដល់កំណត់ថ្ងៃជាក់ច្បាស់នានា ដើម្បីនឹងរក្សាទុកការធានារ៉ាប់រងសុខភាពរបស់អ្នក ឬប្រាក់ជំនួយចេញថ្លៃ។ អ្នកមានសិទ្ធិទទួលព័ត៌មាននេះ និងជំនួយនៅក្នុងភាសារបស់អ្នកដោយមិនអសលុយឡើយ។ 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):**

اين اعلاميە حاوی اطلاعات مهم ميباشد. اين اعلاميە ممکن است حاوی اطلاعات مهم درباره فرم تقاضا و يا پوشش بيمە ای شما از طریق Premera Blue Cross باشد. بە تاريخ های مهم در اين اعلاميە توجە نماييد. شما ممکن است برای حقظ پوشش بیمه تان یا کمک در پرداخت هزینه های درمانی تان، بە تاريخ های مشخصی برای انجام کارهای خاصی احتیاج داشته باشيد. شما حق اين را داريد کە اين اطلاعات و کمک را بە زبان خود بە طور رايگان دريافت نماييد. برای کسب اطلاعات با شماره 1471-722-800 (کاربران TTY تماس باشماره 5357-842-800) 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).

**Pусский (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).