



**BlueCross BlueShield
of Illinois**

Group Enrollment Application | Change Form

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

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association Life and Disability insurance is underwritten by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148. Dearborn Life Insurance Company is an independent Blue Cross and Blue Shield licensee. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

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 ENROLLMENT EVENTS	<p>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.</p> <p>New Enrollee: Complete all sections where applicable.</p> <p>Add Dependent: Complete all sections where applicable.</p> <ul style="list-style-type: none"> 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 5. Additional documentation may be required as addressed in that section. If your employer offers coverage for children and your children are eligible, your children are eligible for health and/or dental coverage up to the dependent limiting age and may not be denied coverage due to marital, student or employment status before age 26 (check with your employer for additional details regarding eligibility requirements). In addition, eligible military personnel may not be denied coverage before age 30 under Illinois law. If you are adding an eligible military personnel dependent who is over the age limit of the employer's plan, completion of a Defense Department Form (DD 214) is required in addition to this application. <p>Open Enrollment: The period of time offered on a regular basis during which you can elect to enroll in a specific group health insurance plan or make changes to your current membership.</p> <p>Special Enrollment Event: If you qualify, special enrollment is any change to your current membership such as marriage*, divorce**, adoption, suit for adoption or placement for adoption, leave/layoff, moving out of the service area, etc. This change may occur outside of open enrollment.</p> <p>Effective Date of Benefits: Field is mandatory and should reflect your requested date.</p> <p>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.</p> <p>Cancel Enrollee/Cancel Dependent/Cancel Coverage: Complete Sections 1, 2, 4 (skip Section 4 if declining coverage), 8 and 9. In Section 4 include name, social security number and date of birth of individual(s) canceling.</p>
SECTION 2 YOUR INFORMATION	<p>Complete this section with details about yourself even if you are declining coverage.</p>
SECTION 3 YOUR COVERAGE	<p>Complete all portions related to the coverages for which you are applying. Please list the seven character plan ID for your selected benefit design (example: S533PPO) 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.</p> <p>If you are enrolling for life or disability insurance enter the information requested. When listing the beneficiary, provide both the first and last name and the relationship to you. List all beneficiaries that apply.</p>
SECTION 4 COVERAGE OPTIONS	<p>Complete all areas that apply to you and each dependent.</p> <p>For HMO Plans Only:</p> <ul style="list-style-type: none"> Those applying for HMO coverage are required to select a primary care physician/practitioner (PCP) for each covered individual. List the name of the physician/practitioner and the provider number from the provider directory or Provider Finder® at bcbsil.com. Be sure to check the appropriate box for a new patient. If you selected HMO coverage, you must select a medical group/individual practice associations (IPAs) and a primary care physician (PCP) for each person to be covered. You must also select a PCP within the selected medical group/IPA for each person to be covered. You may choose a different medical group/IPA for each person. Care received from a woman's principal health care provider (WPHCP) may be eligible for coverage without referrals from your PCP. However, your PCP and your WPHCP must be affiliated with or employed by your medical group/IPA in order for each person to be eligible for coverage. Until we receive your selected medical group/IPA, you may not be eligible and your claims may be denied. Be sure to enter the medical group/IPA number, name, PCP number and name. If you are adding an eligible military personnel dependent who is over the age limit of your employer's plan, completion of a Defense Department Form 214 (DD 214) is required in addition to this application. <p>Change Primary Care Physician/Practitioner: Complete Section 1 and check the "Other Change(s)" box; then, complete Sections 2, 3, 4 and 9. In Section 4, please include enrollee's or dependent's name, social security number, date of birth, name and number of the new PCP and the name and number of the new IPA.</p> <p>Change Address/Name: Complete Section 1 and check the "Other Change(s)" box; then, complete Sections 2 and 9.</p>
SECTION 5 DISABLED DEPENDENT	<p>A disabled dependent must be medically certified as disabled and dependent upon you or your spouse***/domestic partner in order to be considered for coverage if dependent coverage is part of your employer's plan. The disabled dependent is required to be covered prior to age 26 to be eligible for coverage over the dependent child age limit of your employer's plan. A Disabled Dependent Authorization and Disabled Dependent Physician Certification document must be completed and submitted with this enrollment application, if applicable.</p>
SECTION 6 OTHER COVERAGE	<p>Complete this section if you or any dependent have other group or individual health and/or dental coverage (if applicable) that will not be canceled when the coverage under this application becomes effective.</p>
SECTION 7 MEDICARE COVERAGE	<p>Complete this section if you or any of your dependents are covered by Medicare. Enter the start and end dates for the coverage that applies. Your Medicare HIC number must be listed (it can be found on your Medicare ID card). Check the reason for your Medicare coverage.</p>
SECTION 8 DECLINATION OF COVERAGE	<p>Complete this section if you are declining health coverage for yourself and your dependents. Anyone declining coverage for any reason should complete Section 8, not just those declining because of other coverage.</p> <p>IMPORTANT NOTICE: 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, party to a civil union, 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 for adoption, or placement of an eligible foster child in your home.</p>
SECTION 9 COVERAGE CONDITIONS	<p>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 BCBSIL.</p> <p>As used on the application (unless indicated otherwise): These terms may be used in a different way in other documents.</p> <p>* The term "marriage" includes legal marriage and the establishment of a civil union or domestic partnership (coverage subject to your employer's plan).</p> <p>** The term "divorce" includes legal divorce and the comparable termination of a civil union or domestic partnership (coverage subject to your employer's plan).</p> <p>*** The term "spouse" includes a legal spouse and a party to a civil union or domestic partnership (coverage subject to your employer's plan).</p>

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

If you are a current member and have questions, you may call the Customer Service number on the back of your member ID card.

ENROLLMENT APPLICATION/CHANGE FORM



Group #

Account #

Section #

Category

Social Security #

SECTION 1 — ENROLLMENT EVENTS

PLEASE CHECK ALL THAT APPLY – IF YOU ARE DECLINING COVERAGE, COMPLETE SECTIONS 2, 8 AND 9 ONLY

☐ New Enrollee

☐ Add Dependent

☐ Open Enrollment

☐ Other Changes

Are you applying as a result of a Special Enrollment Event?

☐ No

☐ Yes, Event Date: ____/____/____

Event: ☐ New Hire ☐ Marriage* ☐ Birth
☐ Adoption, Placement for Adoption or Suit for Adoption (provide legal documents)
☐ Court Order (provide court order or decree)
☐ Loss of Other Coverage
☐ Other (explain): _____

Effective Date of Benefits: ____/____/____ ☐ Completion of Other Eligibility Requirements

☐ Cancel Enrollee

☐ Cancel Dependent

Cancel Coverage: ☐ Health ☐ Dental
☐ Term Life ☐ Dependent Life
☐ Short-Term Disability ☐ Long-Term Disability
List names of those canceling in Section 4 below
Event: ☐ Divorce** ☐ Death
☐ Terminated Employment ☐ Other
Indicate Event Date: ____/____/____

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

Mailing Address - Street - Apt #

City

State

ZIP code

Email Address

☐ Male
☐ Female

Home/Cell Phone #

Name of Employer

Job Title

Business Phone #

Employment Date (MM/DD/YYYY)

On average, how many hours a week do you work? (required)

Eligibility Status: ☐ Active Employee ☐ Retired Employee - Date of Retirement: _____ ☐ COBRA Coverage Start Date _____ Projected End Date _____

☐ Illinois Continuation (insured plans only) Start Date _____ Projected End Date _____

SECTION 3 — SELECT YOUR COVERAGE

PLEASE CHECK ALL THAT APPLY

Small Group Plans (1-50 Employees)

Affordable Care Act Plans

☐ PPO ☐ Other _____
☐ Blue Choice Preferred PPOSM
☐ Blue OptionsSM
☐ Blue Precision HMOSM
☐ BlueCare DirectSM
Plan # (required) _____

Grandfathered and Grandmothered/Transitional Plans
☐ Blue Advantage Entrepreneur PPOSM
☐ Blue Choice Select PPOSM
☐ BlueEdge Select HSASM
☐ BlueEdge HSASM
☐ BlueEdge HCA DirectSM
☐ PPO Value Choice

☐ Blue Advantage HMOSM
☐ Blue Advantage HMO Value ChoiceSM
☐ Community Participation Organization (CPO)
☐ CPO Value Choice
☐ Other _____
Plan # (required) _____

Mid-Market and Large Group Standard Plans (51+ Employees)

Mid-Market & Large Group Standard Plans 51+

☐ PPO ☐ Blue Choice OptionsSM ☐ BlueEdge Select HSASM
☐ Blue Advantage HMOSM ☐ Blue Choice Select PPOSM ☐ Plan # (required) _____
☐ Blue Advantage HMO Value ChoiceSM ☐ BlueEdge HSASM ☐ Other _____

Previous BCBSIL or HMO Membership
Group #: _____
Section #: _____
Identification #: _____

Large Group Custom Plans (151+ Employees)

☐ Traditional
☐ PPO
☐ CPO
☐ CPO Value Choice
☐ HMO Illinois®
☐ HMO Illinois® w/HCA
☐ Blue Advantage HMOSM

☐ Blue Advantage HMOSM w/HCA
☐ Blue Choice OptionsSM
☐ Blue Choice Select PPOSM
☐ BlueEdge HCASM
☐ BlueEdge HSASM
☐ BlueEdge HCA DirectSM
☐ BlueEdge Select HCASM

☐ BlueEdge Select HSASM
☐ BlueEdge Select HCA DirectSM
☐ Vision
☐ Hearing
☐ Medicare Supplement
☐ Other _____

Dental

☐ BlueCare Dental PPOSM
☐ BlueCare Dental HMOSM
☐ Dental Group # (if different than Medical Group policy #) _____

☐ Employee and Party to a Civil Union or Domestic Partner
Gender: ☐ Male ☐ Female

☐ Individual/Employee
☐ Employee/Children
☐ Employee/Spouse
☐ Family

Primary Language: _____

Group Term Life, Accidental Death and Dismemberment (AD&D) and Disability Insurance

☐ I am not applying for Group Term Life, AD&D or Disability Insurance coverage

Employee Occupation/Job Title: _____ Wage Rate \$ _____ per ☐ hour ☐ week ☐ month ☐ year

Group Basic Term Life and AD&D ☐ I do not apply ☐ I do apply Amount \$ _____

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

Group Supplemental Life ☐ I do not apply ☐ I do apply

Employee Election: \$ _____ Spouse Election: \$ _____ Child Election: \$ _____

Short-Term Disability ☐ I do not apply ☐ I do apply

Long-Term Disability ☐ I do not apply ☐ I do apply

Primary Beneficiary

First Name Initial Last Name Relationship Birth Date (MM/DD/YYYY) Social Security #
- -

Contingent Beneficiary

First Name Initial Last Name Relationship Birth Date (MM/DD/YYYY) Social Security #
- -

As used on the application (unless indicated otherwise): These terms may be used in a different way in other documents.
* The term "marriage" includes legal marriage and the establishment of a civil union or domestic partnership (coverage subject to your employer's plan).
** The term "divorce" includes legal divorce and the comparable termination of a civil union or domestic partnership (coverage subject to your employer's plan).
*** The term "spouse" includes a legal spouse and party to a civil union or domestic partnership (coverage subject to your employer's plan).
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Last Name:

Social Security #

Group #

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SECTION 4 — COVERAGE OPTIONS

PLEASE COMPLETE ALL AREAS THAT APPLY

(If you are adding an eligible military personnel dependent who is over the age limit of your employer's plan, completion of a Defense Department Form 214 (DD 214) is required in addition to this application.)

Employee/Enrollee's Name		PCP Name PCP #		IPA Name IPA #	
WPHCP Name WPHCP #	New Patient? <input type="checkbox"/> Y <input type="checkbox"/> N	HMO OB/GYN Name (optional)		HMO OB/GYN #	
Dependent's Name <input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Party to a Civil Union		Dependent's PCP Name		PCP #	New Patient? <input type="checkbox"/> Y <input type="checkbox"/> N
IPA Name IPA #		WPHCP Name WPHCP #		HMO OB/GYN Name (optional) HMO OB/GYN #	
Dependent's Social Security # - -	Birth Date (MM/DD/YYYY)	Home Address (if different) Street/City/State/ZIP code			
Dependent's Name <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other Eligible Dependent		Dependent's PCP Name		PCP #	New Patient? <input type="checkbox"/> Y <input type="checkbox"/> N
Birth Date (MM/DD/YYYY)	Home Address (if different) Street/City/State/ZIP code	Is this dependent a natural child, stepchild, foster child, adopted child or a child in suit for adoption? <input type="checkbox"/> Y <input type="checkbox"/> N		If not your eligible natural child, stepchild, foster child, adopted child or child in suit for adoption, are you (or your spouse) responsible for this dependent? <input type="checkbox"/> Y <input type="checkbox"/> N	
Dependent's Social Security # - -		IPA Name IPA #		HMO OB/GYN Name (optional) HMO OB/GYN #	
Dependent's Name <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other Eligible Dependent		Dependent's PCP Name		PCP #	New Patient? <input type="checkbox"/> Y <input type="checkbox"/> N
Birth Date (MM/DD/YYYY)	Home Address (if different) Street/City/State/ZIP code	Is this dependent a natural child, stepchild, foster child, adopted child or a child in suit for adoption? <input type="checkbox"/> Y <input type="checkbox"/> N		If not your eligible natural child, stepchild, foster child, adopted child or child in suit for adoption, are you (or your spouse) responsible for this dependent? <input type="checkbox"/> Y <input type="checkbox"/> N	
Dependent's Social Security # - -		IPA Name IPA #		HMO OB/GYN Name (optional) HMO OB/GYN #	
Dependent's Name <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other Eligible Dependent		Dependent's PCP Name		PCP #	New Patient? <input type="checkbox"/> Y <input type="checkbox"/> N
Birth Date (MM/DD/YYYY)	Home Address (if different) Street/City/State/ZIP code	Is this dependent a natural child, stepchild, foster child, adopted child or a child in suit for adoption? <input type="checkbox"/> Y <input type="checkbox"/> N		If not your eligible natural child, stepchild, foster child, adopted child or child in suit for adoption, are you (or your spouse) responsible for this dependent? <input type="checkbox"/> Y <input type="checkbox"/> N	
Dependent's Social Security # - -		IPA Name IPA #		HMO OB/GYN Name (optional) HMO OB/GYN #	
Dependent's Name <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other Eligible Dependent		Dependent's PCP Name		PCP #	New Patient? <input type="checkbox"/> Y <input type="checkbox"/> N
Birth Date (MM/DD/YYYY)	Home Address (if different) Street/City/State/ZIP code	Is this dependent a natural child, stepchild, foster child, adopted child or a child in suit for adoption? <input type="checkbox"/> Y <input type="checkbox"/> N		If not your eligible natural child, stepchild, foster child, adopted child or child in suit for adoption, are you (or your spouse) responsible for this dependent? <input type="checkbox"/> Y <input type="checkbox"/> N	
Dependent's Social Security # - -		IPA Name IPA #		HMO OB/GYN Name (optional) HMO OB/GYN #	

SECTION 5 — DISABLED DEPENDENT

PLEASE COMPLETE IF APPLICABLE

Name of Disabled Dependent	Nature of Disability
Name of Disabled Dependent	Nature of Disability

If disabled child is over the dependent age limit of your employer's plan, please attach a completed Disabled Dependent Certification and the Disabled Dependent Physician Certification document.

SECTION 6 — OTHER COVERAGE INFORMATION

PLEASE COMPLETE ALL AREAS THAT APPLY

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

Group Coverage <input type="checkbox"/> Y <input type="checkbox"/> N	Individual Coverage <input type="checkbox"/> Y <input type="checkbox"/> N	Name and Address of Other Insurance Carrier	Effective Date (MM/DD/YYYY)	Type of Policy <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Family
Name of Policyholder		Birth Date (MM/DD/YYYY)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Applicant <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent
Employer's Name	Employment Date (MM/DD/YYYY)	Health Group #	Health ID #	Dental Group # Dental ID #

SECTION 7 — MEDICARE COVERAGE INFORMATION

PLEASE COMPLETE IF APPLICABLE

Name of person covered:	Medicare A (Hospital) Effective Date: _____ End Date: _____	Medicare HIC # (From Medicare Card)
	Medicare B (Medical) Effective Date: _____ End Date: _____	
	Medicare D (Drug) Effective Date: _____ End Date: _____	
	Medicare D (Drug) Carrier: _____	
Please indicate reason for Medicare Eligibility: <input type="checkbox"/> Entitled Age <input type="checkbox"/> Entitled Disability <input type="checkbox"/> End-Stage Renal Disease <input type="checkbox"/> Disability and Current Renal Disease		
Name of person covered:	Medicare A (Hospital) Effective Date: _____ End Date: _____	Medicare HIC # (From Medicare Card)
	Medicare B (Medical) Effective Date: _____ End Date: _____	
	Medicare D (Drug) Effective Date: _____ End Date: _____	
	Medicare D (Drug) Carrier: _____	
Please indicate reason for Medicare Eligibility: <input type="checkbox"/> Entitled Age <input type="checkbox"/> Entitled Disability <input type="checkbox"/> End-Stage Renal Disease <input type="checkbox"/> Disability and Current Renal Disease		

**SECTION 8 — DECLINATION OF COVERAGE****PLEASE COMPLETE IF YOU ARE DECLINING 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 <input type="checkbox"/> Employee	Reason for declining Health : <input type="checkbox"/> Other Group Health Coverage – Carrier: _____ <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other Individual Health Coverage – Carrier: _____ <input type="checkbox"/> Other (explain) _____ <input type="checkbox"/> I am not enrolled in any health insurance plan, but do not want this coverage
Name <input type="checkbox"/> Employee	Reason for declining Dental : <input type="checkbox"/> Other Group Dental Coverage <input type="checkbox"/> Medicaid <input type="checkbox"/> Individual Dental Coverage <input type="checkbox"/> Other (explain) _____ <input type="checkbox"/> I am not enrolled in any dental insurance plan, but do not want this coverage
Name <input type="checkbox"/> Spouse	Reason for declining: <input type="checkbox"/> Other Group Health Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other Individual Health Coverage <input type="checkbox"/> Other (explain) _____ <input type="checkbox"/> I am not enrolled in any health insurance plan, but do not want this coverage
Name <input type="checkbox"/> Dependent	Reason for declining: <input type="checkbox"/> Other Group Health Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other Individual Health Coverage <input type="checkbox"/> Other (explain) _____ <input type="checkbox"/> I am not enrolled in any health insurance plan, but do not want this coverage
Name <input type="checkbox"/> Dependent	Reason for declining: <input type="checkbox"/> Other Group Health Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other Individual Health Coverage <input type="checkbox"/> Other (explain) _____ <input type="checkbox"/> I am not enrolled in any health insurance plan, but do not want this coverage

SECTION 9 — COVERAGE CONDITIONS

- I am an employee or a retiree 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 Illinois or Dearborn 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 Contract(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).
- 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.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Applicant's Signature _____ Date _____

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Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
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>



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 855-710-6984.

العربية Arabic	إن كان لديك أو لدى شخص تساعدك أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
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 855-710-6984。
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 855-710-6984.
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 855-710-6984 an.
Ελληνικά Greek	Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να μιλήσετε σε έναν διερμηνέα, καλέστε 855-710-6984.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય અથવા કોઈ બાજુ વ્યક્તને અસુખા અમ. કાયકમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કોલ કરો.
हिंदी Hindi	यादि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें।
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ní, éí doodago ła'da bíká anáníłwo'ígíí, na'ídiłkidgo, ts'ídá bee ná ahóótí'i' t'áá níí'k'e níká a'doolwoł dóó bína'ídiłkidígíí bee níł h odoonih. Ata'dahalne'ígíí bich'í' hodiíłnih kwe'é 855-710-6984.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiegokolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
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 855-710-6984.
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 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulongan 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 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے 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، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.