

# Employee Waiver Form

## Waiver for CA 1-100 Small Groups

### California



Health care plans offered by Anthem Blue Cross.  
Insurance plans offered by Anthem Blue Cross Life and Health Insurance Company.

**Anthem Blue Cross Small Group Services**  
P.O. Box 9062  
Oxnard, CA 93031-9062  
[anthem.com/ca](http://anthem.com/ca)

#### Instructions:

Please complete and return to your Group Administrator. You, the employee, must complete this application. You are solely responsible for its accuracy and completeness. To avoid the possibility of delay, please answer all questions and be sure to sign and date your application.

Group/Case no. (if known)

| Section 1: Employee information                                                                                                                                                                                                                                                                                               |                                 |                                                                                                       |                                   |                                                                                                                                   |                                 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|-------------------------------------------------------------------------------------------------------|-----------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|---------------------------------|
| Last name                                                                                                                                                                                                                                                                                                                     |                                 | First name                                                                                            |                                   | M.I.                                                                                                                              | Social Security no.             |
| Street address (P.O. box not acceptable unless rural P.O. box)                                                                                                                                                                                                                                                                |                                 |                                                                                                       | City                              |                                                                                                                                   | State ZIP code                  |
| Email address                                                                                                                                                                                                                                                                                                                 |                                 | Employment status (required)<br><input type="checkbox"/> Part-time <input type="checkbox"/> Full-time |                                   | Marital status<br><input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner (DP) |                                 |
| No. of dependents including spouse/DP                                                                                                                                                                                                                                                                                         | Spouse/DP's Social Security no. |                                                                                                       | Home phone no.                    |                                                                                                                                   | Business phone no.              |
| Employer name                                                                                                                                                                                                                                                                                                                 |                                 |                                                                                                       | Hire date (required) (MM/DD/YYYY) |                                                                                                                                   | Occupation/job title (required) |
| Language choice (optional): <input type="checkbox"/> English (ENG) <input type="checkbox"/> Spanish (SPA) <input type="checkbox"/> Korean (KOR) <input type="checkbox"/> Chinese (ZHGX) (C/M) <input type="checkbox"/> Vietnamese (VIE) <input type="checkbox"/> Tagalog (TGL)<br><input type="checkbox"/> Other (W09): _____ |                                 |                                                                                                       |                                   |                                                                                                                                   |                                 |
| Do you read and write English? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, the translator must sign and submit a Statement of Accountability/Translator's Statement.                                                                                                                                      |                                 |                                                                                                       |                                   |                                                                                                                                   |                                 |
| Section 2: Waiver/Declining coverage – Complete only if any coverage is declined or refused by you and/or your eligible dependents.                                                                                                                                                                                           |                                 |                                                                                                       |                                   |                                                                                                                                   |                                 |
| Type of coverage/Declined for                                                                                                                                                                                                                                                                                                 |                                 |                                                                                                       |                                   |                                                                                                                                   |                                 |
| <b>Medical coverage declined for – check all that apply:</b><br><input type="checkbox"/> Myself <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Dependent(s)                                                                                                                                        |                                 |                                                                                                       |                                   |                                                                                                                                   |                                 |
| <b>Dental coverage (if offered) declined for – check all that apply:</b><br><input type="checkbox"/> Myself <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Dependent(s)                                                                                                                            |                                 |                                                                                                       |                                   |                                                                                                                                   |                                 |
| <b>Vision coverage (if offered) declined for – check all that apply:</b><br><input type="checkbox"/> Myself <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Dependent(s)                                                                                                                            |                                 |                                                                                                       |                                   |                                                                                                                                   |                                 |
| <b>Life/AD&amp;D coverage* (if offered) declined for – check all that apply:</b><br><input type="checkbox"/> Myself <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Dependent(s)                                                                                                                    |                                 |                                                                                                       |                                   |                                                                                                                                   |                                 |
| <b>Dependent Life coverage declined for:</b><br><input type="checkbox"/> Spouse/Domestic Partner and Dependents                                                                                                                                                                                                               |                                 |                                                                                                       |                                   |                                                                                                                                   |                                 |
| <b>Short Term Disability coverage declined for:</b><br><input type="checkbox"/> Myself                                                                                                                                                                                                                                        |                                 |                                                                                                       |                                   |                                                                                                                                   |                                 |
| <b>Long Term Disability coverage declined for:</b><br><input type="checkbox"/> Myself                                                                                                                                                                                                                                         |                                 |                                                                                                       |                                   |                                                                                                                                   |                                 |
| <b>Optional Supplemental/Voluntary coverage declined for:</b><br><input type="checkbox"/> Myself                                                                                                                                                                                                                              |                                 |                                                                                                       |                                   |                                                                                                                                   |                                 |
| <b>Optional Supplemental/Voluntary Dependent Life coverage declined for:</b><br><input type="checkbox"/> Spouse/Domestic Partner and Dependents                                                                                                                                                                               |                                 |                                                                                                       |                                   |                                                                                                                                   |                                 |
| <b>Voluntary Short Term Disability coverage declined for:</b><br><input type="checkbox"/> Myself                                                                                                                                                                                                                              |                                 |                                                                                                       |                                   |                                                                                                                                   |                                 |
| <b>Voluntary Long Term Disability coverage declined for:</b><br><input type="checkbox"/> Myself                                                                                                                                                                                                                               |                                 |                                                                                                       |                                   |                                                                                                                                   |                                 |
| Reason for declining or refusing coverage – Proof of coverage will be required.                                                                                                                                                                                                                                               |                                 |                                                                                                       |                                   |                                                                                                                                   |                                 |
| <input type="checkbox"/> Covered by Spouse's/Domestic Partner's group coverage                                                                                                                                                                                                                                                |                                 |                                                                                                       |                                   |                                                                                                                                   |                                 |
| <input type="checkbox"/> Enrolled in other Insurance – Please provide company name and plan: _____                                                                                                                                                                                                                            |                                 |                                                                                                       |                                   |                                                                                                                                   |                                 |
| <input type="checkbox"/> Enrolled in individual coverage                                                                                                                                                                                                                                                                      |                                 |                                                                                                       |                                   |                                                                                                                                   |                                 |
| <input type="checkbox"/> Spouse/Domestic Partner covered by employer's group medical coverage                                                                                                                                                                                                                                 |                                 |                                                                                                       |                                   |                                                                                                                                   |                                 |
| <input type="checkbox"/> Medicare/Medicaid/VA                                                                                                                                                                                                                                                                                 |                                 |                                                                                                       |                                   |                                                                                                                                   |                                 |
| <input type="checkbox"/> Other – please explain: _____                                                                                                                                                                                                                                                                        |                                 |                                                                                                       |                                   |                                                                                                                                   |                                 |
| <input type="checkbox"/> No coverage                                                                                                                                                                                                                                                                                          |                                 |                                                                                                       |                                   |                                                                                                                                   |                                 |
| List names of dependents to be waived: _____                                                                                                                                                                                                                                                                                  |                                 |                                                                                                       |                                   |                                                                                                                                   |                                 |

Social Security no.

I acknowledge that the available coverages have been explained to me by my employer and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to waive coverage. BY WAIVING THIS GROUP MEDICAL, DENTAL, VISION, DISABILITY AND/OR LIFE COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL, DENTAL, VISION, DISABILITY AND/OR LIFE COVERAGE ELSEWHERE) I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UNTIL THE NEXT OPEN ENROLLMENT TO BE ENROLLED IN THIS GROUP'S MEDICAL, DENTAL, VISION, DISABILITY AND/OR GROUP LIFE INSURANCE PLAN UNLESS I QUALIFY FOR A SPECIAL OPEN ENROLLMENT.

**Special Open Enrollment (Not applicable to Life or Disability)**

If you declined enrollment for yourself or your dependent(s) (including a spouse/domestic partner), you may be able to enroll yourself or your dependent(s) in this health benefit plan or change health benefit plans as a result of certain triggering events, including: (1) you or your dependent loses minimum essential coverage; (2) you gain or become a dependent; (3) you are mandated to be covered as a dependent pursuant to a valid state or federal court order; (4) you have been released from incarceration; (5) your health coverage issuer substantially violated a material provision of the health coverage contract; (6) you gain access to new health benefit plans as a result of a permanent move; (7) you were receiving services from a contracting provider under another health benefit plan, for one of the conditions described in Section 1373.96(c) of the Health and Safety Code and that provider is no longer participating in the health benefit plan; (8) you are a member of the reserve forces of the United States military or a member of the California National Guard, and returning from active duty service; or (9) you demonstrate to the department that you did not enroll in a health benefit plan during the immediately preceding enrollment period because you were misinformed that you were covered under minimum essential coverage. You must request special enrollment within 60 days from the date of the triggering event to be able to enroll yourself or your dependent(s) in this health benefit plan or change health benefit plans as a result of a qualifying triggering event.

\*I hereby certify that I have been given the opportunity to apply for the available group life and/or disability benefits offered by my employer, the benefits have been explained to me, and I and/or my dependent(s) decline to participate. Neither I nor my dependent(s) were induced or pressured by my employer, agent, or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for such coverage in the future, I may be required to provide evidence of insurability at my expense. Please examine your options carefully before waiving this coverage.

Signature of applicant if declining coverage for yourself or dependents

**X**

Date (MM/DD/YYYY)

# Get help in your language

## Language Assistance Services



Curious to know what all this says? We would be too. Here's the English version:

**IMPORTANT:** Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

### Spanish

**IMPORTANTE:** ¿Puede leer esta carta? De lo contrario, podemos hacer que alguien lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721. (TTY/TDD: 711)

### Arabic

مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاستعانة بشخص ما لمساعدتك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم 1-888-254-2721 (TTY/TDD: 711).

### Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող ենք նաև այս նամակը Ձեզ գրավոր տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-888-254-2721 հեռախոսահամարով: (TTY/TDD: 711)

### Chinese

重要事項：您能看懂這封信函嗎？如果您看不懂，我們能夠找人協助您。您有可能可以獲得以您的語言而寫的本信函。如需免費協助，請立即撥打1-888-254-2721。(TTY/TDD: 711)

### Farsi

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر نمی‌توانید، می‌توانیم شخصی را به شما معرفی کنیم تا در خواندن این نامه شما را کمک کند. همچنین می‌توانید این نامه را به صورت مکتوب به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، همین حالا با شماره 1-888-254-2721 تماس بگیرید. (TTY/TDD: 711)

### Hindi

महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम आपको इसे पढ़ने में मदद करने के लिए किसी को उपलब्ध करा सकते हैं। आप यह पत्र अपनी भाषा में लिखवाने में भी सक्षम हो सकते हैं। निःशुल्क मदद के लिए, कृपया 1-888-254-2721 पर तुरंत कॉल करें। (TTY/TDD: 711)

### Hmong

TSEEM CEEB: Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwm tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

### Japanese

重要: この書簡を読めますか？もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたものを入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。1-888-254-2721 (TTY/TDD: 711)

Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

## Khmer

សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ បើអ្នកអាចឱ្យមនុស្សណាម្នាក់អានជូនអ្នក។ អ្នកក៏អាចទទួលលិខិតនេះដោយសេរីដោយសារបង្គាប់អ្នកផងដែរ។ ដើម្បីទទួលបានជំនួយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅលេខ 1-888-254-2721។ (TTY/TDD: 711)

## Korean

중요: 이 서신을 읽으실 수 있으십니까? 읽으실 수 없을 경우 도움을 드릴 사람이 있습니다. 귀하가 사용하는 언어로 쓰여진 서신을 받으실 수도 있습니다. 무료 도움을 받으시려면 즉시 1-888-254-2721로 전화하십시오. (TTY/TDD: 711)

## Punjabi

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸੀਂ ਸ਼ਾਇਦ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵੱਖੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਫੋਨ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

## Russian

ВАЖНО. Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

## Tagalog

MAHALAGA: Nababasa ba ninyo ang liham na ito? Kung hindi, may taong maaaring tumulong sa inyo sa pagbasa nito. Maaari ninyo ring makuha ang liham na ito nang nakasulat sa ginagamit ninyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

## Thai

หมายเหตุสำคัญ: ท่านสามารถอ่านจดหมายฉบับนี้หรือไม่ หากท่านไม่สามารถอ่านจดหมายฉบับนี้ เราสามารถจัดหาเจ้าหน้าที่มาอ่านให้ท่านฟังได้ ท่านยังอาจให้เจ้าหน้าที่ช่วยเขียนจดหมายในภาษาของท่านอีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อที่หมายเลข 1-888-254-2721 (TTY/TDD: 711)

## Vietnamese

QUAN TRỌNG: Quý vị có thể đọc thư này hay không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc thư này. Quý vị cũng có thể nhận thư này bằng ngôn ngữ của quý vị. Để được giúp đỡ miễn phí, vui lòng gọi ngay số 1-888-254-2721. (TTY/TDD: 711)

# Get help in your language

## Notice of Language Assistance



Curious to know what all this says? We would be too. Here's the English version:

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-888-254-2721. For more help call the CA Dept. of Insurance at 1-800-927-4357. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

### Spanish

Servicios lingüísticos sin costo. Puede tener un intérprete. Puede solicitar que le lean los documentos y algunos puede recibirlos en su idioma. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-888-254-2721. Para obtener ayuda adicional, llame al Departamento de Seguros de California al 1-800-927-4357. (TTY/TDD: 711)

### Arabic

يتم تقديم خدمات اللغة دون مقابل. يمكنك الاستعانة بمترجم. ويمكنك المطالبة بأن تُقرأ لك بعض المستندات وأن يُرسل بعضها بلغتك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة التعريف الخاصة بك أو على الرقم 1-888-254-2721. للحصول على مزيد من المساعدة، يُرجى الاتصال بإدارة كاليفورنيا للتأمين على الرقم 1-800-927-4357. (TTY/TDD: 711)

### Armenian

Թարգմանչական անվճար ծառայություններ: Մենք կարող ենք Ձեզ թարգմանչի ծառայություններ առաջարկել Կարող ենք տրամադրել ինչ-որ մեկին, ով փաստաթղթերը կկարդա Ձեզ համար և կուղարկի դրանք Ձեր լեզվով: Օգնություն ստանալու համար զանգահարեք մեզ Ձեզ ID քարտի վրա նշված հեռախոսահամարով կամ 1-888-254-2721 համարով: Լրացուցիչ օգնության համար զանգահարեք Կալիֆոռնիայի ապահովագրության նախարարություն հետևյալ հեռախոսահամարով՝ 1-800-927-4357: (TTY/TDD: 711)

### Chinese

免費語言服務。您能獲得免費的譯員。您能聽到以您的語言讀出的文件內容，也能獲得以您的語言而寫的部分文件。如需協助，請撥打您的 ID 卡上的號碼或者 1-888-254-2721 聯絡我們。如需更多協助，請撥打 1-800-927-4357 聯絡 CA Dept. of Insurance。 (TTY/TDD: 711)

### Farsi

خدمات رایگان زبانی. می‌توانید یک مترجم شفاهی بگیرید. می‌توانید بخوانید اسناد را برای شما بخوانند و برخی اسناد نیز به زبان خودتان برایتان ارسال شود. برای دریافت کمک، از طریق شماره فهرست شده در کارت شناسایی‌تان و یا از طریق 1-888-254-2721 با ما تماس بگیرید. برای دریافت کمکهای بیشتر با اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تماس بگیرید. (TTY/TDD: 711)

### Hindi

बिना लागत की भाषा सेवाएँ। आप दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेज़ पढ़वा सकते हैं और कुछ दस्तावेज़ आपकी भाषा में भेजे जा सकते हैं। मदद के लिए, हमें अपने ID कार्ड पर सूचीबद्ध नंबर पर या 1-888-254-2721 पर कॉल करें। अधिक मदद के लिए 1-800-927-4357 पर CA बीमा विभाग कोकॉल करें। (TTY/TDD: 711)

## Hmong

Tsis Xam Tus Nqi Cov Kev Pab Cuam Ntsig Txog Hom Lus. Koj muaj peev xwm tau txais ib tus neeg txhais lus. Koj muaj peev xwm tau txais cov ntaub ntawv nyeem ua koj hom lus rau koj mloog thiab yuav xa ib co ntaub ntawv sau ua koj hom lus tuaj rau koj. Txog rau kev pab, hu rau peb tus nab npawb xov tooj teev tseg cia nyob rau ntawm koj daim ID los sis 1-888-254-2721. Txog rau kev pab ntiv, hu xov tooj rau Pab Kas Phais Lub Chaw Ua Hauj Lwm CA tus xov tooj 1-800-927-4357. (TTY/TDD: 711)

## Japanese

無料言語サービス。通訳サービスを受けられます。希望する言語で文書を読み上げたり、文書を送るサービスも可能です。支援を受けるには、IDカードに記載された番号、または 1-888-254-2721 にお電話ください。支援の詳細は、カリフォルニア州保険局(1-800-927-4357)にお電話ください。(TTY/TDD: 711)

## Khmer

សេវាភាសាឥតគិតថ្លៃ។ អ្នកអាចទទួលបានសេវាបកប្រែឆាប់រហ័ស។ អ្នកអាចឱ្យគេអានឯកសារឡើងវិញឬអាន និងផ្ញើឯកសារឡើងវិញជាភាសាបកប្រែ។ ដើម្បីទទួលបានជំនួយ សូមហៅ ទូរស័ព្ទមកយើងតាមលេខដែលបានរាយនៅលើកាត ID របស់អ្នក ឬក៏លេខ 1-888-254-2721 ។ ដើម្បីទទួលបានជំនួយបន្ថែម សូមហៅទូរស័ព្ទទៅ CA Dept. of Insurance តាមលេខ 1-800-927-4357។(TTY/TDD: 711)

## Korean

무료 언어 서비스. 번역사를 이용하실 수 있습니다. 귀하의 언어로 녹음되어 작성된 문서를 받아보실 수 있습니다. 도움을 받으시려면 ID 카드에 기재된 번호 또는 1-888-254-2721로 전화하십시오. 다른 도움이 필요하시면 1-800-927-4357로 보험 CA 부서에 문의 주십시오. (TTY/TDD: 711)

## Punjabi

ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਦੇ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਆ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਕੋਈ ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਪੜ੍ਹ ਕੇ ਸੁਣਾ ਸਕਦਾ ਹੈ ਅਤੇ ਕੁਝ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਤੁਹਾਨੂੰ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਸਾਨੂੰ ਤੁਹਾਡੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਸੂਚੀਬੱਧ ਨੰਬਰ ਜਾਂ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। ਜ਼ਿਆਦਾ ਮਦਦ ਲਈ, ਸੀਏ ਡਿਪਾਰਟਮੈਂਟ ਆਫ ਇਨਸ਼ੂਰੈਂਸ ਨੂੰ 1-800-927-4357 ਤੇ ਕਾਲ ਕਰੋ।(TTY/TDD: 711)

## Russian

Бесплатные языковые услуги. Вы можете получить услуги устного переводчика. Вам могут прочитать документы или направить некоторые из них на вашем языке. Для получения помощи звоните нам по телефону, указанному на вашей идентификационной карте, или по номеру 1-888-254-2721. Для получения дополнительной помощи звоните в Департамент страхования штата Калифорния по номеру 1-800-927-4357. (TTY/TDD: 711)

## Tagalog

Mga Libreng Serbisyo para sa Wika. Maaari kayong kumuha ng interpreter. Maaari ninyong ipabasa ang mga dokumento at ipadala ang ilan sa mga ito sa inyo sa wikang ginagamit ninyo. Para sa tulong, tawagan kami sa numerong nakalista sa inyong ID card o sa 1-888-254-2721. Para sa higit pang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. (TTY/TDD: 711)

## Thai

ไม่มีค่าบริการเกี่ยวกับภาษา ท่านสามารถขอใช้บริการสามได้  
ท่านสามารถขอให้เจ้าหน้าที่อ่านเอกสารได้ท่านฟังและเอกสารบางอย่างจะส่งถึงท่านโดยใช้ภาษาของท่าน  
หากต้องการความช่วยเหลือ โปรดโทรหาเราตามหมายเลขที่ระบุอยู่บนบัตรประจำตัวของท่านหรือที่หมายเลข 1-888-254-2721  
หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรติดตามแผนก CA Dept. of Insurance ที่หมายเลข 1-800-927-4357  
(TTY/TDD: 711)

## Vietnamese

Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có thông dịch viên. Quý vị có thể yêu cầu đọc tài liệu cho quý vị nghe và yêu cầu gửi một số tài liệu bằng ngôn ngữ của quý vị cho quý vị. Để được trợ giúp, hãy gọi cho số được ghi trên thẻ ID của quý vị hoặc số 1-888-254-2721. Để được giúp đỡ thêm, hãy gọi cho Sở Bảo Hiểm California (California Department of Insurance) theo số 1-800-927-4357. (TTY/TDD: 711)