BlueCross BlueShield of Oklahoma

BlueLincs HMO℠

Group Enrollment Application | Change Form

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

GHS Health Maintenance Organization, Inc. d/b/a BlueLincs HMO is a wholly-owned subsidiary of Health Care Service Corporation, a Mutual Legal Reserve Company. Both companies are independent licensees of the Blue Cross and Blue Shield Association.

Blue Cross and Blue Shield of Oklahoma, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

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**	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 adding or enrolling a dependent due to adoption or placement for adoption, you must provide legal documents. • If you are adding or enrolling a dependent due to court order, you must submit a copy of the court order or decree. • Employees must notify Blue Cross and Blue Shield of Oklahoma (BCBSOK) within 31 days of the birth of a newborn child, date a child is adopted/placed in their home for adoption, or eligible foster child placed in their home. You must provide legal documents, a court order or decree. If BCBSOK is notified after 31 days, the child may not be eligible to apply for coverage until the next open enrollment period. **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. **SPECIAL ENROLLMENT EVENT:** If you qualify, special enrollment is any change to your current membership such as marriage*, divorce**, adoption, leave/layoff, moving out of the service area, etc. This change may occur outside of open enrollment. **EFFECTIVE DATE OF BENEFITS:** Field is mandatory and should reflect your requested date. **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 owrientation period. **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.
SECTION 2 **YOUR INFORMATION**	Complete this section with details about yourself even if you are declining coverage.
SECTION 3 **YOUR COVERAGE**	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: B718CHC) 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 **COVERAGE OPTIONS**	Complete all areas that apply to you and each dependent. **FOR HMO PLANS ONLY:** • 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 **BCBSOK.com**. Be sure to check the appropriate box for a new patient. **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, and name and number of the new PCP. **CHANGE ADDRESS/NAME:** Complete Section 1 and check the "Other Change(s)" box; then, complete Sections 2 and 9.
SECTION 5 **DISABLED DEPENDENT**	A dependent child who is medically certified as disabled and dependent upon the member or his/her spouse*** or domestic partner (provided the group covers domestic partners) is eligible to continue coverage beyond the limiting age, provided the disability began before the child attained the age of 26. A Request to Extend Coverage for Disabled Dependent form must be completed and submitted with this enrollment application, if applicable.
SECTION 6 **OTHER COVERAGE**	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.
SECTION 7 **MEDICARE COVERAGE**	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.
SECTION 8 **DECLINATION OF COVERAGE**	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. **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, birth, 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 or placement of an eligible foster child in your home.
SECTION 9 **COVERAGE CONDITIONS**	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: **BCBSOK, PO BOX 655924, DALLAS, TX 75265-5924 OR VIA FAX AT 918-551-3179.**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 domestic partnership (coverage subject to your employer's plan).*
*** The term "divorce" includes legal divorce and the comparable termination of a domestic partnership (coverage subject to your employer's plan).*
**** The term "spouse" includes a legal spouse and a party to a domestic partnership (coverage subject to your employer's plan).*

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 Oklahoma website at bcbsok.com, or from your employer. If you are a current member and have questions, you may also call the Customer Service number on the back of your member ID card.

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ENROLLMENT APPLICATION/CHANGE FORM

GROUP #	SECTION #	SOC. SEC. #	ACCOUNT #	CATEGORY

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 (PROVIDE LEGAL DOCUMENTS)
☐ COURT ORDER (PROVIDE COURT ORDER OR DECREE) ☐ LOSS OF OTHER COVERAGE
☐ INSURE OKLAHOMA (O-EPIC APPROVAL LETTER REQUIRED)
☐ OTHER (EXPLAIN):

EFFECTIVE DATE OF BENEFITS: _____ / _____ / _____ ☐ **COMPLETION OF OTHER ELIGIBILITY REQUIREMENTS**

☐ **CANCEL ENROLLEE** ☐ **CANCEL DEPENDENT**

CANCEL COVERAGE: ☐ HEALTH ☐ DENTAL

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:

SECTION 3 — SELECT YOUR COVERAGE

PLEASE CHECK ALL THAT APPLY

SMALL GROUP PLANS (1-50 EMPLOYEES)

HEALTH COVERAGE (SELECT ONE)
☐ BLUE ADVANTAGE PPO℠
☐ BLUE CHOICE PPO℠
☐ BLUE PREFERRED PPO℠
☐ BLUE OPTIONS PPO℠
☐ OTHER
PLAN # (REQUIRED) _____

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
PLAN # (REQUIRED)
_____

WHO IS COVERED? (SELECT ONE)
☐ EMPLOYEE ONLY ☐ EMPLOYEE /SPOUSE
☐ EMPLOYEE /CHILD(REN) ☐ FAMILY
☐ I AM NOT APPLYING FOR DENTAL COVERAGE

LARGE GROUP CUSTOM PLANS (151+ EMPLOYEES)

HEALTH COVERAGE (SELECT ONE)
☐ BLUE ADVANTAGE PPO℠
☐ BLUE CHOICE PPO℠
☐ BLUE PREFERRED PPO℠
☐ BLUE OPTIONS PPO℠
☐ BLUE OPTIONS SELECT PPO℠
☐ BLUE TRADITIONAL®
☐ BLUELINCS HMO℠
☐ HSA BLUE℠
☐ OTHER _____
PLAN # (REQUIRED)
HEALTH DEDUCTIBLE OPTION $_____ *(IF MORE THAN ONE IS AVAILABLE)*

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
PLAN # (REQUIRED)
_____

WHO IS COVERED? (SELECT ONE)
☐ EMPLOYEE ONLY ☐ EMPLOYEE /SPOUSE
☐ EMPLOYEE /CHILD(REN) ☐ FAMILY
☐ I AM NOT APPLYING FOR DENTAL COVERAGE

PRIMARY LANGUAGE:

SECTION 4 — COVERAGE OPTIONS

PLEASE COMPLETE ALL AREAS THAT APPLY

EMPLOYEE/ ENROLLEE'S NAME	PCP NAME / PCP #	NEW PATIENT? ☐ YES ☐ NO

DEPENDENT'S NAME ☐ HUSBAND ☐ WIFE ☐ DOMESTIC PARTNER ☐ PARTY TO A CIVIL UNION	DEPENDENT'S PCP NAME	PCP #	NEW PATIENT? ☐ YES ☐ NO

DEPENDENT'S SOCIAL SECURITY #	BIRTH DATE (MM/DD/YYYY)	HOME ADDRESS (IF DIFFERENT) STREET/CITY/STATE/ZIP CODE

DEPENDENT'S NAME ☐ SON ☐ DAUGHTER ☐ OTHER ELIGIBLE DEPENDENT	DEPENDENT'S PCP NAME	PCP #	NEW PATIENT? ☐ YES ☐ NO

BIRTH DATE (MM/DD/YYYY)	HOME ADDRESS (IF DIFFERENT) STREET/CITY/STATE/ZIP CODE

DEPENDENT'S SOCIAL SECURITY #	IS THIS DEPENDENT A NATURAL CHILD, STEPCHILD, FOSTER CHILD, ADOPTED CHILD OR A CHILD IN SUIT FOR ADOPTION? ☐ YES ☐ NO	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? ☐ YES ☐ NO

DEPENDENT'S NAME ☐ SON ☐ DAUGHTER ☐ OTHER ELIGIBLE DEPENDENT	DEPENDENT'S PCP NAME	PCP #	NEW PATIENT? ☐ YES ☐ NO

BIRTH DATE (MM/DD/YYYY)	HOME ADDRESS (IF DIFFERENT) STREET/CITY/STATE/ZIP CODE

DEPENDENT'S SOCIAL SECURITY #	IS THIS DEPENDENT A NATURAL CHILD, STEPCHILD, FOSTER CHILD, ADOPTED CHILD OR A CHILD IN SUIT FOR ADOPTION? ☐ YES ☐ NO	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? ☐ YES ☐ NO

LAST NAME	SOC. SEC. #	GROUP #

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 IF APPLICABLE

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	INDIVIDUAL COVERAGE	NAME AND ADDRESS OF OTHER INSURANCE CARRIER	EFFECTIVE DATE (MM/DD/YYYY)	TYPE OF POLICY
☐ YES ☐ NO	☐ YES ☐ NO			☐ EMPLOYEE ONLY ☐ EMPLOYEE/SPOUSE ☐ EMPLOYEE/CHILD(REN) ☐ FAMILY

NAME OF POLICYHOLDER	BIRTH DATE (MM/DD/YYYY)		RELATIONSHIP TO APPLICANT
		☐ MALE ☐ FEMALE	☐ SELF ☐ SPOUSE ☐ 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 HIC # (FROM MEDICARE CARD)
	MEDICARE A (HOSPITAL) EFFECTIVE DATE:	END DATE:	
	MEDICARE B (MEDICAL) EFFECTIVE DATE:	END DATE:	
	MEDICARE D (DRUG) EFFECTIVE DATE:	END DATE:	
	MEDICARE D (DRUG) CARRIER:		

PLEASE INDICATE REASON FOR MEDICARE ELIGIBILITY: ☐ ENTITLED AGE ☐ ENTITLED DISABILITY ☐ END-STAGE RENAL DISEASE ☐ DISABILITY AND CURRENT RENAL DISEASE

NAME OF PERSON COVERED:			MEDICARE HIC # (FROM MEDICARE CARD)
	MEDICARE A (HOSPITAL) EFFECTIVE DATE:	END DATE:	
	MEDICARE B (MEDICAL) EFFECTIVE DATE:	END DATE:	
	MEDICARE D (DRUG) EFFECTIVE DATE:	END DATE:	
	MEDICARE D (DRUG) CARRIER:		

PLEASE INDICATE REASON FOR MEDICARE ELIGIBILITY: ☐ ENTITLED AGE ☐ ENTITLED DISABILITY ☐ END-STAGE RENAL DISEASE ☐ 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		REASON FOR DECLINING
NAME	☐ EMPLOYEE	REASON FOR DECLINING **HEALTH:** ☐ OTHER GROUP HEALTH COVERAGE – CARRIER: _____ ☐ MEDICARE ☐ MEDICAID ☐ OTHER INDIVIDUAL HEALTH COVERAGE – CARRIER: _____ ☐ OTHER (EXPLAIN) _____ ☐ I AM NOT ENROLLED IN ANY HEALTH INSURANCE PLAN, BUT DO NOT WANT THIS COVERAGE
NAME	☐ EMPLOYEE	REASON FOR DECLINING **DENTAL:** ☐ OTHER GROUP DENTAL COVERAGE ☐ MEDICAID ☐ INDIVIDUAL DENTAL COVERAGE ☐ OTHER (EXPLAIN) _____ ☐ I AM NOT ENROLLED IN ANY DENTAL INSURANCE PLAN, BUT DO NOT WANT THIS COVERAGE
NAME	☐ SPOUSE	REASON FOR DECLINING: ☐ OTHER GROUP HEALTH COVERAGE ☐ MEDICAID ☐ INDIVIDUAL HEALTH COVERAGE ☐ OTHER (EXPLAIN) _____ ☐ I AM NOT ENROLLED IN ANY HEALTH INSURANCE PLAN, BUT DO NOT WANT THIS COVERAGE
NAME	☐ DEPENDENT	REASON FOR DECLINING: ☐ OTHER GROUP HEALTH COVERAGE ☐ MEDICAID ☐ INDIVIDUAL HEALTH COVERAGE ☐ OTHER (EXPLAIN) _____ ☐ I AM NOT ENROLLED IN ANY HEALTH INSURANCE PLAN, BUT DO NOT WANT THIS COVERAGE
NAME	☐ DEPENDENT	REASON FOR DECLINING: ☐ OTHER GROUP HEALTH COVERAGE ☐ MEDICAID ☐ INDIVIDUAL HEALTH COVERAGE ☐ OTHER (EXPLAIN) _____ ☐ 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 underwritten or administered by Blue Cross and Blue Shield of Oklahoma. 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.

WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

Applicant's Signature _____ Date_____

BlueCross BlueShield of Oklahoma

BlueLincs HMO℠

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.

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.
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 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.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી 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 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि 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 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 h odoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984.
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 شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek 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.
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 855-710-6984.
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، 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.

BlueCross BlueShield of Oklahoma

BlueLincs HMO℠

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, Oklahoma 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

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