

Enrollment Request Form

Please contact us at 888-868-7767 (TTY/TDD:711) if you need help with your enrollment.
 Monday–Friday, 8 a.m. to 8 p.m. (7 days a week, 8 a.m. to 8 p.m., October 1–March 31).

PO Box 262548
 Plano, TX 75026

YOUR INFORMATION

Last Name: _____ First Name: _____ Mid Int: _____ Mr. Mrs. Ms.

Birth Date: / / Sex: M F Phone: ())

Email Address: _____

Permanent residence (P.O. box is not allowed)

Street Address: _____ City: _____

County: _____ State: _____ Zip: _____

Mailing address (only if different from permanent residence address)

Street Address: _____ City: _____

County: _____ State: _____ Zip: _____

Emergency contact

Name: _____ Phone: ())

Relationship to You: _____

Choose the name of a Primary Care Provider (PCP):

PCP Location: _____

PROVIDE YOUR MEDICARE INSURANCE INFORMATION

Please take out your Medicare card to complete this section.

- Please fill in the blanks so they match your red, white, and blue Medicare card.

--- OR ---

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Name (as it appears on your Medicare card): _____	
Medicare Number: _____	
Is Entitled To	EFFECTIVE DATE
HOSPITAL (Part A)	_____
HOSPITAL (Part B)	_____

OFFICE USE ONLY:			
OFFICE USE ONLY	AGENT NAME: _____		WRITING #: _____
	SCOPE OF APPOINTMENT: <input type="checkbox"/> PAPER <input type="checkbox"/> APP MAILED TO AGENT		AGENT RECEIVED DATE: _____
	<input type="checkbox"/> SEMINAR (DATE / LOCATION): _____		EFFECTIVE DATE: _____
	PBP: _____	PLAN #: _____	CONTRACT #: _____ GROUP #: _____
OFFICE USE ONLY			

CHOOSE YOUR MEDICARE ADVANTAGE PLAN

1. Find your county

2. Check the plan you want

KING • PIERCE • SNOHOMISH • THURSTON

- | | |
|--|--|
| <input type="checkbox"/> Premera Blue Cross Medicare Advantage HMO - \$0 | <input type="checkbox"/> Premera Blue Cross Medicare Advantage Peak + Rx (HMO) - \$0 |
| <input type="checkbox"/> Premera Blue Cross Medicare Advantage Classic HMO - \$55 | <input type="checkbox"/> Premera Blue Cross Medicare Advantage Sound + Rx (HMO) - \$40 |
| <input type="checkbox"/> Premera Blue Cross Medicare Advantage Classic Plus HMO - \$167 | <input type="checkbox"/> Premera Blue Cross Medicare Advantage Charter + Rx (HMO) - \$146 |
| | <input type="checkbox"/> Premera Blue Cross Medicare Advantage Alpine (HMO) - \$42 (no prescription coverage) |

LEWIS

- | | |
|---|--|
| <input type="checkbox"/> Premera Blue Cross Medicare Advantage HMO - \$0 | <input type="checkbox"/> Premera Blue Cross Medicare Advantage Classic HMO - \$55 |
|---|--|

SPOKANE

- | | |
|---|---|
| <input type="checkbox"/> Premera Blue Cross Medicare Advantage HMO - \$0 | <input type="checkbox"/> Premera Blue Cross Medicare Advantage Total Health HMO - \$24 |
|---|---|

STEVENS

- | |
|---|
| <input type="checkbox"/> Premera Blue Cross Medicare Advantage Total Health HMO - \$24 |
|---|

SKAGIT

- | |
|---|
| <input type="checkbox"/> Premera Blue Cross Medicare Advantage Core HMO - \$12 |
|---|

WHATCOM

- | | |
|---|--|
| <input type="checkbox"/> Premera Blue Cross Medicare Advantage Core HMO - \$12 | <input type="checkbox"/> Premera Blue Cross Medicare Advantage Charter + Rx (HMO) - \$146 |
| <input type="checkbox"/> Premera Blue Cross Medicare Advantage Peak + Rx (HMO) - \$0 | <input type="checkbox"/> Premera Blue Cross Medicare Advantage Alpine (HMO) - \$42 (no prescription coverage) |
| <input type="checkbox"/> Premera Blue Cross Medicare Advantage Sound + Rx (HMO) - \$40 | |

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PAYING YOUR PLAN PREMIUM

If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay your monthly plan premium, including any late enrollment penalty that you currently have or may owe, by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT pay Premera Blue Cross the Part D-IRMAA.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 800-772-1213. TTY/TDD users should call 800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover. If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

Get a monthly bill

Electronic funds transfer (EFT) from your bank account each month. Enclose a VOIDED check or provide the following:

Account Holder Name: _____

Account type: Checking Savings

Bank Routing #: _____

Bank Account #: _____

Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check

(Please note: The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. Before the deduction begins, you may receive invoices for your premium. You will be responsible for paying your monthly premium directly to Premera from your effective date until the date your withholding begins. Invoices will stop once the deduction is approved. If Social Security or RRB does not approve your request for automatic deduction, we will send you a letter and paper bill for your monthly premiums.)

I get monthly benefits from: Social Security Railroad Retirement Board

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READ AND ANSWER THESE IMPORTANT QUESTIONS

1. Do you have End-Stage Renal Disease (ESRD)? Yes No

If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription coverage in addition to Premera Blue Cross? Yes No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: _____

ID # for this coverage: _____ Group # for this coverage: _____

3. Are you a resident in a long-term care facility, such as a nursing home? Yes No

If "yes," please provide the following information:

Name of institution: _____

Address and phone # of institution (number and street): _____

4. Are you enrolled in your State Medicaid program? Yes No

If "yes," please provide your Medicaid number: _____

5. Do you or your spouse work? Yes No

Please check the box if you would prefer us to send you information in a language other than English or in another format: Audio CD

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ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- I am new to Medicare.
- I am using my one-time only election to switch Medicare Advantage plans between January 1st and March 31st as provided in the 21st Century Cures Act.
- I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date here) _____.
- I recently was released from incarceration. I was released on (insert date here) _____.
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date here) _____.
- I recently obtained lawful presence status in the United States. I got status on (insert date here) _____.
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I get extra help paying for Medicare prescription drug coverage.
- I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date here) _____.
- I am moving into, or live in a Long-Term Care Facility (for example, a nursing home or long term facility) (insert move in date) _____.
- I am moving out of a Long-Term Care Facility (for example, a nursing home or long term facility) (insert move out date) _____.
- I recently left a PACE program (insert date here) _____.
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date here) _____.
- I am leaving employer or union coverage on (insert date here) _____.
- I belong to a pharmacy assistance program provided by my state.
- My plan is ending its contract with Medicare, OR Medicare is ending its contract with my plan.
- I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date here) _____.
- I was impacted by a significant network change with my current plan and was notified on: (insert date here) _____.
- Other: _____.

If none of these statements applies to you or you're not sure, please contact Premera Blue Cross at 888-868-7767 (TTY/TDD: 711) to see if you are eligible to enroll. Our office hours are Monday–Friday, 8 a.m. to 8 p.m. (7 days a week, 8 a.m. to 8 p.m., from October 1–March 31).

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STOP – READ THIS IMPORTANT INFORMATION

If you currently have health coverage from an employer or union, joining Premera Blue Cross could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Premera Blue Cross. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

PLEASE READ AND SIGN BELOW

By completing this enrollment application, I agree to the following:

Premera Blue Cross is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 – December 7 of every year), or under certain special circumstances.

Premera Blue Cross serves a specific service area. If I move out of the area that Premera Blue Cross serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Premera Blue Cross, I have the right to appeal plan decisions about payment or services if I disagree. I understand that the Evidence of Coverage document, available at premera.com/ma or by mail upon request, outlines the rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Premera Blue Cross Medicare Advantage (HMO), or Premera Blue Cross Medicare Advantage Classic (HMO), or Premera Blue Cross Medicare Advantage Classic Plus (HMO), or Premera Blue Cross Medicare Advantage Total Health (HMO), or Premera Blue Cross Medicare Advantage Core (HMO), or Premera Blue Cross Medicare Advantage Peak + Rx (HMO), or Premera Blue Cross Medicare Advantage Sound + Rx (HMO), or Premera Blue Cross Medicare Advantage Charter + Rx (HMO), or Premera Blue Cross Medicare Advantage Alpine (HMO) coverage begins, I must get all of my health care from Premera Blue Cross Medicare Advantage Network Providers, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Premera Blue Cross and other services contained in my Premera Blue Cross Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR PREMERA BLUE CROSS WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with Premera Blue Cross, he/she may be paid based on my enrollment in Premera Blue Cross.

Release of Information:

By joining this Medicare health plan, I acknowledge that Premera Blue Cross will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Premera Blue Cross will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Signature: _____

Today's Date: _____

If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

Phone: () _____

Relationship to Enrollee: _____

Premera Blue Cross is an HMO plan with a Medicare contract. Enrollment in Premera depends on contract renewal.

H7245_2019_Enrollment_Form_PBC_SP_Resubmit_Approved

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
Premera Blue Cross Medicare Advantage Plans -
Complaints & Appeals
PO Box 262527, Plano, TX 75026
Phone: 888-850-8526, fax: 800-889-1076, TTY: 711
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 888-850-8526 (TTY: 711).

አማርኛ (Amharic):

ይህ ማስታወቂያ አስፈላጊ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም የ Premera Blue Cross ሽፋን አስፈላጊ መረጃ ሊኖረው ይችላል። በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀናት 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 888-850-8526 (TTY: 711) ይደውሉ።

العربية (Arabic):

يحيوي هذا الإشعار معلومات هامة. قد يحيوي 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 بـ(888-850-8526 (TTY: 711)

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 888-850-8526 (TTY: 711)。

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 kaffaltiidaan 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 888-850-8526 (TTY: 711) tii bilbilaa.

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 888-850-8526 (TTY: 711).

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。888-850-8526 (TTY: 711)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 Cross 를 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. 888-850-8526 (TTY: 711) 로 전화하십시오.

ភាសាខ្មែរ (Khmer):

សេចក្តីជូនដំណឹងនេះមានព័ត៌មានយ៉ាងសំខាន់។ សេចក្តីជូនដំណឹងនេះប្រហែលជាមានព័ត៌មានយ៉ាងសំខាន់អំពីទម្រង់បែបបទ ឬការរ៉ាប់រងរបស់អ្នកតាមរយៈ Premera Blue Cross ។ ប្រហែលជាមាន កាលបរិច្ឆេទសំខាន់នៅក្នុងសេចក្តីជូនដំណឹងនេះ។ អ្នកប្រហែលជាត្រូវការបញ្ចេញសមត្ថភាព ដល់កំណត់ថ្លៃជាក់ច្បាស់នានា ដើម្បីនឹងរក្សាទុកការធានារ៉ាប់រងសុខភាពរបស់អ្នក ឬប្រាក់ជំនួយចេញថ្លៃ។ អ្នកមានសិទ្ធិទទួលព័ត៌មាននេះ និងជំនួយនៅក្នុងភាសារបស់អ្នកដោយមិនអស់លុយឡើយ។ សូមទូរស័ព្ទ 888-850-8526 (TTY: 711)។

ລາວ (Lao):

ແຈ້ງການນີ້ມີຂໍ້ມູນສໍາຄັນ. ແຈ້ງການນີ້ອາດຈະມີຂໍ້ມູນສໍາຄັນກ່ຽວກັບຄໍາຮ້ອງສະໝັກ ຫຼື ຄວາມຄຸ້ມຄອງປະກັນໄພຂອງທ່ານຜ່ານ Premera Blue Cross. ອາດຈະມີວັນທີສໍາຄັນໃນແຈ້ງການນີ້. ທ່ານອາດຈະຈໍາເປັນຕ້ອງດໍາເນີນການຕາມກຳນົດເວລາສະເພາະ ເພື່ອຮັກສາຄວາມຄຸ້ມຄອງປະກັນສຸຂະພາບ ຫຼື ຄວາມຊ່ວຍເຫຼືອເລື່ອງຄ່າໃຊ້ຈ່າຍຂອງທ່ານໄວ້. ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໃຫ້ໂທຫາ 888-850-8526 (TTY: 711).

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 ਨੋਟਿਸ ਜਵਾਬ
ਖਾਸ ਤਾਰੀਖਾ ਹੋ ਸਕਦੀਆਂ ਹਨ. ਜੇਕਰ ਤੁਸੀਂ ਜਸਹਤ ਕਵਰੇਜ
ਰਿੱਖਣੀ ਹੋਵੇ ਜਾਂ ਓਸ ਦੀ ਲਾਗਤ ਜਵਿੱਚ ਮਦਦ ਦੇ ਇਛੁੱਕ ਹੋ ਤਾਂ
ਤੁਹਾਨੂੰ ਅੰਤਮ ਤਾਰੀਖ ਤੋਂ ਪਹਿਲਾਂ ਕੁੱਝ ਖਾਸ ਕਦਮ ਚੁੱਕਣ ਦੀ
ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ, ਤੁਹਾਨੂੰ ਮੁਫਤ ਵਿੱਚ ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ
ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ, ਕਾਲ
888-850-8526 (TTY: 711).

Русский (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 888-850-8526 (TTY: 711).

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 888-850-8526 (TTY: 711).

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 888-850-8526 (TTY: 711).

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 888-850-8526 (TTY: 711).

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 888-850-8526 (TTY: 711).