EMPLOYER USE ONLY: BLUE KC GROUP NO. ________________ CLASS NO. ______________ SUBGROUP NO. ______________

Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

Employee Application and Change Form

USAble Life

BlueKC.com • One Pershing Square, 2301 Main, P.O. Box 419169, Kansas City, MO 64141-6169 • 816-395-2222

GROUPS WITH 100+ FULL TIME EMPLOYEES

Please Complete All Boxes LEGIBLY (Print) IN BLUE OR BLACK INK and Sign.

Preferred-Care Blue | Preferred-Care | BlueSelect Plus | BlueSelect | Blue-Care*

If application is to be used as a Change Form, please specify event below.

DATE OF EVENT: ________________ **PROPOSED EFFECTIVE DATE:** ________________

☐ Birth ☐ Change of Address ☐ Divorce ☐ Marriage ☐ Death ☐ Change of Beneficiary ☐ Adoption/Placement
☐ Loss of Other Group Coverage

I Employee Information Only

1. LAST NAME **FIRST NAME** **M.I.**		**2. STREET ADDRESS**	
3. CITY **STATE** **ZIP CODE**		**4. HOME PHONE NO.** **WORK PHONE NO.**	
5. GENDER ☐ Male ☐ Female	**6. SOCIAL SECURITY NO.**		**7. BIRTH DATE**
8. EMPLOYER	**9. POSITION**	**10. HIRE DATE**	**11. HOURS WORKED PER WEEK**

12. E-MAIL ADDRESS *Blue KC may use this e-mail address to provide documents, materials, and other notices related to this coverage.*

II Family Information - Employee and Employee's Dependents to be Enrolled or Changed (attach sheet if necessary)

CHECK APPROPRIATE BOX	SOCIAL SECURITY NO.	LAST NAME FIRST NAME M.I.	DATE OF BIRTH	GENDER	HEIGHT	WEIGHT	INDICATE COVERAGE	PRIMARY CARE PHYSICIAN (Complete only if applying for HMO)	CURRENT PATIENT
☐ **New** ☐ **Change**	EMPLOYEE			☐ Male ☐ Female			☐ Medical ☐ Dental ☐ Vision	PCP Name: PCP No.:	☐ Yes ☐ No
☐ **New** ☐ **Change**	SPOUSE			☐ Male ☐ Female			☐ Medical ☐ Dental ☐ Vision	PCP Name: PCP No.:	☐ Yes ☐ No
☐ **New** ☐ **Change**	CHILD			☐ Male ☐ Female			☐ Medical ☐ Dental ☐ Vision	PCP Name: PCP No.:	☐ Yes ☐ No
☐ **New** ☐ **Change**	CHILD			☐ Male ☐ Female			☐ Medical ☐ Dental ☐ Vision	PCP Name: PCP No.:	☐ Yes ☐ No
☐ **New** ☐ **Change**	CHILD			☐ Male ☐ Female			☐ Medical ☐ Dental ☐ Vision	PCP Name: PCP No.:	☐ Yes ☐ No
☐ **New** ☐ **Change**	CHILD			☐ Male ☐ Female			☐ Medical ☐ Dental ☐ Vision	PCP Name: PCP No.:	☐ Yes ☐ No

* Good Health HMO, Inc. d/b/a Blue Care

LAST NAME _____ **FIRST NAME** _____

III Waiver of Coverage Selection

I Decline Coverage For				**Due to:**
Medical	☐ Self	☐ My Spouse	☐ My Dependent Child(ren)	☐ Existence of Other Group Health Coverage
Dental	☐ Self	☐ My Spouse	☐ My Dependent Child(ren)	☐ Existence of Other Individual Health Coverage
Vision	☐ Self	☐ My Spouse	☐ My Dependent Child(ren)	☐ Medicare or Medicaid ☐ Other Reason (explain) _____

If you are declining medical coverage for yourself or your dependents (including your spouse) because of other group coverage, you or your dependents may in the future be able to enroll in this plan, provided that you request enrollment within 31 days after your other group coverage ends. In addition, you may be able to enroll yourself and your dependent(s), provided that you request enrollment within 31 days after a marriage, birth, adoption or placement for adoption. If you decline coverage for yourself or your dependents while Medicaid coverage or coverage under a state children's health insurance program (CHIP) is in effect, you and your dependents may be able to enroll in this plan if you or your dependents lose eligibility for that coverage, provided you request enrollment within 60 days after that coverage ends. If you are declining medical and/or dental coverage for any other reason, or if you fail to complete this form, you may be limited to enrolling only during the annual enrollment period. If you or your dependents become eligible for a state premium assistance subsidy from Medicaid or CHIP with respect to this plan, you and your dependents may be eligible to enroll in this plan, provided you request enrollment within 60 after such eligibility is determined. If you decline the life, dependent life, short term disability, long term disability or supplemental life coverage and elect to enroll for coverage at a later date, you may be required to submit, at your own expense, evidence of insurability to USAble Life. To request a special enrollment for medical and/or dental coverage, please contact our Member Services Department at (816) 395-2950.

IV Medical Coverage Selection

I Elect Coverage For *Select only one available Product. Product availability is limited to your Employer's selections.* ***Applies to Missouri residents only:*** *If an EPO product is offered, your Employer must also offer a non-EPO product. EPO product Benefits are limited to services provided by Preferred Providers, except for Emergency Services and certain Mental Health office visits. Services provided by Non-Preferred Providers are not covered, except as specifically provided under the product certificate. Covered Services for certain Mental Health office visits include 2 office visits per Calendar Year for the diagnosis or assessment of Mental Illness to a Non-Preferred Provider acting within the scope of their license.)*:

Preferred-Care Blue PPO/EPO	**BlueSelect Plus PPO/EPO**	**Preferred-Care PPO/EPO**
☐ Preferred-Care Blue 1	☐ BlueSelect Plus 1	☐ Preferred-Care 1
☐ Preferred-Care Blue 2	☐ BlueSelect Plus 2	☐ Preferred-Care 2
☐ Spira 1	☐ Spira 1	☐ Preferred-Care 3
☐ Spira 2	☐ Spira 2	☐ Preferred-Care BlueValue 1
☐ Preferred-Care Blue BlueValue 1	☐ BlueSelect Plus BlueValue 1	☐ Preferred-Care BlueValue 2
☐ PersonalBlue (Personal Care Account + PPO)	☐ BlueSelect Plus BlueValue 2	☐ BlueSelect Plus PersonalBlue (Personal Care Account + PPO)
☐ Preferred-Care Blue BlueSaver ‡ (High deductible health plan (HDHP) for use with an HSA)	☐ BlueSelect Plus PersonalBlue (Personal Care Account + PPO)	☐ Preferred-Care BlueSaver ‡ (High deductible health plan (HDHP) for use with an HSA)
‡ Would you like to set up an HSA with your Employer's preferred bank?	☐ BlueSelect Plus BlueSaver ‡ (High deductible health plan (HDHP) for use with an HSA)	*‡ Would you like to set up an HSA with your Employer's preferred bank?*
☐ *YES* ☐ *NO*	*‡ Would you like to set up an HSA with your Employer's preferred bank?*	☐ *YES* ☐ *NO*
(if Yes, please complete section VII)	☐ *YES* ☐ *NO*	*(if Yes, please complete section VII)*
	(if Yes, please complete section VII)	

Blue-Care/RateSaver HMO		**Basic EPO**	
☐ Blue-Care 1	☐ RateSaver 1	☐ Basic 1	☐ Basic 2
☐ Blue-Care 2	☐ RateSaver 2	☐ Basic 3	☐ Basic 4

Medical Plan Design Choice *(Select only one. If no selection is made, employee will be enrolled in Base Plan)*
☐ Base Plan ☐ Buy-Up Plan (I understand this election may increase my employee contributions)

V Ancillary Coverage Selection

I Elect Coverage For *Select only one available Product for Dental, Vision and/or Life. Product availability is limited to Employer's selections.*

Dental	**Vision**	**Life** *(If offered, through USAble Life.)*
☐ Yes ☐ No	☐ Yes ☐ No	☐ Life/AD&D (See Section VIII.) ☐ Short Term Disability (STD)
☐ Base plan ☐ Buy-up plan	☐ Base plan ☐ Buy-up plan	☐ Supplemental Life (Supp Life) ☐ Long Term Disability (LTD)
I understand selecting any buy-up plans may increase my premiums.		☐ Dependent Life (Dep Life) (Payable to Employee only.)

LAST NAME _____ **FIRST NAME** _____

VI Other Health Insurance Carrier (for Coordination of Benefits)

1. On the day the coverage begins, will you or any of your dependents applying for this coverage be covered by other health or dental insurance or Medicare, including continuation of coverage?

☐ YES ☐ NO If yes, answer all questions below. Attach sheet if more than one additional policy will be in force.

COVERAGE TYPE ☐ Medical ☐ Dental ☐ Vision	INSURANCE COMPANY NAME (AREA CODE) PHONE NO.	POLICY NO.

NAME OF INSURED	INSURED'S EMPLOYER NAME	EFFECTIVE DATE	TERMINATION DATE

FAMILY MEMBERS COVERED
1. 2. 3.

2. Are any of your dependent children subject to a divorce decree or court order? ☐ YES ☐ NO
If yes, whose coverage is primary? ☐ Yours ☐ The Other Parent's

3. If you or your dependent(s) have Medicare, include a copy of your Medicare card(s) with this Application.
Do you or your dependent(s) have Medicare? ☐ YES ☐ NO If yes, are you actively working? ☐ YES ☐ NO
Are you retired? ☐ YES ☐ NO If yes, please provide date of retirement:

4. Are you or any of your dependent(s) covered under COBRA or State Continuation? ☐ YES ☐ NO
If yes, please provide the effective date and future termination date of coverage:
Effective Date: Future Termination Date:

VII If You Are Enrolling in a BlueSaver and Plan to Establish an HSA With Your Employer's Preferred Banking Institution, Please Complete the Following:

EMPLOYEE'S SOCIAL SECURITY NUMBER *(UNDER FEDERAL RULES, YOUR SOCIAL SECURITY NUMBER IS REQUIRED TO ESTABLISH AN HSA)*

PHYSICAL ADDRESS *(IF YOU PROVIDED A POST OFFICE BOX IN SECTION I, A PHYSICAL ADDRESS IS* **REQUIRED** *UNDER FEDERAL RULES TO ESTABLISH AN HSA. AN HSA WILL* **NOT** *BE OPENED IF ONLY A POST OFFICE BOX IS PROVIDED.)*

VIII If You Are Enrolling in Life Insurance, Please Complete the Following: (attach sheet if necessary)

Employee's Earnings Hourly _____ Monthly _____ Yearly _____

PRIMARY BENEFICIARY(IES) (Will receive proceeds if living at death of Employee):

NAME (LAST, FIRST, M.I.)	ADDRESS	SOCIAL SECURITY NO.	BIRTHDATE	RELATIONSHIP	PERCENTAGE

Total must equal 100% =

CONTINGENT BENEFICIARY(IES) (Will receive proceeds if Primary Beneficiary(ies) are not living):

NAME (LAST, FIRST, M.I.)	ADDRESS	SOCIAL SECURITY NO.	BIRTHDATE	RELATIONSHIP	PERCENTAGE

(For new coverage with USAble Life, or when changing a beneficiary under existing coverage, this designation revokes any existing beneficiary designation you have made.)

Total must equal 100% =

LAST NAME _____ **FIRST NAME** _____

IX(a) All Questions Must be Answered Before Your Application Will be Processed

The federal Genetic Information Nondiscrimination Act prohibits health insurers from requesting, requiring, purchasing, or collecting "genetic information" for underwriting purposes. "Genetic information" includes your genetic tests, the genetic tests of your family members, and the manifestation of a disease or disorder in family members not covered by the policy. Genetic information can also include requests for, or receipt of, genetic services, or participation in clinical research which includes genetic services. Do not report genetic information on this form. However, information about manifested diseases or conditions of anyone applying for coverage is not considered genetic information and is to be reported on this form, even if the disease or condition is caused by or associated with genetics.

Please check (✓) appropriate box if you or a dependent applying for coverage ever received in the past five (5) years, medical services from a health care provider for any of the conditions listed below. If checked yes, please explain completely in the additional medical information section below. WITHIN THE **LAST 5 YEARS** HAVE YOU OR ANY DEPENDENTS APPLYING FOR COVERAGE BEEN DIAGNOSED OR TREATED FOR ANY OF THE FOLLOWING CONDITIONS?:

	YES	NO	
1.	☐	☐	Bone/Joint/Muscular Disorder/ Joint Replacement
2.	☐	☐	Arthritis/Gout/Back or Neck Disorder
3.	☐	☐	Fibromyalgia/Chronic Fatigue Syndrome
4.	☐	☐	Lupus - Type _____
5.	☐	☐	Nervous System/Brain Disorder/ Alzheimer's
6.	☐	☐	Epilepsy/Seizure Disorder
7.	☐	☐	Multiple Sclerosis
8.	☐	☐	Parkinson's Disease
9.	☐	☐	Heart/Circulatory Disorder
10.	☐	☐	Stroke
11.	☐	☐	High Blood Pressure *(Last reading _____ Date _____)*
12.	☐	☐	Blood Disorder/Leukemia/ Hemophilia
13.	☐	☐	Elevated Cholesterol *(Last reading _____ Date _____)*
14.	☐	☐	Diabetes-Hemoglobin A1C *(Last reading _____ Date _____)*
15.	☐	☐	HIV/AIDS/AIDS Related Complex
16.	☐	☐	Abnormal Pap Smear *(If yes, submit copies of last 2 pap smear results)*
17.	☐	☐	Infertility/Reproductive Disorder
18.	☐	☐	Cancer - Type _____
19.	☐	☐	Tumor/Cyst/Polyp
20.	☐	☐	Respiratory/Lung Disorder/Asthma/Tuberculosis
21.	☐	☐	Emphysema/Chronic Obstructive Pulmonary Disease
22.	☐	☐	Pancreatic Disorder
23.	☐	☐	Thyroid Disorder/Goiter
24.	☐	☐	Kidney/Bladder/Urinary Disorder
25.	☐	☐	Liver Disorder/Hepatitis A B C
26.	☐	☐	Chiropractic Treatment – Number of Visits in Last 12 Months _____
27.	☐	☐	Digestive/Intestinal Disorder
28.	☐	☐	Crohn's Disease/Diverticulitis/ Diverticulosis
29.	☐	☐	Mental/Nervous Disorders
30.	☐	☐	Schizophrenia/Manic-Depression/Suicide Attempt
31.	☐	☐	Attention Deficit Disorder
32.	☐	☐	Anorexia/Bulemia
33.	☐	☐	Any Other Abnormality/Deformity/ Birth Defect *(List all below)*
34.	☐	☐	Glaucoma-Eye Pressure Readings R _____ L _____
35.	☐	☐	Eye Disorders/Cataracts

36. PLEASE LIST ANY OTHER CONDITION(S), DIAGNOSED OR TREATED IN THE LAST 5 YEARS, NOT MENTIONED ABOVE: _____

_____

_____

_____

_____

IX(b) Additional Medical Information - List below full details to questions answered in Section VIII(a) (attach sheet if necessary)

QUESTION NO.	PERSON TREATED	CONDITION & TYPE OF TREATMENT	DATE OCCURRED	LAST DATE OF TREATMENT	CURRENT STATUS	COMPLETE NAME AND ADDRESS OF PROVIDER

LAST NAME FIRST NAME

IX(c) Employee and Family Information - Employee and Employee's Dependents to be Enrolled (attach sheet if necessary)

Please check appropriate box to answer the following questions. If the Yes box is checked, please explain completely and in detail.

A. Are you or any family member or dependent currently pregnant? (Including any dependent not applying for coverage?) ☐ YES ☐ NO
If yes, Name(s)_____ Due Date(s):_____
Any multiple births anticipated? ☐ YES ☐ NO

B. Within the past 12 months have you or any dependents been a patient in the hospital? ☐ YES ☐ NO
If yes, who _____ Number of hospital admissions _____
Length of stays _____ Reason for hospitalizations _____

C. Within the past 12 months have you or any dependents been advised to have surgery, treatments, tests or studies NOT YET PERFORMED? □ YES □ NO
If yes, Name(s) _____ Type of test, surgery, treatment or study _____
Date performed or scheduled _____

D. Within the past 12 months have you or any dependents received Emergency Room Care? ☐ YES ☐ NO
If yes, Name(s) _____ Number of ER visits in past 12 months _____
Reason(s) for visit(s) _____

E. Have you or any of your dependents, consulted a physician, psychiatrist, psychologist, social worker, chiropractor, nurse practitioner, physical, occupational or speech therapist or any other health care professional for any reason, including an annual physical in the last 5 years? ☐ YES ☐ NO
If yes, please explain _____

F. Has any family member had individual or group counseling the last 12 months? ☐ YES ☐ NO
If yes, Name(s) _____ Frequency of counseling _____
Date of last counseling session _____

G. Have you or any of your dependents, ever had or been advised to have an organ transplant of any type in the last 5 years? ☐ YES ☐ NO
If yes, Name(s)_____ Type _____

H. Have you or any of your dependents, ever used or been treated, or counseled due to use of the following in the last 5 years:
a) Use of alcohol, sedatives, hallucinogens, illegal substances, narcotics or any other drugs, other than those prescribed by a physician. ☐ YES ☐ NO
b) If yes to any items in (a) please indicate types of use; treatment; and, dates. Date since last use? _____
Date and Type of Treatment: _____
c) Been convicted of a DUI in the last 5 years? ☐ YES ☐ NO If yes, Date(s) _____

I. Are any dependents disabled? ☐ YES (Give details on a separate page) ☐ NO

J. Please list below all prescription medications taken within the last 12 months by you or any of your dependents.

Prescription Information (attach sheet if necessary)

PERSON TREATED	NAME OF DRUG	DOSAGE	FREQUENCY	CONDITION OR ILLNESS	START DATE	STOP DATE	COMPLETE NAME AND ADDRESS OF PHYSICIAN

K. In the past 2 years, has any person listed on this application discontinued medication without approval of a physician or failed to take medication prescribed by a physician?
☐ YES ☐ NO *Name of medication* _____
Reason prescribed _____
Name of person _____

LAST NAME _____ **FIRST NAME** _____

Medical Questionnaire Continued (attach sheet if necessary)

ANY ADDITIONAL INFORMATION

LAST NAME _____ **FIRST NAME** _____

X Agreement and Acknowledgement

I request coverage under the Group Contract(s) ("Contract") issued by Blue Cross and Blue Shield of Kansas City and Good Health HMO, Inc. d/b/a Blue Care Inc. (collectively, "Blue KC") and coverage under the Group Life Policy ("Policy") issued by USAble Life as may from time to time be amended. I authorize my Employer to deduct from my earnings any required contributions. I understand coverage under the Contract and coverage under the Group Life Policy issued by USAble Life will be available subject to the exclusions, limitations and benefits described in, as applicable, the Contract and the Group Life Policy issued by USAble Life and the USAble Life certificate. I authorize any physician, medical practitioner, hospital, clinic, or other medically related facility, insurance or reinsurance company, having information on me or any member of my family (only those who have applied for coverage on this application) regarding our mental and physical health, other insurance coverage, hazardous activities, character, general reputation, finances, and vocation to give to USAble Life, its reinsurers, or its legal representative any and all such information to use for underwriting insurance. I authorize all said sources, to give such records or knowledge to any agency employed by the company to collect and transmit such information in order to facilitate its rapid submission. I agree that this authorization shall be valid for two (2) years from the application date. I agree that a photocopy of this authorization shall be as valid as the original, and I understand that a copy is available to me or my representative upon request. I represent that the statements and answers in this application are true, complete and correctly recorded. I understand that the statements and answers provided by me in this application shall be a basis of any coverage issued and the coverage is conditioned upon its truth.

I understand that if at any time it is determined by Blue KC or USAble Life that a person listed on this application did not meet the Contract's or Policy's definition of dependent, Blue KC and/or USAble Life has the right to terminate or rescind coverage for that person or for all ineligible persons under the application, and to recover any benefit payments made for such ineligible person or persons. **Furthermore, I understand that if I intentionally or fraudulently misrepresented a material fact on the application, made a material misrepresentation of a material fact about any person contained herein, or committed fraud in the process of obtaining the coverage outlined on this application, Blue KC and/or USAble Life have the right to terminate or rescind coverage for that person or for all persons under the application; however, no statement I make voids my coverage unless my statements are material to the risk assumed and contained in my written application.** After my coverage has been in force for two (2) years from the effective date, no statement except fraudulent statements I make voids my medical or dental coverage or reduces my benefits. I understand that my medical records will be maintained with strict confidentiality by Blue KC and USAble Life in accordance with applicable federal and state laws.

If electing the BlueSaver Plan, I acknowledge that this High Deductible Health Plan ("HDHP") is for use with a Health Savings Account ("HSA").

If I have elected the BlueSaver Plan and applied to open an HSA with UMB Bank, n.a. ("UMB"), I acknowledge that the HSA that I have applied for will be governed by the terms and conditions, including the fees, disclosed in the documents that will be mailed to me within ten (10) days after my HSA has been opened. I request that UMB mail me an HSA debit card so that I can use it to access funds in my HSA, and I acknowledge that my use of the debit card will be governed by the Cardholder Agreement that will be sent with the Card.

I authorize Blue KC as the insurer of my HDHP, UMB, and my Employer and/or their third party service providers, to exchange information about my identity, enrollment elections and status and other information necessary to establish my HSA at UMB, to facilitate direct deposits to my HSA, and to accomplish other purposes related to payment for my healthcare expenses. I agree to indemnify and hold harmless my Employer, UMB, Blue KC, and their third party service providers against all claims or losses that any of them may suffer in reliance on this authorization, and release each of them from any claims or liability based on this authorization.

You agree that by checking "Yes" you consent and request that Blue Cross and Blue Shield of Kansas City, our affiliates, and those acting on our or their behalf, may call or text you using an automated telephone dialing system and/or a prerecorded message. The types of calls or texts you may receive include advertisements or telemarketing messages concerning our or our affiliates' benefits and services. You understand that consent is not a condition of purchase. ☐ YES ☐ NO

The translation is for informational purpose only; and the English version will be controlling unless the language in the other language version is shown to be a fraudulent misrepresentation.

La traducción está para el propósito informativo solamente; y la versión inglesa controlará a menos que la lengua en la otraversión de la lengua se demuestre para ser una mala representación fraudulenta.

EMPLOYEE'S SIGNATURE: _____ SPOUSE'S SIGNATURE: _____

PRINTED NAME: _____ PRINTED NAME: _____

DATE: _____ DATE: _____

Notices

NOTICE OF WOMEN'S HEALTH AND CANCER RIGHTS ACT:

Along with benefits detailed in your Certificate of Coverage and Schedule of Benefits, your benefits include coverage for (1) breast reconstruction in connection with a mastectomy, including reconstruction of the other breast to produce a symmetrical appearance; (2) prosthesis; and (3) treatment of physical complications from all stages of mastectomy, including lymphedemas. This coverage is subject to copayments, coinsurance and deductibles consistent with other benefits under your plan. This notice is being provided in accordance with the Women's Health and Cancer Rights Act of 1998, a federal law.

SUMMARY OF BENEFITS AND COVERAGE NOTICE:

If you would like a copy of the Summary of Benefits and Coverage (SBC) for the product you are applying for, please see your employer for a copy. The SBC is available free of charge. SBCs are also available electronically at BlueKC.com. The information in the SBC is subject to change prior to your effective date.

NOTICE RELATING TO THE PROTECTION OF RELIGIOUS BELIEFS AND MORAL CONVICTIONS:

Your health plan's coverage does not include an elective pregnancy termination benefit.

DISCRIMINATION IS AGAINST THE LAW

Blue KC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue KC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue KC:

- 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 Customer Service, 816-395-6340 (local), 844-395-7126 (Toll free), languagehelp@bluekc.com.

If you believe that Blue KC 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: the Appeals Department PO Box 419169, Kansas City, MO 64141-6169, 816-395-3537, TTY: 816-842-5607, appeals@bluekc.com. You can file a grievance in person or by mail, or email. If you need help filing a grievance, the Appeals Department 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 Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-868-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

LAST NAME _____ **FIRST NAME** _____

Language Notices

NEED THIS COMMUNICATION IN ANOTHER LANGUAGE?

If you, or someone you're helping, has questions about Blue KC, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-844-395-7126.

1. Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue KC, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-395-7126.

2. Chinese: 如果您，或是您正在協助的對象，有關於 Blue KC 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 1-844-395-7126。

3. Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue KC, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-395-7126.

4. German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue KC 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 1-844-395-7126 an.

5. Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Blue KC에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-844-395-7126로 전화하십시오.

6. Laotian: ຖ້າທ່ານ, ຫ ຼືບຸ ທ່ານກ ຳລ ັງຊ ່ວຍເຫ ຼືອ, ມ ຄ ຳຖ ามກ ່ຽວກ ັບ Blue KC, ທ ່ານມ ສ ິດ ທ ຈ ່ ະ ໄ ດ ້ ຮ ັ ບ ກ ານ ຊ ່ ວ ຍ ເ ຫ ຼ ືອ ແ ລ ະ ຂ ໍ ້ ມ ູ ນ ຂ ່ າ ວ ສ ານ ຫ ເ ປ ັ ນ ພ າ ສ າ ຂ ອ ງ ທ ່ ານ ບ ມ ຄ າ ໃ ສ ່ จ ่ า ย. ก า น โ อ ้ ม ก บ น า ย พ า ส า, ใ ห ้ โ ท ห า 1-844-395-7126.

7. Arabic: إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Blue KC ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل ب 1-844-395-7126.

8. Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Blue KC, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-395-7126.

9. French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue KC, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-395-7126.

10. Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue KC, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-844-395-7126.

11. Persian: اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Blue KC ، داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید .1-844-395-7126 تماس حاصل نمایید .

12. Serbo-Croation: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue KC, imate pravo da besplatno dobijete pomo i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 1-844-395-7126.

13. Pennsylvanian Dutch: "Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Blue KC, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 1-844-395-7126 uffrufe.

14. Cushite: Isin yookan namni biraa isin deeggartan Blue KC irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-844-395-7126 tiin bilbilaa.

15. Portuguese: Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Blue KC, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-395-7126.

For TTY services, please call 1-816-842-5607.