Enrollment/Change Application

Completed by Group Administrator Only	
Group Number (if applicable):	Blue Cross NC Subscriber ID Number (if available):

Instructions:

- All employees applying for medical coverage complete Sections **A**, **B** (if applicable), **C** (if applicable), **D**, **E**, **F**, **H**, **I**.
- For change requests, complete Sections **A**, **C** and all other applicable sections.
- If declining medical coverage, please complete Sections **A** and **D**.
- For help in reading this notice, Blue Cross and Blue Shield of North Carolina (Blue Cross NC) provides consumer assistance tools and services for individuals living with disabilities (including accessible Web sites and the provision of auxiliary aids and services at no cost to the individual) in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act. Blue Cross NC also provides language services at no cost to the individual, including oral interpretation and written translations. To access these services and more, call **877-258-3334**. For TTY and TDD, call **800-442-7028**.

Please type or print in black or blue, NOT RED ink

A. Employee Information

First Name	Middle Initial	Last Name	Suffix

Employee Birthdate (mm / dd / yyyy)	Employee Social Security Number	☐ Male ☐ Female	Marital Status

Address	P.O. Box (For Blue Options HSA / HSA eligible plans you must also provide a street address.)	Apt. No.	City	State	Zip Code

Company Name	Occupation

Work Location	Date of Full Time Employment (mm / dd / yyyy)	Language Preference ☐ Spanish ☐ English ☐ Other _____

Home Phone Number ( )	Work Phone Number ( )	E-Mail

Ethnicity: (This information is optional and will not be used in a discriminatory manner. Responses or nonresponses to this question will not affect eligibility for coverage.)

☐ African American/Black ☐ Asian/Asian American ☐ Choose not to report
☐ White/Caucasian ☐ Hispanic/Latino ☐ American Indian/Alaska Native ☐ Other (specify) _____

☐ Active Employee ☐ Cobra/State Continuation ☐ Retiree (51+)

COBRA/State Continuation Qualifying Life Event (QLE): ☐ Termination of Employment ☐ Reduction in Hours ☐ Death of Subscriber ☐ Divorce ☐ Over Age Dependent ☐ Medicare Eligible

What was the date of the QLE? (mm / dd / yyyy) Date Continuation Started (mm / dd / yyyy) Date Continuation Ends (mm / dd / yyyy)

B. If Enrolling Due to a Qualifying Life Event

You may apply for coverage for yourself or a dependent outside of open enrollment due to a qualifying life event within 30 days of the date of the event (unless 60 days is required by law). (Legal documentation may be required.) Please fill out this section unless otherwise instructed by your Group Administrator.

Adding a dependent due to:

	Date of Occurrence (mm / dd / yyyy)		Date of Occurrence (mm / dd / yyyy)		Date of Occurrence (mm / dd / yyyy)
☐ Marriage		☐ Adoption		☐ Court Order	
☐ Birth		☐ Foster Placement		☐ Other	

Enrolling and/or adding a dependent due to loss of other coverage as a result of:

☐ Exhaustion of COBRA Continuation ☐ Divorce ☐ Loss of dependent status ☐ Death ☐ Meeting or exceeding the lifetime benefit maximum of other plan
☐ Reduction in hours ☐ Termination of other coverage ☐ Termination of employment
☐ Termination of employer contributions toward coverage ☐ Offered plan is no longer in your service area ☐ Discontinuance of other coverage

If either of the following events occurred, you or your dependent(s) may apply within 60 days of the date of the event. Please indicate the event that applies to you and/or your dependent(s):

☐ Loss of eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP)
☐ Gain eligibility for premium payment assistance from Medicaid or the Children's Health Insurance Program (CHIP)

What was the date of the Qualifying Life Event? (mm / dd / yyyy)

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Employee Name:

C. If Making a Change from Previous Enrollment

Check All That Apply:

- ☐ Name (Legal documentation is required.)
- ☐ Address
- ☐ Other Insurance Information
- ☐ Phone Number
- ☐ Replace ID Card
- ☐ Date of Birth Correction (Legal documentation may be required.)
- ☐ E-Mail Address
- ☐ Other _____

Remove Dependent(s):

	Date of Occurrence (mm / dd / yyyy)
☐ Divorce	
☐ Dependent Age	
☐ Death	
☐ Other _____	

Reinstate Coverage:

Reason: _____

Cancel Coverage:

	Date of Occurrence (mm / dd / yyyy)
☐ Not Eligible	

Reason: _____

☐ Left Employment	
☐ Subscriber Request (Open Enrollment Only)	
☐ Other _____	

Reason: _____

D. Benefits and Coverage Selection – Complete for Blue Cross NC Health and Dental, if Offered by Employer

MEDICAL PLAN:

- ☐ Blue Care® (HMO)
- ☐ Blue Options 1-2-3℠ (PPO)
- ☐ Blue Options HSA℠
- ☐ Blue Options℠ (PPO)
- ☐ Blue Select℠ (PPO)
- ☐ Blue Select Plus℠ (PPO)
- ☐ Blue Local℠ with Atrium Health*
- ☐ Blue Local℠ with Wake Forest Baptist Health**
- ☐ Blue Value 1-2-3℠ (POS)
- ☐ Blue Value℠ (POS)
- ☐ Classic Blue® (CMM)

- ☐ High
- ☐ Low

- ☐ No Medical Coverage

* I understand that I am enrolling in a plan with a local provider network limited to the Blue Local with Atrium Health network. I certify to understanding that in-network providers for this plan are concentrated in the following approved counties: Anson, Cabarrus, Cleveland, Gaston, Lincoln, Mecklenburg, Rowan, Stanly, and Union. I acknowledge that not all Blue Cross NC contracted providers may be in this plan's network, and if I visit a provider not in this plan's network, I may only receive benefits at the out-of-network level, except for emergency, urgent care, or ambulance services.

** I understand that the plan selected has a local provider network limited to the Blue Local with Wake Forest Baptist Health. I certify to understanding that in-network providers for this plan are concentrated in the following approved counties: Davidson, Davie, Forsyth, Guilford, Randolph, Stokes, Wilkes, and Yadkin. I acknowledge that not all Blue Cross NC contracted providers may be in this plan's network, and if I visit a provider not in this plan's network, I may only receive benefits at the out-of-network level, except for emergency, urgent care, or ambulance services.

I can search for a provider in the online "find a doctor" tool to determine if my provider is in my plan's network. I acknowledge that I have the right to decline my employer's coverage and enroll in different coverage outside of the coverage offered by my employer.

MEDICAL COVERAGE (if applicable): ☐ Employee Only ☐ Employee/Spouse/Domestic Partner ☐ Employee/Child(ren) ☐ Employee/Family

If your group is offering multiple plans, please enter plan name selected: _____

DENTAL PLAN: ☐ Dental ☐ No Dental Coverage

If your group is offering multiple plans, please enter plan name selected: _____

DENTAL COVERAGE (if applicable): ☐ Employee Only ☐ Employee/Child(ren) ☐ Employee/Spouse/Domestic Partner ☐ Employee/Family

BLUE 20/20℠ VISION COVERAGE (if applicable): ☐ Employee Only ☐ Employee/Child(ren) ☐ Employee/Spouse/Domestic Partner ☐ Employee/Family

DECLINE MEDICAL COVERAGE: Check one only: ☐ I am rejecting Employee Coverage ☐ I am rejecting Dependent/Spouse Coverage

Declining coverage for the following reason (check one):

- ☐ Another plan offered by my employer
- ☐ COBRA or State Continuation
- ☐ An individual plan
- ☐ I and/or my dependents are not covered by any other health benefit plan
- ☐ My spouse's group coverage
- ☐ A government plan (type): _____
- ☐ Other (explain): _____

Names of any dependents rejecting coverage: _____

I understand that if I elect to apply for coverage for myself, my spouse/domestic partner, and/or my dependent child(ren) through this employer health plan at a later time, I may be delayed until the employer's open enrollment period.

Application Continued on Next Page →

Employee Name:

Important Notice of Special Enrollment:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance (including Medicaid or Children's Health Insurance Program (CHIP)) or group health plan coverage, you may be able to enroll yourself and the dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (other than Medicaid or CHIP) or if the employer stops contributing towards your or your dependents' other coverage and within 60 days after the loss of Medicaid or CHIP eligibility.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption or foster care, except when adding a dependent child will not change your coverage type or premiums that are owed.

Signature of Primary Applicant: **X** _____ Date mm dd yyyy

Notice of Declination of Coverage must be received by Blue Cross and Blue Shield of North Carolina (Blue Cross NC) within 30 days of the date that employee is first eligible for coverage.

E. Family Information – Legal Documentation May be Required

Health	Dental	Blue 20/20 Vision	Name First, Middle Initial, Last, Suffix	Social Security Number (Required for Spouse/Domestic Partner)	Birthdate mm/dd/yyyy	Gender	Child Status (please check if applicable)
☐Y ☐N	☐Y ☐N	☐Y ☐N	☐ Spouse ☐ Domestic Partner		mm dd yyyy	☐M ☐F	NA
☐Y ☐N	☐Y ☐N	☐Y ☐N	**Child 1**		mm dd yyyy	☐M ☐F	☐ Intellectually or physically disabled
☐Y ☐N	☐Y ☐N	☐Y ☐N	**Child 2**		mm dd yyyy	☐M ☐F	☐ Intellectually or physically disabled
☐Y ☐N	☐Y ☐N	☐Y ☐N	**Child 3***		mm dd yyyy	☐M ☐F	☐ Intellectually or physically disabled

☐ **Additional Dependent form attached**
Dependent children include foster, adopted or a child placed by court or administrative order.

* If you have more than three children enrolling on the Plan, complete an Additional Dependent form.

F. Other Health Insurance Information

Additional Health Coverage that will be in-force when this policy becomes active:

Insurance Carrier	Policy Number	Policy Holder Name

Date of Birth mm dd yyyy | Effective Date mm dd yyyy | Termination Date or Expected Termination Date mm dd yyyy (If remaining active leave blank)

What kind of coverage: ☐ Individual ☐ Group

Persons covered: ☐ Employee ☐ Spouse ☐ Domestic Partner ☐ Child 1 ☐ Child 2 ☐ Child 3 ☐ Additional Dependents

Additional Health Coverage that will be in-force when this policy becomes active:

Insurance Carrier	Policy Number	Policy Holder Name

Date of Birth mm dd yyyy | Effective Date mm dd yyyy | Termination Date or Expected Termination Date mm dd yyyy (If remaining active leave blank)

What kind of coverage: ☐ Individual ☐ Group

Persons covered: ☐ Employee ☐ Spouse ☐ Domestic Partner ☐ Child 1 ☐ Child 2 ☐ Child 3 ☐ Additional Dependents

Application Continued on Next Page →

Employee Name:

If anyone covered has Medicare Coverage please complete below:

Persons covered: ☐ Employee ☐ Spouse ☐ Domestic Partner ☐ Child 1 ☐ Child 2 ☐ Child 3 ☐ Additional Dependents

Medicare Claim Number:

Medicare C ☐ Yes ☐ No

If yes, Carrier's Name: _____

Eligible Due To: ☐ Renal Disease; First Day of Dialysis mm dd yyyy ; Where does dialysis take place? ☐ Home ☐ Center;

☐ Kidney Transplant? ☐ Yes ☐ No

☐ Disability; Is the member actively working? ☐ Yes ☐ No

☐ Age

Part A Effective Date: mm dd yyyy

Part B Effective Date: mm dd yyyy

G. Other Dental Insurance Information

Have you or your dependents had any other dental coverage within the last 12 months (other than Blue Cross NC coverage that you are applying for today)? ☐ Yes ☐ No

<u>See important notices regarding special enrollment information attached.</u> Please list any dental coverage the employee and/or dependents has/had within the last 12 months (including Blue Cross NC coverage): (To receive prior dental credit against this group benefit plan, please list prior dental coverage within the last 12 months.) Blue Cross NC may request a certificate of creditable coverage for verification purposes.

Insurance Carrier | Policy Number | Policy Holder Name

Date of Birth mm dd yyyy | Effective Date mm dd yyyy | Termination Date or Expected Termination Date mm dd yyyy (If remaining active leave blank)

What kind of coverage: ☐ Individual ☐ Group

Persons covered: ☐ Employee ☐ Spouse ☐ Domestic Partner ☐ Child 1 ☐ Child 2 ☐ Child 3 ☐ Additional Dependents

Additional Dental Coverage that will be in-force when this policy becomes active.

Insurance Carrier | Policy Number | Policy Holder Name

Date of Birth mm dd yyyy | Effective Date mm dd yyyy | Termination Date or Expected Termination Date mm dd yyyy (If remaining active leave blank)

What kind of coverage: ☐ Individual ☐ Group

Persons covered: ☐ Employee ☐ Spouse ☐ Domestic Partner ☐ Child 1 ☐ Child 2 ☐ Child 3 ☐ Additional Dependents

Additional Dental Coverage that will be in-force when this policy becomes active.

Insurance Carrier | Policy Number | Policy Holder Name

Date of Birth mm dd yyyy | Effective Date mm dd yyyy | Termination Date or Expected Termination Date mm dd yyyy (If remaining active leave blank)

What kind of coverage: ☐ Individual ☐ Group

Persons covered: ☐ Employee ☐ Spouse ☐ Domestic Partner ☐ Child 1 ☐ Child 2 ☐ Child 3 ☐ Additional Dependents

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H. Statement of Understanding / Legal Notices – Your Signature is Required

I understand the benefits for which I (we) will be eligible are those described in the Blue Cross NC (including the benefit booklet) and changes provided for therein. I certify that all statements made herein and on all sections of this application are complete and true to the best of my knowledge. I understand that Blue Cross NC may, within two years of the date of this application, rescind my policy for any of my acts or practices that constitute fraud or if I make an intentional misrepresentation of material fact. If fraudulent misstatements were made, Blue Cross NC may take legal action at any time.

I understand that if I am applying for Blue Options HSA or an HSA eligible plan and my employer has established an HSA, the HSA will be provided to me directly by a separate administrator, unaffiliated with Blue Cross NC. Blue Cross NC is not responsible or liable for administration of the HSA.

I understand that if I am applying for a medical plan paired with an HRA and my employer has established an HRA, the HRA may be administered by Blue Cross NC separately from my health insurance plan, or by a separate administrator.

Detailed information regarding my HSA/HRA will be provided by the designated administrator. I also understand that due to bank regulations, if I provide a P.O. Box as my address I will receive a request for additional information regarding my mailing address. Failure to respond to requests for additional information will result in account closure and return of any funds posted to my account.

I understand that if my employer establishes an HSA/HRA, my employer or their designees will share certain personal information about me with these administrators to facilitate the administrator's establishment of the HSA/HRA account. By signing this application, I authorize my employer or their designees to share pertinent information with these selected administrators as applicable, which may include my name, address, social security number and my employer's name.

I understand that if issued a debit card in connection with my HSA/HRA, I agree that although Blue Cross NC's name and marks may be included on the face of the debit card for convenience, Blue Cross NC is not responsible or liable for administration of my debit card. The terms and conditions associated with my debit card are governed by my agreement with the bank issuing the card.

HSA Only:

If I am applying for Blue Options HSA or an HSA eligible plan, I understand that Blue Cross NC takes no responsibility for determining eligibility to contribute to an HSA and that I should consult a tax advisor if I have questions. By signing this application, I understand that I am authorizing the administrator to establish an HSA on my behalf, as of the date corresponding with the effective date of my Blue Cross NC plan with my employer. In order to activate the account, I will need to provide additional authorization through documents that will be provided to me by the fund administrator.

Notice of Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

For questions or to obtain more information, contact a Blue Cross NC Customer Service Representative at: **Blue Cross NC Customer Service, Blue Cross and Blue Shield of North Carolina, PO Box 2291, Durham, NC 27702, 1-877-258-3334 (toll-free)**

By signing below, I agree to the above Statement of Understanding and have read all of the Legal Notices.

Signature of Primary Applicant: **X** _____ Date mm dd yyyy

Application Continued on Next Page →

Employee Name:

I. Statement of Authorization for Release of Protected Health Information – Your Signature is Required

I understand that if I refuse to sign this authorization that Blue Cross NC may refuse to enroll me or determine that I am not eligible for benefits in Blue Cross NC.

I understand that my protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, or a health care clearinghouse and that relates to:

(i) my past, present, or future physical or mental health or condition;

(ii) the provision of health care to me; or

(iii) the past, present, or future payment for the provision of health care to me.

I authorize any current or past medical professional, medical care institution, pharmacy benefit manager or other medical care giver that has treated me or provided medical services or supplies to me to disclose my protected health information to Blue Cross and Blue Shield of North Carolina ("Blue Cross NC").

I further authorize Blue Cross NC to review any applications for health care coverage that I may have submitted to Blue Cross NC in the past.

I authorize Blue Cross NC to receive, use and disclose as necessary my protected health information in connection with any underwriting or eligibility determination purposes in connection with the coverage for which I have applied.

The protected health information (excluding psychotherapy notes) that may be used and disclosed is as follows:

Medical records or any information concerning my current or past health status or treatment received from my medical care providers or previous applications for health care coverage.

I understand that Blue Cross NC will use my protected health information for the following purposes:

To determine my eligibility for enrollment and my premium rate.

I understand that Blue Cross NC will make every effort to safeguard my protected health information. I further understand that Blue Cross NC will not disclose my protected health information unless I request it or when state or federal privacy laws permit or require Blue Cross NC to disclose my protected health information. I understand that Blue Cross NC may disclose my protected health information to individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by the federal privacy regulations. I understand that if my protected health information is received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by the federal privacy regulations, my protected health information described above may be re-disclosed and no longer protected by federal privacy regulations.

I understand that I may revoke this authorization at any time by sending a written notification addressed to:

Commercial Operations/IDC
Blue Cross and Blue Shield of North Carolina
PO Box 2291
Durham, NC 27702-2291

and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective:

(i) for information that Blue Cross NC already used or disclosed, relying on this authorization or

(ii) if the authorization was obtained as a condition of coverage in Blue Cross NC and, by law, Blue Cross NC has a right to contest the coverage.

This authorization expires 120 days from the date this authorization is signed by the applicable person listed below.

Signature of Primary Applicant
or Legal Personal Representative: **X** _____ Date mm dd yyyy

Name of Legal Personal Representative and
Relationship to Primary Applicant (please print): _____ Date mm dd yyyy

A photographic copy of this authorization shall be as valid as the original.

BlueCross BlueShield of North Carolina

Non-Discrimination and Accessibility Notice

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified interpreters and/or written information in other formats (large print, accessible electronic formats, etc.)
- Free language services to people whose primary language is not English, such as: qualified interpreters and/or information written in other languages

If you need these services, call the Customer Service or TTY number on the back of your member ID card.

If you believe that Blue Cross NC 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:

Blue Cross NC, P.O. Box 2291, Durham, NC 27702
Attention: Civil Rights Coordinator-Privacy,
Ethics & Corporate Policy Office
Call: 919-765-1663, 1-888-291-1783 (TTY)
Fax: 919-287-5613
Email: civilrightscoordinator@bcbsnc.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-Privacy, Ethics & Corporate Policy Office 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:

Online: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Mail: U.S. Department of Health & Human Services
200 Independence Avenue, SW Room 509F
HHH Building Washington, D.C., 20201
Call: 1-800-368-1019, 1-800-537-7697 (TDD)
Complaint forms are available online at:
http://www.hhs.gov/civil-rights/filing-a-complaint/index.html

This notice and/or attachments may have important information about your application or coverage through Blue Cross NC. Look for key dates. 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. If you need these services, call the Customer Service or TTY number on the back of your member ID card.

Discrimination is Against the Law

Blue Cross NC complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Blue Cross NC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

BLUE CROSS®, BLUE SHIELD®, the Cross and Shield symbols and service marks are marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. Blue Cross NC is an independent licensee of the Blue Cross and Blue Shield Association.

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BlueCross BlueShield of North Carolina

Multi-Language Interpreter Services

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call the Customer Service or TTY number on the back of your member ID card.

ATENCIÓN: Si habla otro idioma, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a Servicio de Atención al Cliente al número de teléfono para personas con problemas auditivos (TTY) que figura al dorso de su tarjeta de identificación.

注意：他の言語を話す方は、言語支援サービスを無料でご利用いただけます。

顧客サービスにお電話いただくか、会員IDカードの裏面にあるTTYサービスをご利用ください。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số Dịch vụ khách hàng hoặc TTY trên mặt sau thẻ ID thành viên của bạn.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
가입자 ID 카드 뒷면에 있는 고객 서비스 혹은 TTY 번호로 전화해 주십시오.

ATTENTION$_o$: si vous parlez une autre langue, des services d'aide linguistique vous sont proposés gratuitement. Contactez le service clients au numéro figurant au dos de votre carte de membre.

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم خدمة العملاء أو رقم الهاتف النصي الموضح على ظهر بطاقة هوية العضو.

LUS CEEB TOOM:Yog tias koj hais lus Hmoob, , peb muaj kev pab txhais lus pub dawb rau koj. Hu rau Customer Service tus xov tooj los yog tus xov tooj TTY rau cov neeg tsis hnov lus zoo uas nyob sab tom qab koj daim npav ID.

ВНИМАНИЕ: Если вы говорите на другом языке, то вам доступны бесплатные услуги перевода. Позвоните в Отдел обслуживания по номеру, указанному на обратной стороне вашей идентификационной карточки участника.

PAUNAWA: Kung nagsasalita ka ng ibang lengguwahe, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tawagan ang numero ng Customer Service o TTY sa likod ng iyong member ID card.

સૂચના: જો તમે ગુજરાતી બોલતા હોવ તો તમારા માટે ભાષા સેવાઓ નિ:શુ ક ઉપલ ધ છે. તમારા સ યપદ ઓળખપ રની (આઈ.ડી) પાછળની બાજુ પર આપેલ ગરાહક સેવાઓના નંબર અથવા TTT નંબર પર કૉલ કરો.

ចំណំ៖ ប្រសិនប្របោកអ្នកនិយាយជាភាសាខ្មែរ បសវាកមជំនួយម្ពភាសាមាន្ពល់ជូនសបមាប្រោកអ្នកបោយមិនគិតថ្លៃ។សូមបៅបៅកា ន់បសវាអតិ្ថជនបោយបប្របលទូរសំព្ទបៅខាង្ឆងកាតសមាជិកប្រស់បោកអ្នក។

ACHTUNG: Falls Sie eine andere Sprache sprechen, stehen Ihnen kostenlose Sprachdienste zur Verfügung. Rufen Sie die Nummer des Kundenservices oder von TTY an, die auf der Rückseite Ihrer Mitgliedskarte angegeben ist.

ध्यान दें: यदि आप दूसरी भाषा बोलते हैं, तो आपके लिए भाषा सहायता सेवाएं, मुफ्त में, उपलब्ध हैं। अपने सदस्य आईडी कार्ड के पीछे मौजूद ग्राहक सेवा या TTY नंबर पर कॉल करें।

ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາອື່ນ, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ໄດ້ເສຍຄ່າ.
ໂທຫາຝ່າຍບໍລິການລູກຄ້າຫລື ເບີ TTY ຢູ່ດ້ານຫຼັງບັດປະຈຳຕົວຂອງທ່ານ.

注意：如果您講廣東話或普通話， 您可以免費獲得語言援助服務。請撥打您會員 ID 卡背面的客服或TTY號的電話號碼。

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