Mail Administrator
PO Box 14651
Lexington, KY 40512
Fax: 410-505-2901
800-305-1351

CareFirst BlueChoice, Inc.
MEMBERSHIP CHANGE FORM
(Maryland and District of Columbia Individual Plans Only)
This is not an application for insurance

Subscriber's Name:	Last	First	MI	Birth Date: ___/___/____ *Month/Day/Year*
Residence Address:	Street	City	County	State / Zip
Subscriber ID #(SID)		SSN		Phone Number:
Requested Effective Date of Change: ___/___/____ *Month/Day/Year*				

CHANGES REQUESTED (Please check box of requested change)

☐**Address Change**

☐Residence Address:	Street	City	County	State	Zip
☐Billing Address:	Street	City	County	State	Zip

☐**Phone Number Change:**

Old Phone Number:		New Phone Number:	

☐**Name Change (Documentation required)**

Change from:	Last	First	MI
Change to:	Last	First	MI

Name Change Reason: ☐Marriage ☐Divorce ☐Other ________________________

☐**COMBINING SAME PRODUCT POLICIES**
(benefits must be the same or greater, if not a Minor, signature required.)

Subscriber		**Subscriber ID # (SID)**	**Relationship**
Last	First		

☐**Add a Dependent:**

☐Newborn of Subscriber/Partner
☐Child being adopted Month/Year in which final adoption papers are granted:__/__
☐Child for whom subscriber has been appointed legal guardian Date appointed legal guardian:__/__/__
Documentation required if adoption proceedings are underway or if you are a court-appointed legal guardian

DEPENDENT INFORMATION (Please list all persons to be added)

Last	**First**	**MI**	**Relationship**	**Sex**	**Date of Birth**	**SSN**	**PCP #**
					__/__/__		
					__/__/__		
					__/__/__		

☐**Remove a Dependent:**

Due to: ☐Divorce Date of Divorce: __/__/__ ☐Extended Military ☐ Other:________________
☐Death* Date of Death: __/__/__ ***Documentation required.**

DEPENDENT INFORMATION (Please list all persons to be removed)

Last	**First**	**MI**	**Relationship**	**Sex**	**Date of Birth**	**SSN**
					__/__/__	
					__/__/__	
					__/__/__	

☐ SPLIT MEMBERSHIP – DEPENDENT TO HIS/HER OWN POLICY (non-Medicare related)

Dependent Information - Set up for continuous coverage

Last	First	MI	Type of Current Coverage	SSN	Effective Date
					__/__/__
					__/__/__

Split Reason: ☐ Death of Subscriber* ☐ Other__________________ * **Documentation required.**

Change from:	☐ Individual and Child(ren) ☐ Individual and Adult ☐ Family	**Change to:**	☐ Individual ☐ Individual and Child(ren) ☐ Family

☐ SPLIT MEMBERSHIP - DEPENDENT TO HIS/HER OWN POLICY (Subscriber moving to MediGap)

MOVING MEMBER: PLEASE ATTACH THIS FORM TO THE COMPLETED MEDIGAP APPLICATION

Dependent Information - Set up for continuous coverage

Last	First	MI	Type of Current Coverage	SSN	Effective Date
					__/__/__
					__/__/__

Remaining Members:

☐ Keep remaining family member(s) in the current policy/product.

☐ Remaining family member(s) to move to a Healthcare Reform compliant same or higher deductible policy. Complete **Policy Changes** section below.

**Remaining family members(s) requesting policy/plan changes(s) should visit www.carefirst.com/individual or, call a Product Specialist, M-F 8am-8pm at (410)356-8000/(800) 544-8703 to learn more.*

Change from:	☐ Individual and Child(ren) ☐ Individual and Adult ☐ Family	**Change to:**	☐ Individual ☐ Individual and Child(ren) ☐ Family

☐ POLICY CHANGES

Select Existing plan	Change to: (select higher)
☐ HealthyBlue Triple Option ☐ HealthyBlue Dual Option HSA	
☐ HealthyBlue 2.0 $1,500 ☐ HealthyBlue 2.0 $2,500	☐ HealthyBlue 2.0 $1,500 ☐ HealthyBlue 2.0 $2,500
☐ HealthyBlue Advantage HSA $1,500 ☐ HealthyBlue Advantage HSA $3,000 ☐ HealthyBlue Advantage HSA $4,000 ☐ HealthyBlue Advantage HSA $5,000	☐ HealthyBlue Advantage HSA $1,500 ☐ HealthyBlue Advantage HSA $3,000 ☐ HealthyBlue Advantage HSA $4,000 ☐ HealthyBlue Advantage HSA $5,000
☐ BlueChoice $20/$30 ☐ BlueChoice $15/$25 ☐ BlueChoice $10/$20	
☐ BlueChoice HSA $1,200 ☐ BlueChoice HSA $2,700	☐ BlueChoice HSA $2,700 (Maryland Only)
☐ BlueChoice Saver $20/$30	
☐ BlueChoice HIPAA $20/$30 (DC only) ☐ BlueChoice HIPAA $10/$20 (DC only)	☐ BlueChoice HIPAA $20/$30 (DC only) ☐ BlueChoice HIPAA $10/$20 (DC only)
☐ Other Product not listed ____________	☐ Other Product not listed ____________

☐ Change Rider (where product/rider available)

☐ Add:	☐ Dental ☐ Vision (BlueChoice HSA Only)
☐ Remove:	☐ Extended Maternity (DC only) ☐ Dental ☐ Vision (BlueChoice HSA Only)

☐ELECTRONIC COMMUNICATION CONSENT

You can receive electronic notices via email and/or text messaging instead of paper notices for your CareFirst BlueCross BlueShield (CareFirst) health care coverage by providing your email address and/or cell phone number and consent below. These will include but are not limited to:

- Explanation of Benefits alerts
- Appeal decision alerts
- Notice of HIPAA Privacy Practices
- Certification of Creditable Coverage

You may also receive information on programs related to your existing products and services along with new products and services that may be of interest to you.

- You may change your email and consent information anytime by logging into www.carefirst.com/myaccount or by calling the customer service phone number on your ID card.
- You can request a paper copy of electronic notices at anytime by calling the customer service phone number on your ID card.

I understand that to access the information provided electronically, I must have the following:

- Internet access;
- An email account that allows me to send and receive emails; and
- Microsoft Explorer 7.0 (or higher) or Firefox 3.0 (or higher), and Adobe Acrobat Reader 4 (or higher).

☐By checking this box, I hereby agree to electronic delivery of notices and documents. Is this an update? ☐Yes ☐No

Subscriber Name			Email Address	Cell Phone Number
Last	First	MI		
Spouse/Partner/Dependent Name(s)			**Email Address**	**Cell Phone Number**
Last	First	MI		
Last	First	MI		
Last	First	MI		

CareFirst BlueChoice will not sell your email to any third party and we do not share it with third parties except for CareFirst BlueChoice business associates that perform functions on our behalf or to comply with the law.

☐ADD/CHANGE PRIMARY CARE PHYSICIAN INFORMATION

PCP for member:	Last	First	MI	☐Medical
Change/Add to:	PCP #			Existing Patient: ☐Yes ☐ No
PCP for member:	Last	First	MI	☐Medical
Change/Add to:	PCP #			Existing Patient: ☐Yes ☐ No
PCP for member:	Last	First	MI	☐Medical
Change/Add to:	PCP #			Existing Patient: ☐Yes ☐ No

☐OTHER HEALTH INSURANCE INFORMATION

Is any person listed on the change form covered by another health care plan or HMO? ☐Yes ☐No
If yes, will this coverage be continued? ☐Yes ☐No If No, please provide the cancellation date: __/__/__

Policy Holder's Name:	Last	First	MI	Phone # of Other Insurer:

Name of Insurance Company:

Address of Insurance Company:	Street	City	State	Zip

Policy Number:	Group Number:	Effective Date of Policy: __/__/__

Name of Employer providing coverage (if applicable):

Does this policy cover: You? ☐Yes ☐No Your Spouse/Domestic Partner? ☐Yes ☐No Your children? ☐Yes ☐ No

Please list the name(s) of child(ren) covered:____

Policyholder's working status: ☐Active ☐Retired Retirement date: __/__/__

IF YOU HAVE OTHER HEALTH INSURANCE COVERAGE, FAILURE TO COMPLETE THIS SECTION WILL CAUSE SIGNIFICANT DELAYS IN PROCESSING ANY CLAIMS SUBMITTED.

☐Court Assigned Responsibility for Child(ren)'s Medical Expenses				
To be completed by the natural parents that live apart and provide medical coverage for their child(ren). Please indicate relationship to child(ren) (natural mother, natural father, step-parent). *Please provide legal documentation				
Parent with Court Assigned Responsibility for Child(ren)'s Medical Expenses				
Parent Name	Last	First	MI	Parent Date of Birth ___/___/___
Child Name	Last	First	MI	Child Date Of Birth ___/___/___
Child Name	Last	First	MI	Child Date Of Birth ___/___/___
Child Name	Last	First	MI	Child Date Of Birth ___/___/___
Relationship to child: ☐Natural mother ☐Natural father ☐Step-parent				
Parent with Custody of Child(ren)				
Parent Name	Last	First	MI	Parent Date of Birth ___/___/___
Child Name	Last	First	MI	Child Date Of Birth ___/___/___
Child Name	Last	First	MI	Child Date Of Birth ___/___/___
Child Name	Last	First	MI	Child Date Of Birth ___/___/___
Relationship to child: ☐Natural mother ☐Natural father ☐Step-parent				
MARYLAND WARNING: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.				
DISTRICT OF COLUMBIA WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information, materially related to a claim, was provided by the subscriber.				
Required Signature(s) and Date				
Subscriber's signature				Date ___/___/___
Member's signature				Date ___/___/___

Mail Administrator
PO Box 14651
Lexington, KY 40512
www.carefirst.com

CareFirst BlueChoice, Inc. is an independent licensee of the Blue Cross and Blue Shield Association. CareFirst BlueCross BlueShield is an independent licensee of the Blue Cross and Blue Shield Association, providing access to the Preferred Provider Organization Network only and does not assume any financial risk or obligation with respect to claims.
®Registered trademark of the Blue Cross and Blue Shield Association. ®Registered trademark of CareFirst of Maryland, Inc.

CareFirst
Family of health care plans

Notice of Nondiscrimination and Availability of Language Assistance Services

CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc. and all of their corporate affiliates (CareFirst) comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. CareFirst does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

CareFirst:

- Provides free aid 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, please call 855-258-6518.

If you believe CareFirst 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 our CareFirst Civil Rights Coordinator.

Civil Rights Coordinator, Corporate Office of Civil Rights

Telephone Number	410-528-7820
Mailing Address	P.O. Box 8894 Baltimore, Maryland 21224
Fax Number	410-505-2011
Email Address	civilrightscoordinator@carefirst.com

You can file a grievance by mail, fax or email. If you need help filing a grievance, our CareFirst 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 Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

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

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst BlueChoice, Inc., First Care, Inc. and The Dental Network are independent licensees of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association. ®' Registered trademark of CareFirst of Maryland, Inc.

CareFirst
Family of health care plans

Foreign Language Assistance

Attention (English): This notice contains information about your insurance coverage. It may contain key dates and you may need to take action by certain deadlines. You have the right to get this information and assistance in your language at no cost. Members should call the phone number on the back of their member identification card. All others may call 855-258-6518 and wait through the dialogue until prompted to push 0. When an agent answers, state the language you need and you will be connected to an interpreter.

አማርኛ(Amharic) ማሳሰቢያ:- ይህ ማስታወቂያ ስለ መድን ሽፋንዎ መረጃ ይዟል። ከተወሰኑ ቀነ-ገደቦች በፊት ሊፈጽሟቸው የሚገቡ ነገሮች ሊኖሩ ስለሚችሉ እነዚህን ወሳኝ ቀናት ሊይዝ ይችላል። ይኽን መረጃ የማግኘት እና ያለምንም ክፍያ በቋንቋዎ እገዛ የማግኘት መብት አለዎት። አባል ከሆኑ ከመታወቂያ ካርድዎ በስተጀርባ ላይ ወደተጠቀሰው የስልክ ቁጥር መደወል ይችላሉ። አባል ካልሆኑ ደግሞ ወደ ስልክ ቁጥር 855-258-6518 ደውለው 0ን እንዲጫኑ እስኪነገርዎ ድረስ ንግግሩን መጠበቅ አለብዎ። አንድ ወኪል መልስ ሲሰጥዎ፣ የሚፈልጉትን ቋንቋ ያሳውቁ፣ ከዚያም ከተርጓሚ ጋር ይገናኛሉ።

Èdè Yorùbá (Yoruba) Ìtẹ́tíléko: Àkíyèsí yìí ní ìwífún nípa iṣẹ́ adójútòfò rẹ. Ó le ní àwọn déètì pàtó o sì le ní láti gbé ìgbésẹ̀ ní àwọn ọjọ́ gbèdéke kan. O ni ẹ̀tọ́ láti gba ìwífún yìí àti ìrànlọ́wọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Àwọn ọmọ-ẹgbẹ́ gbọ́dọ̀ pe nọ́mbà fóònù tó wà lẹ́yìn káàdì ìdánimọ̀ wọn. Àwọn míràn le pe 855-258-6518 kí o sì dúró nípasẹ̀ ìjíròrò títí a ó fi sọ fún ọ láti tẹ 0. Nígbàtí aṣojú kan bá dáhùn, sọ èdè tí o fẹ́ a ó sì so ọ́ pọ̀ mọ́ ògbufọ̀ kan.

Tiếng Việt (Vietnamese) Chú ý: Thông báo này chứa thông tin về phạm vi bảo hiểm của quý vị. Thông báo có thể chứa những ngày quan trọng và quý vị cần hành động trước một số thời hạn nhất định. Quý vị có quyền nhận được thông tin này và hỗ trợ bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Các thành viên nên gọi số điện thoại ở mặt sau của thẻ nhận dạng. Tất cả những người khác có thể gọi số 855-258-6518 và chờ hết cuộc đối thoại cho đến khi được nhắc nhấn phím 0. Khi một tổng đài viên trả lời, hãy nêu rõ ngôn ngữ quý vị cần và quý vị sẽ được kết nối với một thông dịch viên.

Tagalog (Tagalog) Atensyon: Ang abisong ito ay naglalaman ng impormasyon tungkol sa nasasaklawan ng iyong insurance. Maaari itong maglaman ng mga pinakamahalagang petsa at maaaring kailangan mong gumawa ng aksyon ayon sa ilang deadline. May karapatan ka na makuha ang impormasyong ito at tulong sa iyong sariling wika nang walang gastos. Dapat tawagan ng mga Miyembro ang numero ng telepono na nasa likuran ng kanilang identification card. Ang lahat ng iba ay maaaring tumawag sa 855-258-6518 at maghintay hanggang sa dulo ng diyalogo hanggang sa diktahan na pindutin ang 0. Kapag sumagot ang ahente, sabihin ang wika na kailangan mo at ikokonekta ka sa isang interpreter.

Español (Spanish) Atención: Este aviso contiene información sobre su cobertura de seguro. Es posible que incluya fechas clave y que usted tenga que realizar alguna acción antes de ciertas fechas límite. Usted tiene derecho a obtener esta información y asistencia en su idioma sin ningún costo. Los asegurados deben llamar al número de teléfono que se encuentra al reverso de su tarjeta de identificación. Todos los demás pueden llamar al 855-258-6518 y esperar la grabación hasta que se les indique que deben presionar 0. Cuando un agente de seguros responda, indique el idioma que necesita y se le comunicará con un intérprete.

Русский (Russian) Внимание! Настоящее уведомление содержит информацию о вашем страховом обеспечении. В нем могут указываться важные даты, и от вас может потребоваться выполнить некоторые действия до определенного срока. Вы имеете право бесплатно получить настоящие сведения и сопутствующую помощь на удобном вам языке. Участникам следует обращаться по номеру телефона, указанному на тыльной стороне идентификационной карты. Все прочие абоненты могут звонить по номеру 855-258-6518 и ожидать, пока в голосовом меню не будет предложено нажать цифру «0». При ответе агента укажите желаемый язык общения, и вас свяжут с переводчиком.

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst BlueChoice, Inc., First Care, Inc. and The Dental Network are independent licensees of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association. ®' Registered trademark of CareFirst of Maryland, Inc.

CareFirst.
Family of health care plans

हिन्दी (Hindi) ध्यान दें: इस सूचना में आपकी बीमा कवरेज के बारे में जानकारी दी गई है। हो सकता है कि इसमें मुख्य तिथियों का उल्लेख हो और आपके लिए किसी नियत समय-सीमा के भीतर काम करना ज़रूरी हो। आपको यह जानकारी और संबंधित सहायता अपनी भाषा में निःशुल्क पाने का अधिकार है। सदस्यों को अपने पहचान पत्र के पीछे दिए गए फ़ोन नंबर पर कॉल करना चाहिए। अन्य सभी लोग 855-258-6518 पर कॉल कर सकते हैं और जब तक 0 दबाने के लिए न कहा जाए, तब तक संवाद की प्रतीक्षा करें। जब कोई एजेंट उत्तर दे तो उसे अपनी भाषा बताएँ और आपको व्याख्याकार से कनेक्ट कर दिया जाएगा।

Ɓǎsɔ́ɔ̀-wùɖù (Bassa) Tò Ɖùǔ Cáo! Bɔ̌ nìà kɛ ɓá nyɔ ɓě ké m̀ gbo kpá ɓó nì fu̖à-fṹá-tìǐn nyɛɛ jè dyí. Bɔ̌ nìà kɛ ɓéɖé wé jɛ́ɛ́ ɓě ɓɛ́ m̀ ké ɖɛ wa mɔ́ m̀ ké nyuɛɛ nyu hwɛ̀ ɓɛ́ wé ɓěa ké zi. Ɔ mɔ̀ nì kpé ɓɛ́ m̀ ké bɔ̌ nìà kɛ kè gbo-kpá-kpá m̀ mɔ́ɛɛ dyé ɖé nì ɓíɖí-wùɖù mú ɓɛ́ m̀ ké se wíɖí ɖò pɛ́ɛ̀. Kpooɔ̀ nyɔ ɓě mɛ ɖá fṹùn-nɔ̀ɓà nìà ɖé waà I.D. káàɔ̀ ɖeín nyɛ. Nyɔ tɔ̀ɔ̀ séín mɛ ɖá nɔ̀ɓà nìà kɛ: 855-258-6518, ké m̀ mɛ fò tee ɓɛ́ wa kéɛ m̀ gbo cɛ̃ ɓɛ́ m̀ ké nɔ̀ɓà mɔ̀à 0 kɛɛ dyi pàɖàin hwɛ̀. Ɔ jǔ ké nyɔ ɖò dyi m̀ gɔ̌ jǔǐn, po wuɖu m̀ mɔ́ poɛ dyiɛ, ké nyɔ ɖò mu ɓó nìin ɓɛ́ ɔ ké nì wuɖuɔ̀ mú zà.

বাংলা (Bengali) লক্ষ্য করুন: এই নোটিশে আপনার বিমা কভারেজ সম্পর্কে তথ্য রয়েছে। এর মধ্যে গুরুত্বপূর্ণ তারিখ থাকতে পারে এবং নির্দিষ্ট তারিখের মধ্যে আপনাকে পদক্ষেপ নিতে হতে পারে। বিনা খরচে নিজের ভাষায় এই তথ্য পাওয়ার এবং সহায়তা পাওয়ার অধিকার আপনার আছে। সদস্যদেরকে তাদের পরিচয়পত্রের পিছনে থাকা নম্বরে কল করতে হবে। অন্যেরা 855-258-6518 নম্বরে কল করে 0 টিপতে না বলা পর্যন্ত অপেক্ষা করতে পারেন। যখন কোনো এজেন্ট উত্তর দেবেন তখন আপনার নিজের ভাষার নাম বলুন এবং আপনাকে দোভাষীর সঙ্গে সংযুক্ত করা হবে।

اردو (Urdu) توجہ :یہ نوٹس آپ کے انشورینس کوریج سے متعلق معلومات پر مشتمل ہے۔ اس میں کلیدی تاریخیں ہو سکتی ہیں اور ممکن ہے کہ آپ کو مخصوص آخری تاریخوں تک کارروائی کرنے کی ضرورت پڑے۔ آپ کے پاس یہ معلومات حاصل کرنے اور بغیر خرچہ کیے اپنی زبان میں مدد حاصل کرنے کا حق ہے۔ ممبران کو اپنے شناختی کارڈ کی پشت پر موجود فون نمبر پر کال کرنی چاہیے۔ سبھی دیگر لوگ 855-258-6518پر کال کر سکتے ہیں اور 0 دبانے کو کہے جانے تک انتظار کریں۔ ایجنٹ کے جواب دینے پر اپنی مطلوبہ زبان بتائیں اور مترجم سے مربوط ہو جائیں گے۔

فارسی (Farsi) توجه: این اعلامیه حاوی اطلاعاتی درباره پوشش بیمه شما است. ممکن است حاوی تاریخ های مهمی باشد و لازم است تا تاریخ مقرر شده خاصی اقدام کنید. شما از این حق برخوردار هستید تا این اطلاعات و راهنمایی را به صورت رایگان به زبان خودتان دریافت کنید.
اعضا باید با شماره درج شده در پشت کارت شناساییشان تماس بگیرند. سایر افراد می توانند با شماره
855-258-6518تماس بگیرند و منتظر بمانند تا از آنها خواسته شود عدد 0 را فشار دهند. بعد از پاسخگویی توسط یکی از اپراتورها، زبان مورد نیاز را تنظیم کنید تا به مترجم مربوطه وصل شوید.

اللغة العربية (Arabic) تنبيه :يحتوي هذا الإخطار على معلومات بشأن تغطيتك التأمينية، وقد يحتوي على تواريخ مهمة، وقد تحتاج إلى اتخاذ إجراءات بحلول مواعيد نهائية محددة .يحق لك الحصول على هذه المساعدة والمعلومات بلغتك بدون تحمل أي تكلفة .ينبغي على الأعضاء الاتصال على رقم الهاتف المذكور في ظهر بطاقة تعريف الهوية الخاصة بهم .يمكن للآخرين الاتصال على الرقم
855-258-6518 والانتظار خلال المحادثة حتى يطلب منهم الضغط على رقم .0 عند إجابة أحد الوكلاء، اذكر اللغة التي تحتاج إلى التواصل بها وسيتم توصيلك بأحد المترجمين الفوريين.

中文繁体 (Traditional Chinese) 注意：本聲明包含關於您的保險給付相關資訊。本聲明可能包含重要日期及您在特定期限之前需要採取的行動。您有權利免費獲得這份資訊，以及透過您的母語提供的協助服務。會員請撥打印在身分識別卡背面的電話號碼。其他所有人士可撥打電話 855-258-6518，並等候直到對話提示按下按鍵 0。當接線生回答時，請說出您需要使用的語言，這樣您就能與口譯人員連線。

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc.
CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst BlueChoice, Inc., First Care, Inc. and The Dental Network are independent licensees of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association.
®' Registered trademark of CareFirst of Maryland, Inc.

CareFirst Family of health care plans

Igbo (Igbo) Nrụbama: Ọkwa a nwere ozi gbasara mkpuchi nchekwa onwe gị. Ọ nwere ike ịnwe ụbọchị ndị dị mkpa, ị nwere ike ịme ihe tupu ụfọdụ ụbọchị njedebe. Ị nwere ikike ịnweta ozi na enyemaka a n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ndị otu kwesịrị ịkpọ akara ekwentị dị n'azụ nke kaadị njirimara ha. Ndị ọzọ niile nwere ike ịkpọ 855-258-6518 wee chere ụbụbọ ahụ ruo mgbe amanyere ịpị 0. Mgbe onye nnọchite anya zara, kwuo asụsụ ị chọrọ, a ga-ejikọ gị na onye ọkọwa okwu.

Deutsch (German) Achtung: Diese Mitteilung enthält Informationen über Ihren Versicherungsschutz. Sie kann wichtige Termine beinhalten, und Sie müssen gegebenenfalls innerhalb bestimmter Fristen reagieren. Sie haben das Recht, diese Informationen und weitere Unterstützung kostenlos in Ihrer Sprache zu erhalten. Als Mitglied verwenden Sie bitte die auf der Rückseite Ihrer Karte angegebene Telefonnummer. Alle anderen Personen rufen bitte die Nummer 855-258-6518 an und warten auf die Aufforderung, die Taste 0 zu drücken. Geben Sie dem Mitarbeiter die gewünschte Sprache an, damit er Sie mit einem Dolmetscher verbinden kann.

Français (French) Attention: cet avis contient des informations sur votre couverture d'assurance. Des dates importantes peuvent y figurer et il se peut que vous deviez entreprendre des démarches avant certaines échéances. Vous avez le droit d'obtenir gratuitement ces informations et de l'aide dans votre langue. Les membres doivent appeler le numéro de téléphone figurant à l'arrière de leur carte d'identification. Tous les autres peuvent appeler le 855-258-6518 et, après avoir écouté le message, appuyer sur le 0 lorsqu'ils seront invités à le faire. Lorsqu'un(e) employé(e) répondra, indiquez la langue que vous souhaitez et vous serez mis(e) en relation avec un interprète.

한국어(Korean) 주의: 이 통지서에는 보험 커버리지에 대한 정보가 포함되어 있습니다. 주요 날짜 및 조치를 취해야 하는 특정 기한이 포함될 수 있습니다. 귀하에게는 사용 언어로 해당 정보와 지원을 받을 권리가 있습니다. 회원이신 경우 ID 카드의 뒷면에 있는 전화번호로 연락해 주십시오. 회원이 아니신 경우 855-258-6518 번으로 전화하여 0을 누르라는 메시지가 들릴 때까지 기다리십시오. 연결된 상담원에게 필요한 언어를 말씀하시면 통역 서비스에 연결해 드립니다.

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst BlueChoice, Inc., First Care, Inc. and The Dental Network are independent licensees of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association. ®' Registered trademark of CareFirst of Maryland, Inc.