HIGHMARK

AGENT & OFFICE USE ONLY	
Date Received:	Effective Date:
Agent Name:	Agent NPN:

In which channel was this application received?

❑ Face to Face Consultation ❑ Medicare Options Seminar
❑ Highmark Direct Store ❑ Member Benefits Forum
❑ Pre-set Home Visit ❑ Other

APPLICATION FOR HIGHMARK MEDIGAP BLUE MEDICARE SUPPLEMENT INSURANCE PLANS

IMPORTANT: IF YOU ARE NOT ELIGIBLE FOR MEDICARE PART A AND ENROLLED IN MEDICARE PART B, YOU ARE NOT ELIGIBLE TO ENROLL IN MEDIGAP BLUE. DO NOT COMPLETE THIS APPLICATION.

SECTION I: APPLICANT INFORMATION

First Name	Middle Initial	Last Name			Suffix
Permanent Address	Apt#	City	State	Zip	County of Residence
Mailing Address (if different)	Apt#	City	State	Zip	
Birthdate MM/DD/YYYY	Social Security Number			Gender ❑ Male ❑ Female	
Preferred Telephone Number ❑ Home ❑ Mobile	Email Address				

Please provide your Medicare information below as shown on your red, white and blue Medicare Health Insurance card.

Medicare Number	Part A (Hospital) Effective Date	Part B (Medical) Effective Date
	/ /	/ /

SECTION II: PLAN SELECTION AND BILLING OPTIONS

Check the one plan for which you are enrolling. Rates subject to change. Enrollment subject to approval.
Please reference the enclosed Medigap Blue Outline of Coverage for the monthly premium based on your age and/or eligibility. If you have any questions or would like to speak with a licensed Medicare Advisor, call 1-888-692-5830. You may also reach out to your agent with questions.

Please indicate your plan choice below:

❑ Plan A
❑ Plan B
❑ Plan D
❑ Plan G
❑ Plan N

Additional plan options available **ONLY if first Medicare Eligible before 2020:**

❑ Plan C
❑ Plan F
❑ High Deductible Plan F

For an additional monthly subscription fee, would you like to enroll in the optional Whole Health Balance Program, which provides optional coverage for hearing, vision, dental and fitness? (See Whole Health Balance Program description for details.) ❑ Yes ❑ No

Requested Coverage Effective Date: / 01 /

In the future bill me*: ❑ Quarterly (every 3 months) ❑ Bimonthly (every 2 months) ❑ Monthly

**If electronic funds transfer (EFT) is desired, please complete and return a separate EFT application which is included.*

SECTION III: ELIGIBILITY FOR GUARANTEED ACCEPTANCE

Please answer all questions to determine if you are eligible for guaranteed acceptance:

1. Are you within 6 months of turning age 65? ❑ Yes ❑ No
2. Are you within 6 months of enrolling in Medicare Part B (Part B effective date on your Medicare card)? ❑ Yes ❑ No
3. Are you guaranteed acceptance into certain Medicare Supplement plans based on the conditions listed in the brochure "Important Information about Your Rights to Guaranteed Issue of Medicare Supplemental Policies" that you received with this application? ❑ Yes ❑ No
4. Are you currently enrolled in a non-Medigap Blue medical policy with Highmark? ❑ Yes ❑ No
5. Have you used any form of tobacco in the last 12 months? ❑ Yes ❑ No
6. If you are under age 65, did you enroll in Medicare due to End Stage Renal Disease? ❑ Yes ❑ No

If you answered "Yes" to any question 1, 2, 3, or 4 above, your application will be accepted. You can skip to section VII. Your answers to questions 5 and 6 will determine your premium rate.

7. Have you lost or are you losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you have certain rights to buy such a policy? ❑ Yes ❑ No

If you answered "Yes" to question 7, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application and skip to Section VII.

SECTION IV: HEALTH QUESTIONS TO DETERMINE ELIGIBILITY

If you answered "No" to all questions in Section III, complete this section in its entirety to determine if you are eligible for this coverage. If you are unsure how to respond, please consult your medical provider. Prior to approving your application for enrollment, Highmark reserves the right to review previous and current applications for coverage as well as claims history.

8. Were you enrolled in Medicare prior to age 65 due to a disability? ❑ Yes ❑ No

9. Are you now or have you been advised in the next year to be any of the following? ❑ Yes ❑ No
   - Admitted as an inpatient to a hospital
   - Confined to a nursing facility for other than short term rehabilitation
   - Paralyzed, bedridden or confined to a wheelchair
   - Receiving dialysis

10. Within the past 2 years, have you been diagnosed or treated (including prescription drugs) for any of the following conditions? Do not include any genetic information, such as family medical history or any information related to genetic testing, services or counseling. ❑ Yes ❑ No
    - Cancer (other than skin cancer), Leukemia or Lymphoma, Melanoma
    - Heart, Coronary, or Carotid Artery Disease (not including high blood pressure), Heart attack, Aneurysm, Congestive Heart Failure or any other type of Heart Failure, Enlarged Heart, Stroke, Transient Ischemic Attacks (TIA), or Hemophilia
    - Diabetes (using insulin)
    - Bone marrow or other organ transplant
    - ALS (Lou Gherig's Disease), Multiple Sclerosis (MS), Parkinson's, Systemic Lupus Erythematosus (SLE), Alzheimer's or Dementia
    - AIDS, AIDS Related Complex (ARC), or tested positive for HIV
    - Chronic Renal Disease such as ESRD
    - Cirrhosis of the Liver, Hepatitis C
    - Chronic Obstructive Pulmonary Disease (COPD), Emphysema
    - Alcohol Abuse or Alcoholism, Drug Abuse or use of illegal drugs
    - Bipolar or Manic Depressive, Schizophrenia, Psychological illness requiring hospitalization

11. Have you been advised to have a joint replacement in the next year, or have you received a joint replacement within the past 6 months? ❑ Yes ❑ No

If you answered YES to any of the questions in Section IV , you are not eligible for these plans.

SECTION V: HEALTH QUESTIONS TO DETERMINE RATE

If you answered "No" to all questions in Section III, complete this section in its entirety.
If you are unsure how to respond, please consult your medical provider.

12. Have you been diagnosed, received treatment (including prescription drugs), or had any of the following conditions?

Heart Conditions
A. Heart Rhythm Disorders ❑ Yes ❑ No

Musculoskeletal Conditions
B. Amputation due to disease ❑ Yes ❑ No
C. Rheumatoid Arthritis ❑ Yes ❑ No
D. Spinal Stenosis ❑ Yes ❑ No
E. Degenerative Disc or Herniated Disc ❑ Yes ❑ No
F. Osteoporosis ❑ Yes ❑ No

Gastrointestinal Conditions
G. Chronic Pancreatitis ❑ Yes ❑ No
H. Esophageal Varices ❑ Yes ❑ No
I. Ulcerative Colitis ❑ Yes ❑ No

13. Within the past 2 years, have you been hospitalized or had inpatient surgery? ❑ Yes ❑ No

SECTION VI: OTHER HEALTH INFORMATION

If you answered "No" to all questions in Section III, complete this section in its entirety to provide additional health information which is subject to underwriting review.

14. Enter your Height and Weight. Body Mass Index (BMI) values greater or equal to 40 may result in a higher rate or denial.

Height _____ ft. _____ inches Weight (lbs.) _____

15. List all prescription drugs you are currently taking or have been medically advised to take: (If none, write in "None." If additional space is needed, attach a separate page and sign and date that page.)

MEDICATION	AMOUNT	CONDITION FOR WHICH PRESCRIBED	CURRENTLY TAKING
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No

SECTION VII. ADDITIONAL INFORMATION

16. Are you covered for Medical Assistance through the state Medicaid program? ❑ Yes ❑ No

(NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question).

If yes,

A. Will Medicaid pay your premiums for this Medicare supplement policy? ❑ Yes ❑ No

B. Do you receive any benefits from Medicaid OTHER THAN payments towards your Medicare Part B premium? ❑ Yes ❑ No

17. If you had coverage from any Medicare plan other than the original Medicare within the last 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START / / END / /

18. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? ❑ Yes ❑ No

19. Was this your first time in this type of Medicare plan? ❑ Yes ❑ No

20. Did you drop a Medicare supplement policy to enroll in the Medicare plan? ❑ Yes ❑ No

21. Do you have another Medicare supplement policy in force? ❑ Yes ❑ No

If yes,

A. With what company _____

B. Letter Plan of existing policy _____

C. Current Rate Tier (Choose one of the following)

❑ Preferred ❑ Standard | ❑ Tobacco ❑ Non-tobacco | ❑ Other (Please specify) _____

D. Current Monthly Premium Amount _____

E. Do you intend to replace your current Medicare supplement policy with this policy? ❑ Yes ❑ No

22. Have you had coverage under any other health insurance within the past 63 days? ❑ Yes ❑ No

(For example, an employer, union, or individual plan)

A. If so, with what company and what kind of policy? _____

B. What are your dates of coverage under the policy? (If you are still covered under the other policy, leave "END" blank.) ❑ Yes ❑ No

START / / END / /

23. Do you have coverage under a Medicare Prescription Drug Program through Highmark or another company? ❑ Yes ❑ No

If Highmark, please list the identification number on the front of your ID card: _____

SECTION VIII. APPLICATION STATEMENTS FOR MEDICARE SUPPLEMENT PROGRAM

- You **do not need** more than one Medicare supplement policy
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy or, if the Medicare supplement policy is no longer available, a substantially equivalent policy will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

- If you are eligible for and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan.

  If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). Call ELDERinfo at 800-336-9500.

IMPORTANT: For the purposes of the sections that follow below, **"Creditable Health Care Coverage" includes, but is not limited to**, any Highmark group or individual health care program; another insurance company's individual, group, or Medicare Supplement program; certain Medicare health plans, for example, a Medicare health care maintenance organization (HMO) or preferred provider organization (PPO); a Program of All-Inclusive Care for the Elderly; or other government health plans such as Medicare, Medicaid, a state risk pool or FEHBP.

If you are currently enrolled in Creditable Health Care Coverage and your new Medigap Blue coverage will replace this Creditable Health Care Coverage without interruption - you are eligible for all Medigap Blue plan benefits as soon as your new coverage becomes effective. There is no waiting period for any pre-existing conditions you may have.

If you were previously, but are not currently, enrolled in some form of Creditable Health Care Coverage, you may be eligible for a waiver or reduction of your pre-existing condition exclusion if you satisfy **all** of the following requirements:

- Your prior Creditable Health Care Coverage was for a period of at least six (6) consecutive months; **and**
- You submit your completed application for Medigap Blue coverage to Highmark within sixty-three (63) days from the date that your most recent prior Creditable Health Care Coverage ended (or in certain instances, the date on which you were notified that your coverage will end); and
- You attach a copy of your "Certificate of Prior Creditable Coverage" to your application for Medigap Blue coverage or provide other proof of your Creditable Health Care Coverage prior coverage.

If you were not enrolled in any type of Creditable Health Care Coverage within the last sixty-three (63) day period prior to your application for Medigap Blue coverage, the following pre-existing exclusion clause will apply:

These Highmark Medigap Blue plans will not provide benefits during the first six (6) months of your coverage for any disease or physical condition for which you received treatment or advice from a physician during the six (6) month period before your new coverage became effective.

Notice: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The accuracy and validity of the information that you provide in the Application, including your responses to the health questionnaire, is subject to review by the Plan. The Plan reserves the right to take appropriate action in the event the information is not true or accurate.

The Plan shall terminate the Agreement if the Subscriber obtained or attempted to obtain benefits or payment for benefits as a result of a material misrepresentation. If benefits were provided due to a material misrepresentation, the Subscriber agrees to reimburse the Plan for such benefits.

I understand and agree that the terms and conditions of my coverage will be controlled by the written agreement with Highmark and that they may adopt reasonable policies, procedures, rules and interpretations to administer the program. I recognize that my coverage will only apply to services or supplies that are provided on or after the effective date of my coverage. To the best of my knowledge, the information provided on this application is true and correct.

I acknowledge and agree that certain personally identifiable information about me (collectively, "Personal Information") is subject to various statutory privacy standards, including, but not limited to, state insurance regulations implementing Title V of the Gramm-Leach-Bliley Act and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations adopted thereunder by the Department of Health and Human Services (45 CFR Parts 160, 162, 164). In accordance with those standards, Highmark may use and disclose Personal Information as permitted or required by law, and to facilitate payment, treatment and health care operations as described in its Notice of Privacy Practices ("NPP"). I understand that a copy of Highmark's current NPP is available on Highmark's Web site, or from the Highmark Privacy Department.

I hereby apply for coverage under the Highmark Medigap Blue Agreement. I understand this application is subject to approval by Highmark and the provisions of the Agreement.

I further understand that any approval of this application by Highmark is conditioned upon my being enrolled in Parts A and B of Medicare. If for any reason I am not enrolled in Medicare Part A or B, Highmark has the right to deny my application for Medigap Blue. If for any reason I become ineligible for Medicare A and B at some future date, I agree to notify Highmark immediately.

I understand that when I purchase this coverage, any other direct pay Highmark coverage I may have in effect will be cancelled as of the effective date of the Medigap Blue coverage.

I hereby authorize the Centers for Medicare and Medicaid Services (CMS) to furnish Highmark medical or other information acquired by it under the Title VII program (Medicare) to the extent necessary to process any claim under the Highmark Medigap Blue Agreement in effect with Highmark.

I understand the insurance producer cannot approve coverage. This Application does not guarantee that coverage will be provided. I further understand coverage, if provided, will not take effect until issued by Highmark and that the actual subscription rate will not be determined until coverage is issued. I understand the person discussing Medigap Blue plan options with me is either employed by or contracted with Highmark and may be entitled to receive compensation based on my enrollment in a plan.

To the best of my knowledge and belief, the information provided on this application is true and correct.

SIGNATURE

I hereby acknowledge and agree that I have received an Outline of Medicare Supplement Coverage and the Guide to Health Insurance for People with Medicare. My signature below verifies that I have read, understand and agree to all items contained in Section VIII ("Application Statements for Medicare Supplement Program") of this form:

_____ _____ Phone #: ( )

Signature Date

EMERGENCY CONTACT

_____ Phone #: ( )

Print Name

POWER OF ATTORNEY

_____ _____

Signature Date

THIS SECTION TO BE COMPLETED BY INSURANCE BROKER OR AGENT ONLY

A. List any other health insurance policies you have sold to this applicant which are still in force: _____

_____

B. List any other health insurance policies you have sold to this applicant in the past five years which are no longer in force:

_____

Signature of Agent or Broker _____ Date _____

Print Name and NPN _____

Agency Name and Number _____

Phone #: ( ) _____

FOR OFFICE USE:

_____

_____

_____

_____

INSTRUCTIONS FOR MAILING IN APPLICATION

Please review this checklist before you mail your application:

- ❑ Have you completed all required sections of the application form?
- ❑ Are your name and address written correctly on the application form?
- ❑ Have you attached your Certificate of Prior Creditable Coverage or your previous plan's letter of termination? (if applicable)
- ❑ Have you signed and dated your application?
- ❑ Have you attached the applicant's Power of Attorney or documentation of Legal Guardianship? (if applicable)

Return your completed application to us.

Use the envelope provided or mail to:

Highmark Blue Cross Blue Shield
P.O. Box 535049
Pittsburgh, PA 15253-9801

Benefits and/or benefit administration may be provided by or through Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield, which serves the state of Delaware and is an independent licensee of the Blue Cross Blue Shield Association.

All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

HIGHMARK
An Independent Licensee of the Blue Cross and Blue Shield Association

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Plan will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Plan will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Plan:

- 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 the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. 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 Avenue, 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.

Pennsylvania, Delaware, West Virginia, and New York: 1-844-679-6930 (TTY:711)

We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call the number provided for your state of residence. Someone who speaks English can help you. This is a free service.

Tenemos servicios gratis de interpretación para responder cualquier pregunta que pueda tener sobre nuestro plan médico o de medicamentos. Para obtener un intérprete, simplemente llame al número correspondiente a su estado de residencia. Alguien que hable español puede ayudarlo. Este servicio es gratis.

我们免费提供口译服务，为您解答有关我们健康计划或药物计划的任何疑问。如需口译服务，只需拨打您所在州相应的电话号码即可。说中文的工作人员可为您提供帮助。此项服务免费。

我們免費提供口譯服務，爲您解答有關我們健康計畫或藥物計畫的任何疑問。若要獲得口譯服務，只需撥打您所在州的電話號碼即可。講漢語的工作人員可爲您提供協助。此項服務免費。

Mayroon kaming mga libreng serbisyo ng interpreter para sagutin ang anumang tanong na posibleng mayroon ka tungkol sa aming planong pangkalusugan o plano sa gamot. Para kumuha ng interpreter, tawagan lang ang numerong ibinigay para sa estadong tinitirhan mo. May taong nagsasalita ng Tagalog na makakatulong sa iyo. Isa itong libreng serbisyo.

Nous disposons de services d'interprétation gratuits pour répondre à toutes les questions que vous vous posez sur notre régime d'assurance maladie ou d'assurance médicaments. Pour obtenir les services d'un interprète, il vous suffit d'appeler le numéro correspondant à votre État de résidence. Une personne parlant français pourra vous aider. Ce service est gratuit.

Chúng tôi cung cấp dịch vụ thông dịch miễn phí để giải đáp mọi thắc mắc của quý vị về chương trình sức khỏe hoặc thuốc của chúng tôi. Để có thông dịch viên, chỉ cần gọi số được cung cấp cho tiểu bang cư trú của quý vị. Ai đó nói Tiếng Việt có thể giúp quý vị. Đây là dịch vụ miễn phí.

Wir verfügen über kostenlose Dolmetschdienste, damit Sie alle eventuellen Fragen zu unserer Krankenversicherung oder zur Medikamenten-Zusatzversicherung klären können. Rufen Sie hierzu einfach die Nummer für den Bundesstaat an, in dem Sie Ihren Wohnsitz haben. Jemand, der Deutsch spricht, wird Ihnen behilflich sein. Dies ist ein kostenloser Service.

لدينا خدمات ترجمة فورية مجانية للإجابة عن أي أسئلة قد تراودك حول خطتنا الصحية أو الدوائية. للحصول على مترجم فوري، فقط اتصل بالرقم المقدم للولاية التي تقيم فيها. ويمكن لشخص يتحدث العربية مساعدتك. هذه خدمة مجانية.

건강 또는 약물 플랜에 대한 귀하의 질문에 답변해 드릴 수 있는 무료 통역 서비스를 제공해 드립니다. 통역사를 구하려면 거주하시는 주의 전화 번호로 문의하십시오. 한국어을(를) 말할 수 있는 직원이 도와드릴 수 있습니다. 이 서비스는 무료로 제공합니다.

Мы предоставляем бесплатные услуги устного перевода, чтобы помочь вам получить ответы на любые вопросы, которые могут у вас возникнуть в отношении нашего медицинского плана или плана лекарственных препаратов. Чтобы заказать услуги переводчика, просто позвоните по номеру, указанному для штата, в котором вы проживаете. Один из наших переводчиков, специализацией которого является русский язык, поможет вам. Эта услуга предоставляется бесплатно.

हमारे पास हमारी स्वास्थ्य या दवा योजना के बारे में आपके किसी भी प्रश्न का उत्तर देने के लिए मुफ्त दुभाषिया सेवाएँ हैं। एक दुभाषिया प्राप्त करने के लिए, बस अपने निवास स्थान की स्टेट के लिए दिए गए नंबर पर कॉल करें। हिंदी बोलने वाला कोई व्यक्ति आपकी सहायता कर सकता है। यह एक निःशुल्क सेवा है।

Disponiamo di servizi di interpretariato gratuiti per rispondere a ogni sua domanda riguardo al suo piano sanitario o farmaceutico. Per ottenere l'assistenza di un interprete, chiami il numero fornito per il suo stato di residenza. Qualcuno che parla italiano la aiuterà. Il servizio è gratuito.

Temos serviços de interpretação gratuitos para esclarecer suas dúvidas sobre nosso plano de saúde ou de medicamentos. Para contar com um intérprete, ligue para o número fornecido para o seu estado de residência. Alguém que fale Português pode ajudar você. Este é um serviço gratuito.

Nou gen sèvis entèpretasyon gratis pou reponn ak nenpòt kesyon ou ta ka genyen sou plan asirans sante oswa medikaman nou an. Pou jwenn yon entèprèt ede w, senpleman rele nimewo ki koresponn ak Eta kote w rete a. Yon moun ki pale Kreyòl Ayisyenap ede w. Sèvis sa a gratis.

Dysponujemy darmowymi usługami tłumaczeniowymi, dzięki którym może Pan/Pani uzyskać odpowiedzi na pytania dotyczące naszego planu zdrowia lub leków. Aby uzyskać pomoc tłumacza, wystarczy zadzwonić pod numer podany dla stanu, w którym Pan/Pani mieszka. Ktoś, kto zna język polsku, może Panu/Pani pomóc. Ta usługa jest darmowa.

当院では、無料の通訳サービスを用意し、治療や投薬計画に関するご質問にお答えしています。通訳を手配したい場合は、お住まいの州で指定された番号までお電話でご連絡ください。日本語話せる者が対応をお手伝いします。サービスは無料でご利用いただけます。