Alaska Individual Enrollment Application

January 1, 2013

2550 Denali Street, Suite 1404
Anchorage, AK 99503-2753
888-669-2583
Fax: 907-258-1619

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Please read all accompanying material before completing this application. All questions must have complete and accurate answers. Omissions or incomplete answers will result in the return of your application and may cause a delay in the effective date of your coverage.
Please PRINT, sign and date in ink.

SECTION 1 – AM I ELIGIBLE?

You're eligible to apply for a Premera plan if you are:

- A resident of and have a principal residence in the state of Alaska; and
- Not entitled to Medicare
  If you are 65 or older but not eligible for Medicare, please submit a "Not Eligible for Medicare" document from the Social Security Administration.

Eligible dependents that can enroll on your plan include:

- Your spouse or domestic partner
- Your natural or legally adopted child(ren) under the age of 26
- Child(ren) under the age of 26 and you are their legal guardian

SECTION 2 – TYPE OF APPLICATION (check one box)

Office Use Only
☐ Direct transfer

☐ New Enrollment Application:
Requested effective date: ____/____/_____ (month) ☐ 1st ☐ 15th (no more than 60 days after the signature date)
☐ YES ○ NO If you are a new applicant, have you had prior coverage with Premera in the last 12 months?

☐ Plan Change **(from and to a current Premera Plan)**: Subscriber ID# _____ (first of the month effective date only)

☐ Adding Spouse/Domestic Partner: Subscriber ID# _____ Date of Marriage: _____/_____/_____

☐ Adding Child: Subscriber ID# _____ ☐ Newborn ☐ Adoption* Date of birth / placement: ____/____/_____

☐ Adding Child: Legal Ward/Guardianship/Medical Child Support Order Date of Order: ____/____/_____ (attach copy of court order)
Subscriber ID# _____

* For adoption, attach a copy of placement/adoption agreement.

SECTION 3 – PRIMARY APPLICANT, SPOUSE/DOMESTIC PARTNER & DEPENDENT INFORMATION

Name—Last, First, Middle Initial (as you would like it to appear on your ID card—26 character max.)		**Social Security #**	**Height (Ft. In.)**	**Weight**	**Gender**	**Date of Birth (MM/DD/YYYY)**
Self					☐ Male ☐ Female	/ /
Legal Spouse/ Domestic Partner					☐ Male ☐ Female	/ /
Dependent Child (under 26 only)					☐ Male ☐ Female	/ /
Dependent Child (under 26 only)					☐ Male ☐ Female	/ /
Dependent Child (under 26 only)					☐ Male ☐ Female	/ /

Home Address (not P.O. Box) required	City / State / ZIP	Home Telephone Number ( )
Mailing Address (if different from Home Address)	City / State / ZIP	Work Telephone Number ( )
Billing Address (if different from Mailing Address)	City / State / ZIP	Cell Telephone Number ( )
E-mail Address of Primary Applicant		

SECTION 4 – BENEFIT PLAN SELECTION

Check one box to indicate your family's plan selection and deductible option:

1. Access Plan	Deductible Option:	☐ $10,000			
2. Safeguard Plan	Deductible Option:	☐ $2,500	☐ $5,000	☐ $7,500	
3. Safeguard III Plan	Deductible Option:	☐ $3,000	☐ $6,000		
4. Peak Plan	Deductible Option:	☐ $1,000	☐ $2,500	☐ $5,000	☐ $7,500
5. Peak III Plan	Deductible Option:	☐ $3,000	☐ $6,000		

Health Savings Account (HSA) Qualified Plans

6. Active HSA Plan	Deductible Option:	☐ $2,500 (Individual)	☐ $5,000 (Family)
7. Active HSA III Plan	Deductible Option:	☐ $3,250 (Individual)	☐ $6,450 (Family)
8. Secure HSA Plan	Deductible Option:	☐ $5,500 (Individual)	☐ $11,000 (Family)

SECTION 5 – DENTAL / VISION / HEARING

☐ Yes ○ No Dental/Vision/Hearing coverage is available to Alaska residents only.
I request additional information and an enrollment application.

FOR COMPANY USE ONLY

Producer Number | | | | | | **Subscriber ID** | | | | | | | | | | **Effective Date** / /

SECTION 6 – TOBACCO USE SECTION

The smoker rate will apply if either you or your spouse/domestic partner (if included on this application) has used tobacco products within the 12 months prior to this application. That person's rate(s) will be the smoker rate(s).

- I have used tobacco products during the prior 12 months: ☐ Yes ○ No
- My spouse/domestic partner has used tobacco products during the prior 12 months: ☐ Yes ○ No

SECTION 7 – RATE / BILLING INFORMATION

Will any of the subscription charges for this policy be paid from employer funds specifically designated for the purchase of health insurance or for healthcare expenses? This includes money from a health reimbursement account or extra wages specifically provided by your employer.
☐ Yes ○ No

If you answered yes:
- Does your employer offer a health benefit plan AND have they offered one in the last 6 months? ☐ Yes ○ No
- Are you eligible for your employer's health benefit plan? ☐ Yes ○ No

PAYMENT OPTIONS (*Do not send payment with this application)*
Select One: ☐ Monthly Billing (by mail) ☐ Monthly Automatic Funds Transfer (Complete Section 8.)

SECTION 8 – AUTOMATIC FUNDS TRANSFER AUTHORIZATION

I have selected the Automatic Funds Transfer (AFT), and I hereby authorize Premera to initiate funds transfer from the bank or depository financial institution account indicated below. I authorize my financial institution to honor these transfers.

Financial Institution or Bank Name	Bank Routing Number 9-digit number at the bottom of check (for checking account) or deposit slip (for savings account)
Account Holder's Name (print)	City, State, ZIP
Account Number	☐ Checking ☐ Savings

Additional Terms and Conditions:

- Funds are to be transferred on the **1st business day of each month** or as soon thereafter as practical, paying for that month's coverage. (For example: The deduction on February 1st pays for coverage in February.)
- I understand that if I have chosen an effective date of the 15th of the month, the initial transfer will be for the initial pro-rated month PLUS the first full month's subscription charge. Subsequent transfers will be for single months.
- I understand that this Automatic Funds Transfer Authorization will remain in effect until Premera has received notice from me that it should be cancelled. To ensure prompt cancellation of my Automatic Funds Transfer, this notice must be submitted at least 20 days prior to my next scheduled transfer. I have the right to stop payment of a specific transfer from my depository financial institution at least three days before the next scheduled withdrawal date.
- It may take as long as 45 days to set up an AFT. You may receive an invoice to cover initial month(s).
- I affirm that premiums for this plan are not paid by third parties or government agencies, except as required or allowed by law.

Please enclose a voided check (for checking account) or deposit slip (for savings account) from the account TO BE DEDUCTED.

Signature of Account Holder: **X** _____ Date (MM/DD/YYYY): ___/___/_____

SECTION 9 – ADDITIONAL INFORMATION

In addition to the information requested in this Alaska Individual Enrollment Application, please make certain to provide the information requested below **if it applies to you**. This information is used to determine eligibility for Interplan transfer and provides us other information important to your application for coverage. **If anyone applying for coverage is now or ever has been covered by a Blue Cross or Blue Shield plan, please provide complete information below.**

Subscriber Name	Group Number	Identification Number	Date Coverage Began	Date Coverage Ended/ Will End	State
			/ /	/ /	
			/ /	/ /	
			/ /	/ /	

SECTION 10 – CURRENT COVERAGE

Do you have health insurance coverage currently? ☐ Yes ○ No
If you answered "yes," what is the name of your insurance carrier? _____

What type of coverage is it? ☐ Group ☐ Individual ☐ Other (explain) _____

SECTION 11 – HEALTH QUESTIONNAIRE

Have you or *any family member listed* on this application ever experienced symptoms, been advised of, diagnosed with, received treatment or had treatment recommended for any of the following conditions? If you answer "yes" to any question in section 11, you will need to supply detail, in question 21 on page 5. This questionnaire must be completed for all family members listed.

Please check each item either Yes or No		Yes ☐	No ○
1.	**Alcohol or Drug Abuse / Dependence**		
a.	Alcohol / Chemical / Drug / DUI	☐	○
2.	**Autoimmune Disorders**		
a.	Lupus / Scleroderma / Mixed	☐	○
3.	**Bleeding / Blood / Circulatory Disorders**		
a.	Anemia / Bleeding / Hypercoagulation	☐	○
b.	Blood Disorder (TCP, etc.) / Leukemia	☐	○
c.	Aneurysm / Impaired Circulation	☐	○
d.	High Cholesterol, Triglycerides	☐	○
e.	Hypertension (Last: _____/____)	☐	○
f.	Phlebitis / Clots / Raynaud's / PVD	☐	○
4.	**Congenital Conditions**		
a.	Congenital Disorder / Birth Defects	☐	○
5.	**Ear / Nose / Throat / Eye**		
a.	Ear Infections (#____ past yr.) / Tubes	☐	○
b.	Nasal Malformation / Deviated Septum	☐	○
c.	Nasal Polyps / Sinusitis / Tonsillitis	☐	○
d.	Crossed Eyes / Strabismus	☐	○
e.	Retina / Macular: Detach, Degeneration	☐	○
f.	Cataract(s) / Lens Implants / Glaucoma	☐	○
6.	**Gastrointestinal Conditions**		
a.	Swallowing Problems / GERD / Reflux	☐	○
b.	Ulcers / Chronic Abd. Pain / Gallbladder	☐	○
c.	Diverticulitis / Hemorrhoids / IBS	☐	○
d.	Ulcerative Colitis / Crohn's / Colitis	☐	○
e.	Hernia (Specify type) / Polyps	☐	○
f.	Weight gain or loss > 10 lbs. within 1 yr.	☐	○
7.	**Glandular or Hormonal Disorders**		
a.	Diabetes / Elevated Blood Sugar	☐	○
b.	Goiter / Nodule / Thyroid: Hyper / Hypo	☐	○
c.	Adrenal / Pituitary Condition	☐	○
8.	**Heart Conditions**		
a.	Angina / Chest Pain / Heart Attack	☐	○
b.	Arterio-Atherosclerosis / Coronary Artery Disease / Congestive Failure	☐	○
c.	Heart Murmur / Arrhythmia / Pacemaker	☐	○
d.	Valve Disorder (Specify type, cause)	☐	○
9.	**Immune Disorders**		
a.	AIDS / AIDS Related Complex / HIV	☐	○
10.	**Kidney/Bladder Conditions**		
a.	Bladder: Infections / Incontinence	☐	○
b.	Kidney Infections / Kidney Stones	☐	○
c.	Kidney Failure / Nephritis	☐	○
11.	**Liver Conditions**		
a.	Hepatitis A / B / C / Other	☐	○
b.	Cirrhosis / Liver Failure	☐	○

Please check each item either Yes or No		Yes ☐	No ○
12.	**Musculoskeletal Conditions**		
a.	Chronic Back or Neck Pain / Strain	☐	○
b.	Disc Problems / Bone spurs	☐	○
c.	Arthritis / Rheumatoid / Osteoporosis	☐	○
d.	Fibromyalgia / Chronic Fatigue	☐	○
e	Muscular Dystrophy / Polio Residuals	☐	○
f.	Tendon / Joint: Inflammation / Gout / Carpal Tunnel / Replacement (Specify site)	☐	○
g.	Foot Disorder / Bunions / Hammertoe	☐	○
h.	Fractures (Specify site, hardware present)	☐	○
i.	Gait Abnormality / Loss of Limb(s)	☐	○
j.	Chronic Pain / Decreased Motion	☐	○
13.	**Mental Health Disorders**		
a.	Schizophrenia / Bipolar / Psychosis	☐	○
b.	Depression / Anxiety / Suicide Attempt	☐	○
c.	Anorexia / Bulimia	☐	○
d.	Attention Deficit Hyperactivity Disorder	☐	○
14.	**Neurological Conditions**		
a.	Brain Injury / Seizures / Cerebral Palsy	☐	○
b.	Stroke / TIA / Paralysis	☐	○
c.	Headaches (Recurrent or migraine)	☐	○
d.	MS / Alzheimer's / Huntington's / ALS / Parkinson's	☐	○
e.	Meningitis / Encephalitis	☐	○
f.	Developmental delay (Specify type, cause)	☐	○
15.	**Organ**		
a.	Transplant (Previous or pending)	☐	○
b.	Critical Organ Cyst / Tumor (i.e., brain)	☐	○
c.	Cancer (Specify type, location, extent)	☐	○
16.	**Reproductive System Conditions**		
a.	Menstrual Irregularity / Pregnant	☐	○
b.	Breast Disorder / Fibrocystic / Implant	☐	○
c.	Abnormal Pap Smear / Dysplasia	☐	○
d.	Endometrial / Uterine / Cervix Disorders	☐	○
e.	Ovarian / Testicular: Cyst / Torsion	☐	○
f.	Prostate Problems / Sexual Dysfunction	☐	○
17.	**Respiratory Conditions**		
a.	Allergies / Asthma / Sleep Apnea	☐	○
b.	Chronic Bronchitis / Pneumonia / TB	☐	○
c.	Lung Clot / Collapsed Lung	☐	○
d.	Chronic Obstructive Lung Diseases	☐	○
18.	**Sexually Transmitted Diseases**		
a.	Genital Herpes / HPV / Other	☐	○
19.	**Skin Conditions**		
a.	Burns / Scars / Acne / Ulcers (Specify site)	☐	○
20.	**Specify other condition(s) not listed above:**		
a.		☐	○
b.		☐	○

Note: Applicants under age 19 will not be denied coverage due to a health condition. Those age 19 and older must meet our medical underwriting guidelines to be accepted for coverage.

21. If you have answered "yes" to ANY of the previous questions or have experienced any other health issues, complete this question. Instructions: Include complete details including site, cause, and extent of condition. Attach additional sheet if needed. You may wish to submit copies of relevant medical records to expedite the process (at your own expense).

#	Name	Dates	Describe Condition	Provider	Current Status	Follow Up
		Start Mo ___ Yr ___	Diagnosis	Practitioner	Condition Present? ☐ Yes, persists OR ○ No, resolved *(Describe):*	Future Care? ☐ Yes, future surgery or treatment ○ No, resolved *(Describe type, reason):*
		End Mo ___ Yr ___	Treatment	Hospital _______ Days		
		Start Mo ___ Yr ___	Diagnosis	Practitioner	Condition Present? ☐ Yes, persists OR ○ No, resolved *(Describe):*	Future Care? ☐ Yes, future surgery or treatment ○ No, resolved *(Describe type, reason):*
		End Mo ___ Yr ___	Treatment	Hospital _______ Days		
		Start Mo ___ Yr ___	Diagnosis	Practitioner	Condition Present? ☐ Yes, persists OR ○ No, resolved *(Describe):*	Future Care? ☐ Yes, future surgery or treatment ○ No, resolved *(Describe type, reason):*
		End Mo ___ Yr ___	Treatment	Hospital _______ Days		
		Start Mo ___ Yr ___	Diagnosis	Practitioner	Condition Present? ☐ Yes, persists OR ○ No, resolved *(Describe):*	Future Care? ☐ Yes, future surgery or treatment ○ No, resolved *(Describe type, reason):*
		End Mo ___ Yr ___	Treatment	Hospital _______ Days		

22. ☐ Yes ○ No **Has anyone listed on this application taken medications within the past year?** If yes:

Name	Medication (name, dose, duration)	Prescriber	Diagnosis

23. ☐ Yes ○ No **Has any insurance company refused or restricted any insurance coverage for you or any person listed on this application?** If yes, explain:

____

____

24. ☐ Yes ○ No **Has any other future surgery, diagnostic testing or medical treatment been recommended or discussed for any person listed on this application?** If yes, explain:

____

____

25. ☐ Yes ○ No **Is any family member applying for coverage currently pregnant?** If yes, explain:

____

26. ☐ Yes ○ No **Is any person on this application, including male applicants and dependent males or females, responsible for a current pregnancy?** If yes, explain:

____

27. Please list the date of last menstrual cycle for every female applicant age 13 and over.

____

SECTION 12 – HEALTH INFORMATION

To identify applicants who may benefit from our health management programs, please complete the following questions.
Note: *Do not list individuals who will not be enrolled for coverage.*

A. ☐ Yes ○ No Do you or any dependents have a disability, chronic health condition (i.e., diabetes, heart condition, etc.), or been advised in the last 12 months that hospitalization, surgery or treatment is needed or pending?

NAME	REASON

SECTION 13 – NOTICE OF INFORMATION USE AND DISCLOSURE

Type Of Information To Be Disclosed: I (We) authorize: any physician, health care provider, hospital, insurance or reinsurance company, pharmacy benefits manager or third party benefits administrator to disclose a copy of my (our) personal health information, including any and all diagnostic, procedural, treatment, claim, prescription or other health related information including records concerning alcohol and/or chemical dependency, reproductive health (including abortion), sexually transmitted diseases, HIV, AIDS, psychiatric disorders and mental illness to Premera Blue Cross Blue Shield of Alaska (PBCBS AK) or its representatives as allowed by law.

Notice To Applicant: Except that each applicant, including any family member, listed on this form must provide information on diseases and disorders for which he or she has symptoms, please do not provide any information on any part of this application about genetic testing or genetic information relating to you or to any family member, including any decision by an insurance company that is based on a genetic test or on genetic information.

Purpose Of Disclosure: I (We) understand that personal information will be used for underwriting, evaluating enrollment in the health plan, determining eligibility for benefits and paying claims.

Timeframe Of Release: Unless I revoke it, this release will remain valid for twenty-four (24) months from the date of my signature below.

Revocation Of Release: I understand that I may change my mind and revoke this release at any time. I will do this by letting PBCBS AK know of my decision. Any change will be effective five (5) business days after PBCBS AK receives my written notice at the address listed on this form. I understand that some or all of this information may already have been used by PBCBS AK to make decisions, which will not be affected by its revocation.

Redisclosure: PBCBS AK may be required to redisclose this information to another party that is not subject to state and federal privacy rules.

Effect of Not Authorizing: This authorization is a condition of your enrollment in our health plan or your eligibility for benefits. If you decide not to sign this authorization, we may decline to enroll you in our health plan or to give you benefits.

Please Note: You or your authorized representative will receive a copy of this authorization.

SECTION 14 – BASIC TERMS OF ENROLLMENT

1.) I, the undersigned, apply for enrollment with Premera Blue Cross Blue Shield of Alaska (PBCBS AK) for myself and family members listed. To the best of my knowledge, the information provided on this application is complete and accurate. I understand the following terms and conditions:
   a. I have read this form, and I have supplied all of the requested information on this form. (If not, please attach a letter which explains why.)
   b. No one listed on this application is eligible for Medicare (Persons eligible for Medicare may apply for a Medicare Supplement contract offered by PBCBS AK.)

2.) **I understand and agree that**:
   a. Persons listed on this application must be residents of the State of Alaska in order to apply for and maintain coverage under this Contract. "Resident" means a person who currently lives in the State of Alaska and intends to live in the state permanently or indefinitely. In no event will coverage be extended to an applicant or family member who resides here for the primary purpose of obtaining health-care coverage. The confinement of a person in a nursing home, hospital, or other medical institution in the state shall not by itself be sufficient to qualify such person as a resident. We may require proof of residency from time to time. Such proof shall include, but not be limited to, the street address of the Enrollee's residence and not a post office box;
   b. Coverage does not begin until this application is received, reviewed and accepted by PBCBS AK and an effective date of coverage is assigned; and

SECTION 14 – BASIC TERMS OF ENROLLMENT (CONTINUED)

c. Once approved, coverage does not begin until my complete and correct payment is received. Receipt of any money by PBCBS AK prior to approval does not constitute coverage/enrollment under any Individual plan.

3.) **I also understand and agree that PBCBS AK may**:

a. Accept this application, but exclude certain conditions by rider. A rider is a form which, when attached to the contract, becomes a part thereof, and lists medical conditions for which coverage is not available under the contract, for the person specified, based on his/her past medical history. If a rider is required for enrollment, I will be notified in writing. Riders may be included only for members age 19 and older. All riders will remain for the duration of the coverage, or will be reviewed, upon the subscriber's request, after a period of five years of continuous coverage; or

b. Deny this application; or

c. Modify or cancel my contract retroactively to its effective date, deeming some or all entitlements or rights to benefits under the contract void, if I am involved in fraud, or I make any intentional misrepresentation of material fact on this application or health statement that affects my acceptance for coverage or the risk to be assumed by Premera.

SECTION 15 – SIGNATURES

1.) **I also understand and agree that**:

a. If accepted, this application becomes a part of my contract (a copy can be obtained upon request).

b. Further terms and conditions of enrollment are described in the contract.

c. Correct and complete payment of subscription charges must be made before benefits can be provided.

d. Any additions, deletions, or other alterations to the terms of conditions of enrollment are ineffective.

e. **This coverage is issued as individual health coverage, and is not sold or issued for use as an employer-sponsored group health plan except as allowed by law**.

2.) **I also understand and agree that no soliciting producer may**:

a. Accept risk for or waive any eligibility or underwriting requirements;

b. Make or modify the terms of the application or contract; or

c. Waive any of the PBCBS AK rights or requirements.

3.) If accepted, I authorize PBCBS AK, at its option, to pay providers directly for services rendered.

4.) **If transferring from another Premera Blue Cross Blue Shield of Alaska Individual Plan**: I understand that I and all approved dependents may be transferred to the requested plan and once transferred, any existing riders previously assigned will still apply on the new plan.

5.) I also understand that the plan I am applying for will not cover me or my enrolled family members for any care or treatment of a pre-existing condition as defined in the contract until 12 months after my effective date of coverage (except for individuals under 19 years of age). If I am transferring from PBCBS AK Group plan to a PBCBS AK Individual plan with no lapse in coverage, I may receive credit for my previous coverage.

6.) I/we authorize separate policies issued to any combination of family members approved, even if coverage for the main applicant is declined.
☐ Yes ○ No

7.) Have you received a product brochure containing benefit information and the exclusions and limitations of the Individual plans? ☐ Yes ○ No

Applications postmarked by the 14th of the month will be effective on the 15th of the same month, if approved (for new enrollment only). A pro-rated subscription charge will apply for the partial month of coverage. Applications postmarked by the last day of the month will be effective on the first day of the following month, if approved.

Be sure to sign and date the application. Signature applies to the completeness and correctness of the application and the release of information. A legally recognized spouse's or domestic partner's signature is required if applicable. All persons applying for coverage who are 18 years or older must sign and date below.

X _____	_____	___/___/___
Signature of Applicant/Subscriber* (subscriber must sign if adding legally recognized spouse/domestic partner or child)	Printed Name	Signature Date (mm/dd/yyyy)
X _____	_____	___/___/___
Signature of legally recognized spouse or domestic partner	Printed Name	Signature Date (mm/dd/yyyy)
X _____	_____	___/___/___
Signature of child age 18 or over	Printed Name	Signature Date (mm/dd/yyyy)
X _____	_____	___/___/___
Signature of child age 18 or over	Printed Name	Signature Date (mm/dd/yyyy)

*If not the applicant, I am the: ☐ Parent ☐ Holder of Power of Attorney ☐ Legal Guardian
(If you are the legal guardian or holder of a power of attorney for the applicant, attach legal documentation.)

SECTION 16 – PRODUCER USE ONLY

Completion of this section BY THE PRODUCER is required if the producer wishes to be considered the producer of record for this applicant. All producer information must be provided below to ensure credit/commission for the application and to enable the producer to receive copies of correspondence.

1. Are you aware of any information not disclosed on this application relating to the health habits of the applicant which might have bearing on the risk? ☐ Yes ○ No

2. Did you see the applicant at the time this application was completed? ☐ Yes ○ No
   If the answer is "YES" to question 1, and/or "NO" to question 2, please explain on a separate sheet.

<table>
<tr><td colspan="2">Producer Name (Please print)</td><td colspan="2">Producer Signature</td></tr>
<tr><td colspan="3">Street Address</td><td>PBCBS AK Producer Number</td></tr>
<tr><td>City</td><td>State</td><td>ZIP</td><td>Telephone Number</td></tr>
</table>

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

An Independent Licensee of the Blue Cross Blue Shield Association

Discrimination is Against the Law

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

Premera:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
Civil Rights Coordinator - Complaints and Appeals
PO Box 91102, Seattle, WA 98111
Toll free 855-332-4535, Fax 425-918-5592, TTY 800-842-5357
Email AppealsDepartmentInquiries@Premera.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence 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.

Getting Help in Other Languages

This Notice has Important Information. This notice may have important information about your application or coverage through Premera Blue Cross Blue Shield of Alaska. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 800-508-4722 (TTY: 800-842-5357).

አማሪኛ (Amharic):
ይህ ማስታወቂያ አስፈላጊ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም የ Premera Blue Cross Blue Shield of Alaska ሽፋን አስፈላጊ መረጃ ሊኖረው ይችላል። በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀኖች ሊኖሩ ይችላሉ። የጤናን ሽፋንዎን ለመጠበቅና በአከፋፈል እርዳታ ለማግኘት በተወሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ እንዲያገኙ እና ያለምንም ክፍያ በቋንቋዎ እርዳታ እንዲያገኙ መብት አለዎት።በስልክ ቁጥር 800-508-4722 (TTY: 800-842-5357) ይደውሉ።

العربية (Arabic):
يحوي هذا الإشعار معلومات هامة. قد يحوي هذا الإشعار معلومات مهمة بخصوص طلبك أو التغطية التي تريد الحصول عليها من خلال Premera Blue Cross Blue Shield of Alaska. قد تكون هناك تواريخ مهمة في هذا الإشعار. وقد تحتاج لاتخاذ إجراء في تواريخ معينة للحفاظ على تغطيتك الصحية أو للمساعدة في دفع التكاليف. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك دون تكبد أية تكلفة. اتصل بـ800-508-4722 (TTY: 800-842-5357)

中文 (Chinese):
本通知有重要的訊息。本通知可能有關於您透過 Premera Blue Cross Blue Shield of Alaska 提交的申請或保險的重要訊息。本通知內可能有重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 800-508-4722 (TTY: 800-842-5357)。

Oromoo (Cushite):
Beeksisni kun odeeffannoo barbaachisaa qaba. Beeksisti kun sagantaa yookan karaa Premera Blue Cross Blue Shield of Alaska tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qabaachuu danda'a. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa 800-508-4722 (TTY: 800-842-5357) tii bilbilaa.

Français (French):
Cet avis a d'importantes informations. Cet avis peut avoir d'importantes informations sur votre demande ou la couverture par l'intermédiaire de Premera Blue Cross Blue Shield of Alaska. Le présent avis peut contenir des dates clés. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez le 800-508-4722 (TTY: 800-842-5357).

Kreyòl ayisyen (Creole):
Avi sila a gen Enfòmasyon Enpòtan ladann. Avi sila a kapab genyen enfòmasyon enpòtan konsènan aplikasyon w lan oswa konsènan kouvèti asirans lan atravè Premera Blue Cross Blue Shield of Alaska. Kapab genyen dat ki enpòtan nan avi sila a. Ou ka gen pou pran kèk aksyon avan sèten dat limit pou ka kenbe kouvèti asirans sante w la oswa pou yo ka ede w avèk depans yo. Se dwa w pou resevwa enfòmasyon sa a ak asistans nan lang ou pale a, san ou pa gen pou peye pou sa. Rele nan 800-508-4722 (TTY: 800-842-5357).

Deutsche (German):
Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält unter Umständen wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Premera Blue Cross Blue Shield of Alaska. Suchen Sie nach eventuellen wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 800-508-4722 (TTY: 800-842-5357).

Hmoob (Hmong):
Tsab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb. Tej zaum tsab ntawv tshaj xo no muaj cov ntsiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog koj qhov kev pab cuam los ntawm Premera Blue Cross Blue Shield of Alaska. Tej zaum muaj cov hnub tseem ceeb uas sau rau hauv daim ntawv no. Tej zaum koj kuj yuav tau ua qee yam uas peb kom koj ua tsis pub dhau cov caij nyoog uas teev tseg rau hauv daim ntawv no mas koj thiaj yuav tau txais kev pab cuam kho mob los yog kev pab them tej nqi kho mob ntawd. Koj muaj cai kom lawv muab cov ntshiab lus no uas tau muab sau ua koj hom lus pub dawb rau koj. Hu rau 800-508-4722 (TTY: 800-842-5357).

Iloko (Ilocano):
Daytoy a Pakdaar ket naglaon iti Napateg nga Impormasion. Daytoy a pakdaar mabalin nga adda ket naglaon iti napateg nga impormasion maipanggep iti apliksayonyo wenno coverage babaen iti Premera Blue Cross Blue Shield of Alaska. Daytoy ket mabalin dagiti importante a petsa iti daytoy a pakdaar. Mabalin nga adda rumbeng nga aramidenyo nga addang sakbay dagiti partikular a naituding nga aldaw tapno mapagtalinaedyo ti coverage ti salun-atyo wenno tulong kadagiti gastos. Adda karbenganyo a mangala iti daytoy nga impormasion ken tulong iti bukodyo a pagsasao nga awan ti bayadanyo. Tumawag iti numero nga 800-508-4722 (TTY: 800-842-5357).

Italiano (Italian):
Questo avviso contiene informazioni importanti. Questo avviso può contenere informazioni importanti sulla tua domanda o copertura attraverso Premera Blue Cross Blue Shield of Alaska. Potrebbero esserci date chiave in questo avviso. Potrebbe essere necessario un tuo intervento entro una scadenza determinata per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere queste informazioni e assistenza nella tua lingua gratuitamente. Chiama 800-508-4722 (TTY: 800-842-5357).

日本語 (Japanese):
この通知には重要な情報が含まれています。この通知には、Premera Blue Cross Blue Shield of Alaska の申請または補償範囲に関する重要な情報が含まれている場合があります。この通知に記載されている可能性がある重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。800-508-4722 (TTY: 800-842-5357)までお電話ください。

한국어 (Korean):
본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 Premera Blue Cross Blue Shield of Alaska 를 통한 커버리지에 관한 정보를 포함하고 있을 수 있습니다. 본 통지서에는 핵심이 되는 날짜들이 있을 수 있습니다. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 800-508-4722 (TTY: 800-842-5357) 로 전화하십시오.

ລາວ (Lao):
ແຈ້ງການນີ້ມີຂໍ້ມູນສຳຄັນ. ແຈ້ງການນີ້ອາດຈະມີຂໍ້ມູນສຳຄັນກ່ຽວກັບຄຳຮ້ອງສະໝັກ ຫຼື ຄວາມຄຸ້ມຄອງປະກັນໄພຂອງທ່ານຜ່ານ Premera Blue Cross Blue Shield of Alaska. ອາດຈະມີວັນທີສຳຄັນໃນແຈ້ງການນີ້. ທ່ານອາດຈະຈຳເປັນຕ້ອງດຳເນີນການຕາມກຳນົດເວລາສະເພາະເພື່ອຮັກສາຄວາມຄຸ້ມຄອງປະກັນສຸຂະພາບ ຫຼື ຄວາມຊ່ວຍເຫຼືອເລື່ອງຄ່າໃຊ້ຈ່າຍຂອງທ່ານໄວ້. ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໃຫ້ໂທຫາ 800-508-4722 (TTY: 800-842-5357).

ភាសាខ្មែរ (Khmer):
សេចក្តីជូនដំណឹងនេះមានព័ត៌មានយ៉ាងសំខាន់ៗ សេចក្តីជូនដំណឹងនេះប្រហែលជាមានព័ត៌មានយ៉ាងសំខាន់អំពីទម្រង់បែបបទ ឬការរ៉ាប់រងរបស់អ្នកតាមរយៈ Premera Blue Cross Blue Shield of Alaska ។ ប្រហែលជាមាន កាលបរិច្ឆេទសំខាន់នៅក្នុងសេចក្តីជូនដំណឹងនេះ។ អ្នកប្រហែលជាត្រូវការបញ្ចេញសមត្ថភាពដល់កំណត់ថ្ងៃជាក់ច្បាស់នានា ដើម្បីនឹងរក្សាទុកការជានារ៉ាប់រងសុខភាពរបស់អ្នក ឬប្រាក់ជំនួយចេញផ្លែ។ អ្នកមានសិទ្ធិទទួលព័ត៌មាននេះ និងជំនួយនៅក្នុងភាសារបស់អ្នកដោយមិនអស់លុយឡើយ។ សូមទូរស័ព្ទ 800-508-4722 (TTY: 800-842-5357)។

ਪੰਜਾਬੀ (Punjabi):
ਇਸ ਨੋਟਿਸ ਵਿਚ ਖਾਸ ਜਾਣਕਾਰੀ ਹੈ. ਇਸ ਨੋਟਿਸ ਵਿਚ Premera Blue Cross Blue Shield of Alaska ਵਲੋਂ ਤੁਹਾਡੀ ਕਵਰੇਜ ਅਤੇ ਅਰਜੀ ਬਾਰੇ ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ ਹੋ ਸਕਦੀ ਹੈ . ਇਸ ਨੋਜਿਸ ਜਵਚ ਖਾਸ ਤਾਰੀਖਾ ਹੋ ਸਕਦੀਆਂ ਹਨ. ਜੇਕਰ ਤੁਸੀ ਜਸਹਤ ਕਵਰੇਜ ਰਿੱਖਣੀ ਹੋਵੇ ਜਾ ਓਸ ਦੀ ਲਾਗਤ ਜਵਿੱਚ ਮਦਦ ਦੇ ਇਛੁੱਕ ਹੋ ਤਾਂ ਤੁਹਾਨੂੰ ਅੰਤਮ ਤਾਰੀਖ਼ ਤੋਂ ਪਹਿਲਾਂ ਕੁੱਝ ਖਾਸ ਕਦਮ ਚੁੱਕਣ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ ,ਤੁਹਾਨੂੰ ਮੁਫ਼ਤ ਵਿੱਚ ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ ,ਕਾਲ 800-508-4722 (TTY: 800-842-5357).

فارسی (Farsi):
این اعلامیه حاوی اطلاعات مهم میباشد .این اعلامیه ممکن است حاوی اطلاعات مهم درباره فرم تقاضا و یا پوشش بیمه ای شما از طریق Premera Blue Cross Blue Shield of Alaska باشد. به تاریخ های مهم در این اعلامیه توجه نمایید .شما ممکن است برای حفظ پوشش بیمه تان یا کمک در پرداخت هزینه های درمانی تان، به تاریخ های مشخصی برای انجام کارهای خاصی احتیاج داشته باشید .شما حق این را دارید که این اطلاعات و کمک را به زبان خود به طور رایگان دریافت نمایید. برای کسب اطلاعات با شماره 800-508-4722 (کاربران TTY تماس باشماره 800-842-5357) تماس برقرار نمایید.

Polskie (Polish):
To ogłoszenie może zawierać ważne informacje. To ogłoszenie może zawierać ważne informacje odnośnie Państwa wniosku lub zakresu świadczeń poprzez Premera Blue Cross Blue Shield of Alaska. Prosimy zwrócic uwagę na kluczowe daty, które mogą być zawarte w tym ogłoszeniu aby nie przekroczyć terminów w przypadku utrzymania polisy ubezpieczeniowej lub pomocy związanej z kosztami. Macie Państwo prawo do bezpłatnej informacji we własnym języku. Zadzwońcie pod 800-508-4722 (TTY: 800-842-5357).

Português (Portuguese):
Este aviso contém informações importantes. Este aviso poderá conter informações importantes a respeito de sua aplicação ou cobertura por meio do Premera Blue Cross Blue Shield of Alaska. Poderão existir datas importantes neste aviso. Talvez seja necessário que você tome providências dentro de determinados prazos para manter sua cobertura de saúde ou ajuda de custos. Você tem o direito de obter esta informação e ajuda em seu idioma e sem custos. Ligue para 800-508-4722 (TTY: 800-842-5357).

Română (Romanian):
Prezenta notificare conține informații importante. Această notificare poate conține informații importante privind cererea sau acoperirea asigurării dumneavoastre de sănătate prin Premera Blue Cross Blue Shield of Alaska. Pot exista date cheie în această notificare. Este posibil să fie nevoie să acționați până la anumite termene limită pentru a vă menține acoperirea asigurării de sănătate sau asistența privitoare la costuri. Aveți dreptul de a obține gratuit aceste informații și ajutor în limba dumneavoastră. Sunați la 800-508-4722 (TTY: 800-842-5357).

Русский (Russian):
Настоящее уведомление содержит важную информацию. Это уведомление может содержать важную информацию о вашем заявлении или страховом покрытии через Premera Blue Cross Blue Shield of Alaska. В настоящем уведомлении могут быть указаны ключевые даты. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 800-508-4722 (TTY: 800-842-5357).

Fa'asamoa (Samoan):
Atonu ua iai i lenei fa'asilasilaga ni fa'amatalaga e sili ona taua e tatau ona e malamalama i ai. O lenei fa'asilasilaga o se fesoasoani e fa'amatala atili i ai i le tulaga o le polokalame, Premera Blue Cross Blue Shield of Alaska, ua e tau fia maua atu i ai. Fa'amolemole, ia e iloilo fa'alelei i aso fa'apitoa olo'o iai i lenei fa'asilasilaga taua. Masalo o le'a iai ni feau e tatau ona e faia ao le'i aulia le aso ua ta'ua i lenei fa'asilasilaga ina ia e iai pea ma maua fesoasoani mai ai i le polokalame a le Malo olo'o e iai i ai. Olo'o iai iate oe le aia tatau e maua atu i lenei fa'asilasilaga ma lenei fa'matalaga i legagana e te malamalama i ai aunoa ma se togiga tupe. Vili atu i le telefoni 800-508-4722 (TTY: 800-842-5357).

Español (Spanish):
Este Aviso contiene información importante. Es posible que este aviso contenga información importante acerca de su solicitud o cobertura a través de Premera Blue Cross Blue Shield of Alaska. Es posible que haya fechas clave en este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 800-508-4722 (TTY: 800-842-5357).

Tagalog (Tagalog):
Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay maaaring naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Premera Blue Cross Blue Shield of Alaska. Maaaring may mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 800-508-4722 (TTY: 800-842-5357).

ไทย (Thai):
ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้อาจมีข้อมูลที่สำคัญเกี่ยวกับการการสมัครหรือขอบเขตประกันสุขภาพของคุณผ่าน Premera Blue Cross Blue Shield of Alaska และอาจมีกำหนดการในประกาศนี้ คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร 800-508-4722 (TTY: 800-842-5357)

Український (Ukrainian):
Це повідомлення містить важливу інформацію. Це повідомлення може містити важливу інформацію про Ваше звернення щодо страхувального покриття через Premera Blue Cross Blue Shield of Alaska. Зверніть увагу на ключові дати, які можуть бути вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону 800-508-4722 (TTY: 800-842-5357).

Tiếng Việt (Vietnamese):
Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn xin tham gia hoặc hợp đồng bảo hiểm của quý vị qua chương trình Premera Blue Cross Blue Shield of Alaska. Xin xem ngày quan trọng trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 800-508-4722 (TTY: 800-842-5357).