Wellmark

Individual Health Plan Contract Change Form
(For Grandfathered Plans and pre-ACA Non-Grandfathered Plans)

Instructions: Use a ballpoint pen to complete the form and follow guidelines listed below:

GUIDELINES

Complete checked section if you are using this form to:	A	B	C	D	E	F	G	I
Add an eligible individual or a newborn to current coverage Reinstate an eligible individual on current coverage	✓	✓		✓		✓		✓
Change billing option	✓					✓		✓
Remove a member	✓	✓						✓
Remove a member and member moving to new policy	✓	✓	✓	✓		✓		✓
Remove the policyholder	✓	✓	✓	✓		✓		✓
Cancel entire policy	✓						✓	✓
Complete if removing an optional benefit	✓				✓			✓

A. EXISTING POLICYHOLDER INFORMATION

Existing Policyholder Name *(First, Middle, Last)*	Social Security Number/Tax Identification Number

Social Security Number (SSN) or Tax Identification Number (TIN) must be provided for you and every covered member for timely processing. Further review may be necessary if a SSN or TIN is not provided.

Please check the box to the left of item(s) you are changing and provide complete information. (Supporting documentation is required for all Special Enrollment Events.)

B. MAINTAINING COVERAGE

Removing Policyholder

- ☐ Active military duty
- ☐ Death
- ☐ Obtains Medicare coverage
- ☐ Obtains employer group coverage
- ☐ Obtains Medicaid coverage

List date of event: _____/_____/_____

Removing Member:

- ☐ Active military duty service (Please provide a copy of military papers, indicating date of entry.)
- ☐ Completion of full-time schooling of a dependent child age 26 or older
- ☐ Death
- ☐ Dependent child reaches age 26 and is not a full-time student or permanently disabled
- ☐ Divorce/annulment/legal separation
- ☐ Marriage of a dependent child age 26 or older
- ☐ Spouse obtains employer group coverage
- ☐ Other, Specify: _____

List date of event: _____/_____/_____ **List name(s) of member(s) removed:** _____

If removing a member without an event, your cancellation date will be the first of the month following your signature date on this change form.

Cancellation date will be as applicable:

- Day after death of policyholder or through the end of the month if family policy
- Date your Medicare coverage becomes effective
- Date you begin basic training or are called to active military service
- First of the month following start of employer group coverage (or same day if coverage starts on the first of the month)
- First of the month following start of Medicaid coverage (or same day if coverage starts on the first of the month)

Adding Eligible Member to Existing Policy

- ☐ Adoption/foster care
- ☐ Birth
- ☐ Court ordered coverage
- ☐ Legal guardianship
- ☐ Marriage, including common law
- ☐ Previously enrolled dependent loses coverage

List date of event: _____/_____/_____

Existing Policyholder Name *(First, Middle, Last)*	Social Security Number/Tax Identification Number

C. POLICYHOLDER INFORMATION - (If converting an existing policy to a different policyholder)

Policyholder Name *(First, Middle, Last)*		Social Security Number/Tax Identification Number[1]			
Physical/Home Address, Street	Bldg. Name/No., Apt. No.	PO Box	City	State	ZIP
Provide name of county in which policyholder resides:					
Mailing Address, Street (if different from Physical/Home Address)	Bldg. Name/No., Apt. No.	PO Box	City	State	ZIP
Telephone Number ( )	Email Address:				

D. MEMBERS ADDED TO EXISTING CONTRACT OR MEMBERS MOVED TO CONVERTED CONTRACT

Name (First, MI, Last)	Relationship	Date of Birth	Social Security Number / Tax Identification Number[1]	Gender	Full-time Student[2]	Disabled[2]	Tobacco User[3]
Applicant	Self			☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Spouse	Spouse			☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent 1				☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent 2				☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If you are adding a spouse/dependent to a Blue Advantage plan, you must select a personal doctor below.

☐ Yes ☐ No Are you, your spouse, or any dependents listed above enrolled in Medicare?

If yes, please provide names: _____

[1]The IRS requires Wellmark to collect SSNs/TINs for federal reporting purposes. Failure to provide the SSN/TIN information may result in a monetary penalty, per violation, assessed to you by the IRS.

[2]Disabled dependents and full-time students age 26 or older must be unmarried to be eligible for coverage as a dependent.

[3]Answer yes if the person listed has used any form of tobacco during the 12 months immediately preceding the date of this application.

Personal Doctor: Please choose a Personal Doctor for each member of your family. This information is required for applicants choosing an HMO (Wellmark Health Plan of Iowa, Inc.) plan, including family members who live outside the network area (for example, those who are under age 26 and remain on a parent's policy). The personal doctor you choose must participate in the network associated with your plan. In addition, female members may choose an OB/GYN. You can access the Wellmark provider directory at Wellmark.com/finder or by calling 800-978-3221. You may also see a Personal Doctor referred to as a Primary Care Provider (PCP) in other Wellmark documentation. (If you need to provide information for more than four dependents, please provide that information on a separate sheet of paper and attach to this application.)

For each person named in Section A and D, complete the following information:

Applicant

Doctor Name: _____

Doctor Address Line 1 (Street Address or Apt/Suite#): _____

Doctor Address Line 2 (PO Box, Street Address): _____

City: _____ State: _____ ZIP: _____

☐ Yes ☐ No Are you an established patient?

OB/GYN Name (optional): _____

OB/GYN Address Line 1 (Street Address or Apt/Suite#): _____

OB/GYN Address Line 2 (PO Box, Street Address): _____

City: _____ State: _____ ZIP: _____

☐ Yes ☐ No Are you an established patient?

Existing Policyholder Name *(First, Middle, Last)*	Social Security Number/Tax Identification Number

D. MEMBERS ADDED TO EXISTING CONTRACT OR MEMBERS MOVED TO NEW CONTRACT (CONT'D)

Personal Doctor, cont'd: Please choose a Personal Doctor for each member of your family. This information is required for applicants choosing an HMO (Wellmark Health Plan of Iowa, Inc.) plan, including family members who live outside the network area (for example, those who are under age 26 and remain on a parent's policy). The personal doctor you choose must participate in the network associated with your plan. In addition, female members may choose an OB/GYN. You can access the Wellmark provider directory at Wellmark.com/finder or by calling 800-978-3221. You may also see a Personal Doctor referred to as a Primary Care Provider (PCP) in other Wellmark documentation. (If you need to provide information for more than four dependents, please provide that information on a separate sheet of paper and attach to this application.)

For each person named in Section A and D, complete the following information:

Spouse

Doctor Name:_____

Doctor Address Line 1 (Street Address or Apt/Suite#):_____

Doctor Address Line 2 (PO Box, Street Address):_____

City:_____ State:_____ ZIP:_____

☐ Yes ☐ No Are you an established patient?

OB/GYN Name (optional):_____

OB/GYN Address Line 1 (Street Address or Apt/Suite#):_____

OB/GYN Address Line 2 (PO Box, Street Address):_____

City:_____ State:_____ ZIP:_____

☐ Yes ☐ No Are you an established patient?

Dependent 1

Doctor Name:_____

Doctor Address Line 1 (Street Address or Apt/Suite#):_____

Doctor Address Line 2 (PO Box, Street Address):_____

City:_____ State:_____ ZIP:_____

☐ Yes ☐ No Are you an established patient?

OB/GYN Name (optional):_____

OB/GYN Address Line 1 (Street Address or Apt/Suite#):_____

OB/GYN Address Line 2 (PO Box, Street Address):_____

City:_____ State:_____ ZIP:_____

☐ Yes ☐ No Are you an established patient?

Dependent 2

Doctor Name:_____

Doctor Address Line 1 (Street Address or Apt/Suite#):_____

Doctor Address Line 2 (PO Box, Street Address):_____

City:_____ State:_____ ZIP:_____

☐ Yes ☐ No Are you an established patient?

OB/GYN Name (optional):_____

OB/GYN Address Line 1 (Street Address or Apt/Suite#):_____

OB/GYN Address Line 2 (PO Box, Street Address):_____

City:_____ State:_____ ZIP:_____

☐ Yes ☐ No Are you an established patient?

Existing Policyholder Name *(First, Middle, Last)*	Social Security Number/Tax Identification Number

E. REMOVAL OF OPTIONAL BENEFITS

To remove an optional benefit, please check the box to the left of the optional benefit you would like to remove.

☐ **Blue Dental**

☐ **Contraceptives** *(Available with grandfathered plans only. Contraceptive coverage included with non-grandfathered plans.)*

F. BILLING INFORMATION - Complete if converted policyholder or changing billing option.

1. ☐ Yes ☐ No Will your employer be paying any part of the premium or fee for this policy?

If "Yes":

1a. ☐ Yes ☐ No Are you a sole proprietor purchasing coverage only for yourself, yourself and spouse/dependents, and not purchasing coverage for any common law employee?

1b. ☐ Yes ☐ No Is your premium being paid by your employer through after-tax wage adjustments or payroll deductions?

Note: If you answered "yes" to number 1 and "no" to both 1a and 1b – State and federal law prohibits an employer from contributing to the payment of an employee's premiums for this plan unless the applicant is the sole proprietor or owner of a sole proprietorship or the premium is being paid by the employer after tax wage adjustment or payroll deduction. Therefore, you are not eligible to have premiums withdrawn from an employer's account.

2. How do you want to pay for health premiums? **Please do not send payment with this form.**

Note: All billing periods are based on a calendar year.

a. ☐ **Direct Bill.** On what basis? ☐ Semi-annually ☐ Annually

If you checked a, provide the billing address if different than the policyholder's mailing address.

Billing street address_____ Bldg. Name/No., Apt. No._____ PO Box_____

City_____ State_____ ZIP_____

b. ☐ **Automatic Account Withdrawal from Policyholder's account.**

c. ☐ **Automatic Account Withdrawal from account other than Policyholder's.**

If you checked b or c, please complete the following:

On what basis? ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

Date of withdrawal: ☐ First of the month ☐ Fifth of the month

From: ☐ Checking

☐ Savings *(If you want to have premiums and fees withdrawn from your savings account, please complete Form M-5779.)*

Attach a voided check OR complete the following information:

Financial Institution Name: _____

Bank Account Name(s) (exactly as it appears on the account): _____

Financial Institution Routing Number (9 digits): _____

Account Number: _____

State Code (found on your check on top right corner above the date - e.g., 78): _____

If direct bill is ***not*** selected:

I hereby certify that I have read and understand the section below entitled "Authorization and Certification," and agree to the terms regarding automatic premium withdrawals as described therein. As the bank account holder, I authorize Wellmark to make automatic withdrawals from the account shown in the amount of the premium and fees. I understand and agree that notices of any premium and fee adjustments provided to the policyholder shall constitute notice to the undersigned of any such adjustment. This authorization supersedes and replaces any previous authorization given by me for automatic premium withdrawal.

Bank Account Holder's Signature (if other than Policyholder): _____ **Date:** _____/_____/_____

You may cancel automatic account withdrawal at any time. However, we need to receive your written notification by the 10th of the month before your next scheduled withdrawal.

G. CANCELLATION OF ENTIRE POLICY

I am requesting cancellation of my entire policy effective _____/ 1 /_____. I understand Wellmark does not allow cancellation on odd dates, and the earliest available cancellation date is the first day of the month after Wellmark's receipt of this request. My coverage will continue through the last day of the month in which I notify Wellmark to cancel. If I have vision and/or dental benefits for any member under age 19 included in my health coverage, these vision and/or dental benefits will be canceled with my health coverage. To cancel automatic account withdrawal, Wellmark must receive this request by the 10th of the month prior to my next scheduled withdrawal. To otherwise stop payment, I will notify my bank. I will be responsible for any associated fees from my bank.

H. EFFECTIVE DATES

The coverage effecitve dates will be assigned according to Wellmark guidelines. For special enrollment events, Wellmark must be notified within 60 days of the event. The coverage effective date for special enrollment events will be the first of the month following the event. Exceptions are birth, adoption, placement for adoption, legal guardianship, court-ordered coverage, and foster child placement, or as otherwise required or permitted under federal or state law. For those events, coverage effective date is the date of the event.

Existing Policyholder Name *(First, Middle, Last)*	Social Security Number/Tax Identification Number

I. AUTHORIZATION, CERTIFICATION AND SIGNATURE

I certify that I have carefully and fully read the Authorization and Certification language appearing below.

I certify that I am legally authorized to make changes in coverage for myself and on behalf of all other persons named on my current policy and in this form, and I further have confirmed with all persons named on my current policy and on this form that my signature is binding to change coverage. I further understand that coverage applied for will not start until this form and the appropriate premium and service fee payment amount, if applicable, are received and accepted by Wellmark.

If I am electing Health Plan Options offered by Wellmark Health Plan of Iowa, Inc., I understand that as a condition of eligibility for benefits under the coverage specified in this form, each person to be covered on one of these Health Plan Options must maintain his/her residency in an Iowa county. Failure to maintain such residency by any person named in this application will give Wellmark Health Plan of Iowa, Inc. the right to terminate the coverage specified in this application for that person not maintaining residency by giving that person not less than thirty (30) days notice in advance of termination of coverage and benefits will be denied unless the medical services are related to emergency services or an accidental injury.

The statements and answers set forth in this form are full, true, and correct. I have consulted with each other person named in this form to confirm that information about him/her is full, true, and correct. I understand that Wellmark will rely on the completeness and truthfulness of the information given in the statements made in this form or by telephone or in writing to Wellmark, and that, if I performed an act, practice, or omission that constitutes fraud or I have made an intentional misrepresentation of material fact in this form, Wellmark will be entitled to declare coverage applied for void and to refuse allowance of benefits to any person thereunder.

Special Enrollment Notification Period
For special enrollment events, Wellmark must be notified within 60 days of the event. Please see Section H for effective date information.

Tobacco User Status
If I answered "No" to the tobacco user question for any person listed in Section D, that person is eligible for a special tobacco non-user rate. If this status changes, I must notify Wellmark immediately. Wellmark may require me to recertify this status in the future. If Wellmark determines within the initial two years that this status is incorrect, Wellmark will retroactively collect historical differences in premiums before claims will be paid, and will start applying the tobacco user rate on the first of the month following Wellmark's receipt of this information.

Dental Exclusion Periods
In the event I am adding a member to Blue Dental coverage which is underwritten by Wellmark, Inc. doing business as Wellmark Blue Cross and Blue Shield of Iowa, I certify that I have been informed that there will be a six-month exclusion period before benefits are available for basic restorative services including, but not limited to, fillings, extractions, and oral surgery, and a 12-month exclusion period before benefits are available for major restorative services including, but not limited to endodontics, periodontics, crowns, onlays, and inlays. I understand these dental coverage exclusion periods will not be waived or reduced even if I or any other person named in this form have qualifying existing coverage or qualifying previous coverage.

Eligibility
If I become enrolled in Medicare during the term of this benefits policy, I understand that this benefits policy will provide benefits secondary to Medicare unless application of federal law determines this benefit policy must provide benefits primary to Medicare.

Providing Social Security Numbers or Tax Identification Numbers
In order for Wellmark to report my coverage status to the federal government, I understand I must provide to Wellmark my Social Security number or tax identification number and the Social Security numbers or tax identification numbers of all members covered under my coverage. The IRS requires that Wellmark report this information using the Social Security number or tax identification number of the plan member and each dependent. If Wellmark does not have Social Security or tax identification numbers, I understand that Wellmark will be unable to report and send the information needed to complete federal tax returns. If I have not previously provided the Social Security numbers or tax identification numbers to Wellmark for all members covered under my coverage, I will contact Wellmark by calling the Customer Service number on my ID card. I understand if I do not provide the Social Security numbers or taxpayer identification numbers to Wellmark for this purpose, I may be subject to a monetary penalty per violation imposed by the Internal Revenue Service.

Health Care Reform Mandates
If I currently have a grandfathered health plan, I understand that making a change to my current benefits could potentially change the grandfathered status of my health care plan. If I lose the grandfathered status of my health care plan, I may be required to move to an ACA health plan. If I currently have a pre-ACA non-grandfathered plan, I understand that making a change to my current benefits may require I move to an ACA health plan.

Payment Arrangements
I understand and agree that the amount of my periodic premium payment and fee, if applicable, will change as provided in the policy being applied for and from time to time based on changes in my coverage, including but not limited to, changes in benefits, payment obligations (such as deductible, coinsurance and copayments), the number of covered family members, members' ages, changes in tobacco user status, or other factors that require adjustments to the total premium and fee, if applicable. These changes may occur at times other than at annual or other policy renewal.

I further understand and agree that, if I have elected to authorize automatic premium withdrawals from a deposit account, the automatic withdrawal will change periodically to correspond with the applicable premium and fee. My authorization for automatic premium withdrawals shall include authorization for automatic withdrawal of any changed amount unless I call or provide my bank with written notice not less than three (3) business days before a scheduled withdrawal to stop the payment. If I call my bank to stop payment, I may be required to provide a

Existing Policyholder Name *(First, Middle, Last)*	Social Security Number/Tax Identification Number

I. AUTHORIZATION, CERTIFICATION AND SIGNATURE (CONT'D)

written request within fourteen (14) days after my call. I will be responsible for any fee assessed by my bank for stop-payment orders that I make.

Coverage Renewability
I understand that coverage is automatically renewed by payment of my premium and applicable fees in advance; that a grace period of 31 days will be granted for the payment of each premium and fee due after the first premium and fees; and that, during this grace period, my policy will continue in force.

I understand that Wellmark may terminate my policy if:

- I fail to pay my premium and service fee when due; or
- I fraudulently use my policy or make an intentional misrepresentation of a material fact under the terms of my policy; or
- I become ineligible for coverage under this policy; or
- Wellmark decides to terminate coverage of similar policies by giving written notice prior to termination. In the event Wellmark terminates individual policies of the same coverage, I will be allowed to transfer to the offered replacement policy.
- I change my residence from the geographic service area served by Wellmark Health Plan of Iowa, Inc. if I am enrolling in a health plan option offered by Wellmark Health Plan of Iowa, Inc.

Wellmark.com
Important information is available to you at *Wellmark.com/Inform* that addresses a number of topics such as Wellmark's guidelines on investigational and experimental procedures, the methodologies Wellmark uses to compensate providers, and information on how to access Wellmark's internal claims appeal and external review process. You can also obtain this information by calling Wellmark Customer Service at 800-978-3221.

Consent to receive Marketing Information and Solicitations Via Residential Telephone, Cellular Phone, Text and Email Messages
By checking the box later in this application and entering my signature on this application, I hereby provide my consent to Wellmark to contact me about Wellmark products and services that may be available to me. Wellmark may provide this information to me using residential telephone, cellular telephone or wireless device, text message or email contact information provided to Wellmark from time to time. If I provide a telephone number for voice calls, I understand that Wellmark may contact me via live or prerecorded calls. I give Wellmark permission to use my personal data (including personally identifiable information) in accordance with Wellmark's privacy policy to determine the types of products and services that may be offered to me. I understand the telephone company or other communications carrier may impose charges for these contacts and that I am not required to give this consent to purchase any goods or service. I understand I may revoke this consent at any time by calling 800-819-0893.

Consent to Electronic Delivery of Information
By checking the box later in this application and entering my signature on this application, I hereby provide my consent to Wellmark to deliver important notices and information about my health plan and coverage electronically. I understand I am being asked to consent to notices and documents being delivered to me electronically. My consent applies to notices and documents relating to my health insurance coverage ("Coverage") with Wellmark.

Right to Request for Paper Copies
I understand that I have the right to have a notice or document provided or made available in paper form at no cost. To obtain a paper copy of a notice or document delivered by electronic means or to withdraw consent, please contact Wellmark at 800-819-0893.

Right to Withdraw Consent
I understand that I have the right to withdraw consent to have a notice or document delivered by electronic means. Such consent will be deemed withdrawn upon receipt by Wellmark of the request to withdraw consent. Any withdrawal of consent shall not affect the legal effectiveness, acidity or enforceability a notice or document delivered by electronic means before the withdrawal of consent is effective. To withdrawal consent for electronic notice of documents please contact Wellmark at 800-819-0893 or select "unsubscribe" option located within the email message.

Scope of Consent
This consent applies to all notices and documents relating to my Coverage, including, but not limited to:

- Explanation of Benefits;
- Disclosures and notices;
- Summary of Benefits and Coverage;
- Notices of cancellation, nonrenewal or termination;
- Benefits Policy, riders or endorsements;
- Responses to communications from you;
- Appeals correspondence;
- Billing and payment notices; and
- Other important information

Hardware and Software Requirements
In order to access, view and retain documents electronically, I understand I must have access to a personal computer or other device capable of accessing the internet with a web browser, email or web service capabilities, the ability to receive and review attachments to emails and software which permits me to receive and access Portable Document Format (PDF) files and MS Word files. Free software to view PDF files

Existing Policyholder Name *(First, Middle, Last)*	Social Security Number/Tax Identification Number

I. AUTHORIZATION, CERTIFICATION AND SIGNATURE (CONT'D)

is available from: http://get.adobe.com/reader/. I confirm that I have access to the hardware and software necessary to receive and review electronic records and I have an active email account with the ability to receive and access emails and email attachments in the formats described.

NOTICE/DISCLAIMER

WELLMARK IS NOT RESPONSIBLE FOR ANY UNAUTHORIZED ACCESS BY THIRD PARTIES TO INFORMATION PROVIDED ELECTRONICALLY, INCLUDING, WITHOUT LIMITATION, ANY DIRECT, INDIRECT, SPECIAL, INCIDENTAL OR CONSEQUENTIAL DAMAGES RESULTING FROM SUCH UNAUTHORIZED ACCESS. WELLMARK ALSO IS NOT RESPONSIBLE FOR DELAYS IN TRANSMISSION OF NOTICES AND DOCUMENTS.

CONSENT

By accessing or opening the documents sent to me via the email address provided, I certify that (1) I consent and agree to receive notices and documents electronically and confirm that I will download or print them for my records; and (2) I have the ability to access the information that is provided electronically via email communications.

☐ I give my permission to the licensed agent/licensed agency who is identified with this application to enter my application on line through Wellmark.com.

☐ I authorize Wellmark to contact me via residential telephone, cellular phone, text and/or email for marketing purposes (**optional**).

☐ I consent to receive important information electronically (**optional**).

ACKNOWLEDGEMENT

I have read and understand the Authorization and Certification language and hereby confirm the authority of Wellmark to make automatic withdrawals from my deposit account as described therein. This authorization supersedes and replaces any previous authorizations given by me for automatic premium withdrawal.

If a Wellmark Health Plan of Iowa, Inc. plan option was selected the applicant is a resident of Iowa.

Existing Policyholder Signature X _____ Date _____/_____/_____

Converted Policyholder Signature X _____ Date _____/_____/_____

If applicant is a minor, please sign below.

Parent/Legal Guardian Printed Name _____

Parent/Legal Guardian Signature X_____ Date _____/_____/_____

If child(ren) only policy, list parent's (s')/legal guardian's (s') name(s) _____

Agent Signature, if applicable X_____ Agent No. __ __ __ __ __ __ __ __

This completed contract change form (pages 1 - 6) must be received within 15 days of the signature date.

Send completed form to:

Wellmark Blue Cross and Blue Shield of Iowa
Mail Station 3W190
PO Box 14527
Des Moines, IA 50306-3527
OR
Fax to: 515-376-9045
OR
E-mail to: INDMEMMAIN@wellmark.com

Required Federal Accessibility and Nondiscrimination Notice

Discrimination is against the law

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

Wellmark provides:

- Free aids and services to people with disabilities so they may communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- 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, call 800-524-9242.

If you believe that Wellmark 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: Wellmark Civil Rights Coordinator, 1331 Grand Avenue, Station 5W189, Des Moines, IA 50309-2901, 515-376-4500, TTY 888-781-4262, Fax 515-376-9073, Email CRC@Wellmark.com. You can file a grievance in person, by mail, fax or email. If you need help filing a grievance, the Wellmark 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, phone or fax at: U.S. Department of Health and Human Services, 200 Independence Avenue S.W., Room 509F, HHH Building, Washington DC 20201, 800-368-1019, 800-537-7697 (TDD).

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

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意：如果您说普通话，我们可免费为您提供语言协助服务。请拨打 800-524-9242 或（听障专线：888-781-4262）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobe oštećena sluha: 888-781-4262).

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 800-524-9242 أو (خدمة الهاتف النصي: 888-781-4262).

ສ່ຽງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາ ໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ຫາ. (TTY: 888-781-4262.)

주의: 한국어 를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

ध्यान रखें : अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, नि:शुल्क उपलब्ध हैं। 800-524-9242 पर संपर्क करें या (TTY: 888-781-4262)।

ATTENTION : si vous parlez français, des services d'assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

Geb Acht: Wann du Deitsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิดค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

တၢ်နုးသ့ဉ်ညါ–နမ့ၢ်ကတိၤကညီကျိာ်.ကျိာ်တၢ်မၤစၢၤတၢ်ဖံးတၢ်မၤတဖဉ်.လၢတဘဉ်လာ်ဘူးလဲ.ဆိဉ်လၢနဂီၢ်လီၤ.ဆဲးကျိုးဆူ ၈၀၀–၅၂၄–၉၂၄၂မ့တမ့ၢ်(TTY:၈၈၈–၇၈၁–၄၂၆၂)တက့ၢ်.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

सावधान: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंका लागि नि:शुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ। 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस्।

ማሳሰቢያ: አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ እገዛ አገልግሎቶች፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም (በTTY: 888-781-4262) ይሙሉ ያነጋግሩን።

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maaɗa. Heɓir 800-524-9242 malla (TTY: 888-781-4262).

FUULEFFANNAA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajiloonni gargaarsa afaanii, kaffaltii malee, isiniif ni jiru. 800-524-9242 yookin (TTY: 888-781-4262) quunnamaa.

УВАГА! Якщо ви розмовляєте українською мовою, для вас доступні безкоштовні послуги мовної підтримки. Зателефонуйте за номером 800-524-9242 або (телетайп: 888-781-4262).

Ge': Diné k'ehjí yáníłti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóló. Kojį' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)

09/16 A