



California Small Group Business (1 - 50 Eligible Employees) Employee Enrollment/Change Form

TO COMPLY WITH CALIFORNIA LAW WHEREVER THE TERM "SPOUSE" APPEARS IT SHALL BE CONSTRUED TO INCLUDE DOMESTIC PARTNER.

Coverage is provided by the following entities: Aetna Health of California Inc. for HMO, Aetna Dental of California Inc. for Dental (DMO® only) and Aetna Life Insurance Company for all other coverages.

| | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|
| Group Number | | | | | | | | | | |
| Applicant Social Security Number | | | | | | | | | | |
| <table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table> | | | | | | | | | | |
| | | | | | | | | | | |

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|-----------------------|---|---|---|---|--|
| Company Name | | INSTRUCTIONS: You, the employee, must complete this enrollment form in full or it will be returned to you resulting in a delay in processing. You are solely responsible for its accuracy and completeness. If enrolling, please be sure to sign and date Employee Signature on Page 4. If waiving coverage, please complete Section B and Declination/Waiver of Coverage on Page 5 only. | | | |
| Effective Date | <input type="checkbox"/> New Hire <input type="checkbox"/> Rehire/Reinstatement <input type="checkbox"/> New Group Enrollment <input type="checkbox"/> Late Enrollment <input type="checkbox"/> Other _____ | <input type="checkbox"/> Add Spouse/Dependent Child <input type="checkbox"/> Change of Coverage <input type="checkbox"/> Name Change <input type="checkbox"/> Other _____ | <input type="checkbox"/> Employee Termination <input type="checkbox"/> Remove Spouse/Dependent Child <input type="checkbox"/> Cancel Coverage | <input type="checkbox"/> COBRA <input type="checkbox"/> Cal-COBRA for: <input type="checkbox"/> Employee <input type="checkbox"/> Dependent Length of Continuation: <input type="checkbox"/> 18 <input type="checkbox"/> 36 <input type="checkbox"/> Other _____ Original Qualifying Event Date _____ Loss of Coverage Date _____ | |
| Date of Hire | | | | | |

A. Coverage Selection – Please print clearly, using black ink. (Shaded sections for Employer/Aetna Use Only)

| Control/Group No. | Suffix | Account | Plan No. | Class Code |
|---|--|---------------------------------------|------------------------------------|------------------------------------|
| [1. Medical | | | | |
| PLAN NAME | | Networks | | |
| Select Plan Option(s) and then check the box(es) for the Networks you choose for each Plan. | | | | |
| <input type="checkbox"/> Platinum Vitalidad HMO 25 | <input type="checkbox"/> Vitalidad HMO | | | |
| <input type="checkbox"/> Platinum HMO Copay Plan | <input type="checkbox"/> HMO | <input type="checkbox"/> AVN HMO | <input type="checkbox"/> Basic HMO | |
| <input type="checkbox"/> Gold HMO 10 | <input type="checkbox"/> HMO | <input type="checkbox"/> AVN HMO | <input type="checkbox"/> Basic HMO | <input type="checkbox"/> PrimeCare |
| <input type="checkbox"/> Gold HMO 20 | <input type="checkbox"/> HMO | <input type="checkbox"/> AVN HMO | <input type="checkbox"/> Basic HMO | |
| <input type="checkbox"/> Gold HMO 30 | <input type="checkbox"/> HMO | <input type="checkbox"/> AVN HMO | <input type="checkbox"/> Basic HMO | <input type="checkbox"/> PrimeCare |
| <input type="checkbox"/> Gold HMO Copay Plan | <input type="checkbox"/> HMO | <input type="checkbox"/> AVN HMO | <input type="checkbox"/> Basic HMO | |
| <input type="checkbox"/> Silver HMO Deductible 1000 | <input type="checkbox"/> Basic HMO | <input type="checkbox"/> HMO DED | <input type="checkbox"/> PrimeCare | |
| <input type="checkbox"/> Silver HMO Deductible 1500 | <input type="checkbox"/> Basic HMO | <input type="checkbox"/> HMO DED | | |
| <input type="checkbox"/> Silver HMO Deductible 2000 | <input type="checkbox"/> Basic HMO | <input type="checkbox"/> HMO DED | <input type="checkbox"/> PrimeCare | |
| <input type="checkbox"/> Silver HMO Deductible Copay Plan | <input type="checkbox"/> Basic HMO | <input type="checkbox"/> HMO DED | | |
| <input type="checkbox"/> Bronze HMO Deductible 5500 | <input type="checkbox"/> Basic HMO | <input type="checkbox"/> HMO DED | <input type="checkbox"/> PrimeCare | |
| <input type="checkbox"/> Platinum MC Copay Plan | <input type="checkbox"/> MC | <input type="checkbox"/> Savings Plus | | |
| <input type="checkbox"/> Gold MC 500 80/50 | <input type="checkbox"/> MC | <input type="checkbox"/> Savings Plus | | |
| <input type="checkbox"/> Gold MC Copay Plan | <input type="checkbox"/> MC | <input type="checkbox"/> Savings Plus | | |
| <input type="checkbox"/> Silver MC 1000 75/50 | <input type="checkbox"/> MC | <input type="checkbox"/> Savings Plus | | |
| <input type="checkbox"/> Silver MC 1000 60/50 | <input type="checkbox"/> MC | <input type="checkbox"/> Savings Plus | <input type="checkbox"/> PrimeCare | |
| <input type="checkbox"/> Silver MC 1500 60/50 | <input type="checkbox"/> MC | <input type="checkbox"/> Savings Plus | <input type="checkbox"/> PrimeCare | |
| <input type="checkbox"/> Silver MC 2000 60/50 | <input type="checkbox"/> MC | <input type="checkbox"/> Savings Plus | | |
| <input type="checkbox"/> Silver MC Coinsurance Plan | <input type="checkbox"/> MC | <input type="checkbox"/> Savings Plus | |] |

A. Coverage Selection (continued)

| | | | | |
|--|------------------------------|---------------------------------------|------------------------------------|--|
| [1. Medical - continued] | | | | |
| PLAN NAME | | Networks | | |
| <input type="checkbox"/> Bronze MC 3500 50/50 | <input type="checkbox"/> MC | <input type="checkbox"/> Savings Plus | | |
| <input type="checkbox"/> Bronze MC 4000 Copay Plan | <input type="checkbox"/> MC | <input type="checkbox"/> Savings Plus | | |
| <input type="checkbox"/> Bronze MC 6350 100/50 | <input type="checkbox"/> MC | <input type="checkbox"/> Savings Plus | <input type="checkbox"/> PrimeCare | |
| <input type="checkbox"/> Bronze MC Plan | <input type="checkbox"/> MC | <input type="checkbox"/> Savings Plus | | |
| <input type="checkbox"/> Bronze MC HSA 2500 50/50 | <input type="checkbox"/> MC | <input type="checkbox"/> Savings Plus | | |
| <input type="checkbox"/> Bronze MC HSA 3500 70/50 | <input type="checkbox"/> MC | <input type="checkbox"/> Savings Plus | <input type="checkbox"/> PrimeCare | |
| <input type="checkbox"/> Bronze MC HSA 6300 100/50 | <input type="checkbox"/> MC | <input type="checkbox"/> Savings Plus | <input type="checkbox"/> PrimeCare | |
| <input type="checkbox"/> Gold PPO 750 | <input type="checkbox"/> PPO | | | |
| <input type="checkbox"/> Silver Indemnity] | | | | |

| | | | |
|-------------------|--------|---------|----------|
| Control/Group No. | Suffix | Account | Plan No. |
|-------------------|--------|---------|----------|

[2. Dental - Check one (if applicable).

Standard Plans: Aetna Dental® Plan - Plan Option: _____ For FOC, choose: DMO® or PPO

Voluntary Plans: Aetna Dental® Plan - Plan Option: _____ For FOC, choose: DMO® or PPO

Before today, were you covered under this employer's dental plan? Yes No]

| | | | |
|-------------------|--------|---------|----------|
| Control/Group No. | Suffix | Account | Plan No. |
|-------------------|--------|---------|----------|

[3. Life (if applicable)

Basic Life/AD&D Ultra® Optional Dependent Life

| | | |
|--|---|--------------------------------------|
| Full Beneficiary Name (First, Middle, Last) | Beneficiary Social Security Number | Birthdate (MM/DD/YYYY) / / |
| Beneficiary Address (Number, Street, Apt. No., City, State, ZIP Code) | Telephone Number () - | Relationship to Employee] |

B. Employee Information - Must be completed by the employee.

| | | | | |
|--|--|---|--|------------------|
| Member Aetna ID Number (if available) | Last Name, First Name, M.I. | | | |
| Home Address (PO Box not acceptable) | | Apt. No. | City, State | ZIP Code |
| Work Address (PO Box not acceptable) | | City, State | | ZIP Code |
| Home Telephone | Work Telephone | Primary Language Spoken (Optional) | Number of Dependents enrolling for coverage including Spouse | |
| Salary \$ _____ | <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly | Number of Hours Worked Per Week | Check One: <input type="checkbox"/> Full-Time <input type="checkbox"/> 1099 <input type="checkbox"/> Seasonal <input type="checkbox"/> Union <input type="checkbox"/> Part-Time <input type="checkbox"/> Retiree <input type="checkbox"/> Temporary | Job Title |

C. Individuals Covered - List individuals for whom you are enrolling or adding/changing/removing coverage. Insert additional sheets if necessary. For dependents with different last names or living at another address, complete Section D below. NOTE FOR MEDICAL AND DENTAL COVERAGE: While the Federal Patient Protection and Affordable Care Act mandates coverage of dependent children up to age 26, your plan may allow coverage beyond age 26. Disabled children may be covered if they are over age 26. Some exceptions apply. Please refer to your plan documents or contact your benefits administrator.

| | | | | | |
|--|--|---|-------------------------------|--|--|
| 1 | Employee Name (Last, First, M.I.) | Sex (M/F) | Social Security Number | Birthdate (MM/DD/YYYY) / / | |
| Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Domestic Partnership | | Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life | | PCP Provider Office ID Number | Current Patient <input type="checkbox"/> |
| 2 | Name (Last, First, M.I.) | Sex (M/F) | Social Security Number | Birthdate (MM/DD/YYYY) / / | |
| Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Other _____ | | Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life | | PCP Provider Office ID Number | Current Patient <input type="checkbox"/> |
| | | | | Dental Office ID Number (if applicable) | Current Patient <input type="checkbox"/> |

continued on next page

C. Individuals Covered (continued)

| | | | | | | | |
|---|---------------------------------------|--|------------------------|-------------------------------|---|---|---|
| 3 | Child Name (Last, First, M.I.) | Sex (M/F) | Social Security Number | Birthdate (MM/DD/YYYY) / / | | | |
| Relationship <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____ | | Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life | | PCP Provider Office ID Number | Current Patient <input type="checkbox"/> | Dental Office ID Number (if applicable) | Current Patient <input type="checkbox"/> |
| 4 | Child Name (Last, First, M.I.) | Sex (M/F) | Social Security Number | Birthdate (MM/DD/YYYY) / / | | | |
| Relationship <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____ | | Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life | | PCP Provider Office ID Number | Current Patient <input type="checkbox"/> | Dental Office ID Number (if applicable) | Current Patient <input type="checkbox"/> |
| 5 | Child Name (Last, First, M.I.) | Sex (M/F) | Social Security Number | Birthdate (MM/DD/YYYY) / / | | | |
| Relationship <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____ | | Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life | | PCP Provider Office ID Number | Current Patient <input type="checkbox"/> | Dental Office ID Number (if applicable) | Current Patient <input type="checkbox"/> |
| 6 | Child Name (Last, First, M.I.) | Sex (M/F) | Social Security Number | Birthdate (MM/DD/YYYY) / / | | | |
| Relationship <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____ | | Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life | | PCP Provider Office ID Number | Current Patient <input type="checkbox"/> | Dental Office ID Number (if applicable) | Current Patient <input type="checkbox"/> |

D. Dependent Information

List any dependent in Section C living at another address.

| Name | Address |
|------|---------|
| | |
| | |
| | |
| | |

For Dependent Life: If age 19 and over and a full-time student, provide information below.

| Child Name | School Name | Expected Graduation Date | Number of Credit Hours |
|------------|-------------|--------------------------|------------------------|
| | | | |
| | | | |
| | | | |

E. Coordination of Benefits

Will you have other health insurance at the same time as this coverage? Yes No

| Name of Person | Carrier Name | Name of Person | Carrier Name |
|----------------|--------------|----------------|--------------|
| | | | |
| | | | |
| | | | |

Conditions of Enrollment

NOTICE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

On behalf of myself and the dependents listed on the reverse side, I agree to or with the following:

1. I acknowledge that by enrolling in the following plans, coverage is provided by the following entities (collectively referred to as "Aetna"):
 - Aetna HMO: Aetna Health of California Inc.
 - Aetna Dental DMO: Aetna Dental of California Inc.
 - Life, Accidental Death & Personal Loss, Dental and all other health coverages: Aetna Life Insurance Company.
2. I understand and agree that my employer's application will determine coverage and that there is no coverage unless and until both the eligible employee enrollment form and employer applications have been accepted and approved by Aetna. If Aetna demonstrates that I have acted fraudulently or intentionally misrepresented material facts, Aetna may rescind the policy or may increase premiums after giving me at least 30 days prior notice by certified mail. However, after 24 months following the issuance of the policy, Aetna will not rescind the policy for any reason and will not cancel the policy, limit the policy, or raise premiums due on the policy due to misrepresentation or inaccuracies in this form, whether willful or not. Aetna does not base its eligibility rules on any of the following factors:
 - (A) Health status.
 - (B) Medical condition, including physical and mental illnesses.
 - (C) Claims experience.
 - (D) Receipt of health care.
 - (E) Medical history.
 - (F) Genetic information.
 - (G) Evidence of insurability, including conditions arising out of acts of domestic violence.
 - (H) Disability.
 - (I) Any other health status-related factor as determined by any federal regulations, rules, or guidance issued pursuant to Section 2705 of the federal Public Health Service Act.

For life coverages: I understand that the effective date of insurance for myself or for any of my dependents is subject to my being actively at work on that date and that the effective date of insurance for any of my dependents is also subject to the dependent health condition requirements of the benefit plan. Further, I understand that any insurance subject to evidence of good health or medical information will not become effective until Aetna gives its written consent. For Dependent Life, dependents are eligible from 14 days of age up to their 19th birthday, or up to their 23rd birthday, if a full-time student.

3. The plan documents will determine the rights and responsibilities of member(s) and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
4. I understand and agree that, with the exception of Aetna Rx Home Delivery®, all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.
5. I understand and agree that, with certain exceptions described in the plan documents, HMO and DMO® plans only provide coverage for referred benefits, and that, in order to be covered, services must be performed either by a participating primary care physician, primary care dentist, or by the participating specialist, hospital, pharmacy, dentist, or other provider as authorized by a referral from a participating primary care physician.

To the best of my knowledge, I represent that all information supplied in this form is true and complete. I have read and agree to the Conditions of Enrollment on this California Small Group Business (1 - 50 Eligible Employees) Employee Enrollment/Change Form. I understand in the event I fail to sign and return this form within 31 days of my eligibility date or for any reason Aetna does not receive notice of the above transaction request within a reasonable time following the event, my and my dependents' eligibility may be affected. I am employed by the employer shown on Page 1, and I am working full time at least 30 hours per week (or 20-29 hours per week if elected by my employer) for this employer at the regular place of business.

CA HMO ENROLLEES - NOTICE OF BINDING ARBITRATION: ANY DISPUTE ARISING FROM OR RELATED TO HEALTH PLAN MEMBERSHIP WILL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION, AND NOT BY A LAWSUIT OR RESORT TO COURT PROCESS EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. THE AGREEMENT TO ARBITRATE INCLUDES, BUT IS NOT LIMITED TO, DISPUTES INVOLVING ALLEGED PROFESSIONAL LIABILITY OR MEDICAL MALPRACTICE, THAT IS, WHETHER ANY MEDICAL SERVICES COVERED BY THIS AGREEMENT WERE UNNECESSARY OR WERE UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED. THE HEALTH PLAN AGREEMENT ALSO LIMITS CERTAIN REMEDIES AND MAY LIMIT THE AWARD OF PUNITIVE DAMAGES. SEE THE EVIDENCE OF COVERAGE FOR FURTHER INFORMATION.

I understand that I am giving up the constitutional right to have disputes decided in a court of law before a jury, and instead am accepting the use of binding arbitration. This means that members will not be able to try their case in court. I further understand that the agreement contains limitations on certain remedies and that there may be certain limitations to the recovery of punitive damages.

| | | |
|---|---|------------------------------|
| <input type="checkbox"/> I AM ENROLLING FOR COVERAGE: Employee Signature X | Employee E-mail Address (optional) | Date (Month/Day/Year) |
|---|---|------------------------------|

Declination/Waiver of Coverage - To be completed if medical and/or dental coverage is declined or refused by an eligible employee and/or their eligible family members.

| | | |
|--|---|---------------------------------|
| I understand I am eligible to apply for this coverage through my employer; however, I am waiving coverage as noted below. | | |
| <input type="checkbox"/> Employee: | <input type="checkbox"/> Medical <input type="checkbox"/> Life | <input type="checkbox"/> Dental |
| <input type="checkbox"/> Spouse | <input type="checkbox"/> Medical <input type="checkbox"/> Life | <input type="checkbox"/> Dental |
| <input type="checkbox"/> Child(ren): | <input type="checkbox"/> Medical <input type="checkbox"/> Life | <input type="checkbox"/> Dental |
| Reason for declining coverage <input type="checkbox"/> Spousal group coverage <input type="checkbox"/> Parental group coverage <input type="checkbox"/> COBRA coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Retiree coverage <input type="checkbox"/> Another group plan provided by my employer | | |
| <input type="checkbox"/> Insurance through another job <input type="checkbox"/> TRICARE <input type="checkbox"/> VA coverage <input type="checkbox"/> Individual coverage - On or Off Exchange <input type="checkbox"/> Do not want <input type="checkbox"/> Other _____ | | |
| I certify I have been given the right to apply for this coverage; however, I am electing not to enroll. By declining this group coverage I acknowledge that I and/or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage | | |
| Please sign here ONLY if you are declining coverage for yourself and/or your dependent(s). | | Date (Month/Day/Year) |
| <input type="checkbox"/> I AM DECLINING COVERAGE: Employee Signature X | | |

DMHC Written Notice of Availability of Language Assistance

HMO and DMO-based plans - IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-877-287-0117.

Planes basados en DMO y HMO - IMPORTANTE: ¿Puede leer esta carta? En caso de no poder leerla, le brindamos nuestra ayuda. También puede obtener esta carta escrita en su idioma. Para obtener ayuda gratuita, por favor llame de inmediato al 1-877-287-0117.

Traditional Plans:

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-877-287-0117. For more help call the CA Dept. of Insurance at 1-800-927-4357 English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-877-287-0117. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

免費語言服務。您可獲得口譯員服務，用中文把文件唸給您聽。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打 1-877-287-0117 與我們聯絡。欲取得其他協助，請致電 1-800-927-4357 與加州保險部聯絡。Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch và được người khác đọc giúp các tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-877-287-0117. Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-877-287-0117번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-877-287-0117. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 Tagalog

Անվճար Լեզվախոս Ծառայություններ: Հոք կարող եք թարգմանի և կարդալ ձեր փաստաթղթերը ընթերցել սույլ ձեզ համար հայերեն լեզվով: Օգնության համար սեզ զանգահարեք ձեր ինքնության (ID) ստուխի վրա նշված կամ 1-877-287-0117 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆոռնիայի Ապահովագրության Բաժանմունք: Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-877-287-0117. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または1-877-287-0117までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Japanese

خدمات مجاني مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسایی شما قید شده است و یا این شماره 1-877-287-0117 تماس بگیرید. برای دریافت کمک بیشتر، به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تلفن کنید. Persian

ਮੁਫਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-877-287-0117 'ਤੇ ਸਾਨ ਫ਼ਨ ਕਰੋ। ਵਧੇਰ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੂਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ਨ ਕਰੋ। Punjabi

សេវាកម្មភាសាឥតគិតថ្លៃ ៖ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដៃសមាស ចម្លើយលើស្តីពីការសុំសេវាសម្រាប់អ្នក ឬលេខ 1-877-287-0117 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រនី តាមលេខ 1-800-927-4357 Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-877-287-0117. للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357. Arabic

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau pab ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-877-287-0117. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong