



SMALL BUSINESS GROUP ENROLLMENT AND CHANGE FORM

Medical and Life/AD&D plans are provided by Health Net of California, Inc. and/or Health Net Life Insurance Company (together, the “Health Net Entities”). Dental HMO plans are provided by Dental Benefit Providers of California, Inc. and dental PPO and Indemnity insurance plans are underwritten by Unimerica Insurance Company (together, the “DBP Entities”). Vision plans are provided by Fidelity Security Life Insurance Company and serviced by Eyemed Vision Care LLC (together, the “Fidelity Entities”).

Neither the DBP Entities nor the Fidelity Entities are affiliated with the Health Net Entities. Obligations under dental and vision plans are not obligations of, and are not guaranteed by, the Health Net Entities.

Welcome to Health Net

SIMPLE STEPS FOR COMPLETING THE FORM:

- 1) Review the materials enclosed in your enrollment packet. Be sure that you understand the coverage options that are available to you by your employer.
- 2) Carefully review and select the plan option(s) that are best for you and your covered family members.
- 3) If you choose to enroll in the HMO, HMO Silver Network, HMO Salud con Health Net, SELECT (POS), ELECT Open Access (EOA) or Dental HMO (DHMO), you must select your dental provider, physician group and primary care physician. Be sure to fill in the names and numbers as they appear in the HMO Health Net Directory of Providers, or call the Customer Contact Center from 8:00 a.m.- 6:00 p.m., Monday through Friday for assistance.

Small Business Group (English): 1-800-361-3366

Small Business Group (Spanish): 1-800-331-1777

Small Business Group (Mandarin): 1-877-891-9053

Health Net Life: 1-800-865-6288

Health Net Dental: 1-866-249-2382

Health Net Vision: 1-866-392-6058

- 4) If you choose to select PPO or Flex Net, you are not required to select a primary care physician or physician group to enroll.
- 5) Make a copy of the completed application for your records.

Existing Business/Group

Post Office Box 9103

Van Nuys, California 91409-9103

www.healthnet.com

New Business/Group

Please send all completed

paperwork to your

designated Account Executive

or Broker.

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3 FAMILY INFORMATION Please list all eligible family members to be enrolled.
(Attach additional sheets if necessary)

<input type="checkbox"/> Spouse	<input type="checkbox"/> M	Last Name	First Name	M.I.
<input type="checkbox"/> Domestic Partner	<input type="checkbox"/> F			
Residence Address <input type="checkbox"/> Check here if same as subscriber		City	State	Zip
Date of Birth Mo/Day/Yr		Social Security #/Matricular ID #		
Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B		Overage Dependent Type Not Applicable		Participating Physician Group/PPG#
Health Net Primary Care Physician/PCP#		Physician Name (First, Last)	Is this your current M.D.? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental HMO Provider ID#
<input type="checkbox"/> Son		Last Name	First Name	M.I.
<input type="checkbox"/> Daughter				
Residence Address <input type="checkbox"/> Check here if same as subscriber		City	State	Zip
Date of Birth Mo/Day/Yr		Social Security #/Matricular ID #		
Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B		Overage Dependent Type <input type="checkbox"/> Disabled <input type="checkbox"/> Full-time Student <input type="checkbox"/> Over 50% support		Participating Physician Group/PPG#
Health Net Primary Care Physician/PCP#		Physician Name (First, Last)	Is this your current M.D.? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental HMO Provider ID#
<input type="checkbox"/> Son		Last Name	First Name	M.I.
<input type="checkbox"/> Daughter				
Residence Address <input type="checkbox"/> Check here if same as subscriber		City	State	Zip
Date of Birth Mo/Day/Yr		Social Security #/Matricular ID #		
Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B		Overage Dependent Type <input type="checkbox"/> Disabled <input type="checkbox"/> Full-time Student <input type="checkbox"/> Over 50% support		Participating Physician Group/PPG#
Health Net Primary Care Physician/PCP#		Physician Name (First, Last)	Is this your current M.D.? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental HMO Provider ID#
<input type="checkbox"/> Son		Last Name	First Name	M.I.
<input type="checkbox"/> Daughter				
Residence Address <input type="checkbox"/> Check here if same as subscriber		City	State	Zip
Date of Birth Mo/Day/Yr		Social Security #/Matricular ID #		
Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B		Overage Dependent Type <input type="checkbox"/> Disabled <input type="checkbox"/> Full-time Student <input type="checkbox"/> Over 50% support		Participating Physician Group/PPG#
Health Net Primary Care Physician/PCP#		Physician Name (First, Last)	Is this your current M.D.? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental HMO Provider ID#
<input type="checkbox"/> Son		Last Name	First Name	M.I.
<input type="checkbox"/> Daughter				
Residence Address <input type="checkbox"/> Check here if same as subscriber		City	State	Zip
Date of Birth Mo/Day/Yr		Social Security #/Matricular ID #		
Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B		Overage Dependent Type <input type="checkbox"/> Disabled <input type="checkbox"/> Full-time Student <input type="checkbox"/> Over 50% support		Participating Physician Group/PPG#
Health Net Primary Care Physician/PCP#		Physician Name (First, Last)	Is this your current M.D.? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental HMO Provider ID#
<input type="checkbox"/> Son		Last Name	First Name	M.I.
<input type="checkbox"/> Daughter				
Residence Address <input type="checkbox"/> Check here if same as subscriber		City	State	Zip
Date of Birth Mo/Day/Yr		Social Security #/Matricular ID #		
Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B		Overage Dependent Type <input type="checkbox"/> Disabled <input type="checkbox"/> Full-time Student <input type="checkbox"/> Over 50% support		Participating Physician Group/PPG#
Health Net Primary Care Physician/PCP#		Physician Name (First, Last)	Is this your current M.D.? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental HMO Provider ID#

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4 DO YOU OR YOUR DEPENDENTS HAVE OTHER HEALTH CARE COVERAGE?

If yes, please complete this section including Medicare.

<input type="checkbox"/> Self	Name	Name of Other Insurance Carrier			Prior Coverage Start Date Mo/ Day / Yr		
Prior Coverage End Date Mo/ Day / Yr	Reason for Ending Coverage	Group #/Policy ID #	Does it cover? Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Medicare Claim/ HICN #	
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	Name	Name of Other Insurance Carrier			Prior Coverage Start Date Mo/ Day / Yr		
Prior Coverage End Date Mo/ Day / Yr	Reason for Ending Coverage	Group #/Policy ID #	Is this your dependent's primary coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does it cover? Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Medicare Claim/ HICN #
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Name	Name of Other Insurance Carrier			Prior Coverage Start Date Mo/ Day / Yr		
Prior Coverage End Date Mo/ Day / Yr	Reason for Ending Coverage	Group #/Policy ID #	Is this your dependent's primary coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does it cover? Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Medicare Claim/ HICN #
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Name	Name of Other Insurance Carrier			Prior Coverage Start Date Mo/ Day / Yr		
Prior Coverage End Date Mo/ Day / Yr	Reason for Ending Coverage	Group #/Policy ID #	Is this your dependent's primary coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does it cover? Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Medicare Claim/ HICN #
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Name	Name of Other Insurance Carrier			Prior Coverage Start Date Mo/ Day / Yr		
Prior Coverage End Date Mo/ Day / Yr	Reason for Ending Coverage	Group #/Policy ID #	Is this your dependent's primary coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does it cover? Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Medicare Claim/ HICN #
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Name	Name of Other Insurance Carrier			Prior Coverage Start Date Mo/ Day / Yr		
Prior Coverage End Date Mo/ Day / Yr	Reason for Ending Coverage	Group #/Policy ID #	Is this your dependent's primary coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does it cover? Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Medicare Claim/ HICN #
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Name	Name of Other Insurance Carrier			Prior Coverage Start Date Mo/ Day / Yr		
Prior Coverage End Date Mo/ Day / Yr	Reason for Ending Coverage	Group #/Policy ID #	Is this your dependent's primary coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does it cover? Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Medicare Claim/ HICN #

5 YOUR EMPLOYER COMPLETES THIS SECTION (if applying for Group Life/AD&D.)

Effective Date	Annual Salary	Occupation	Life Class	Life/AD&D Amount
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6 GROUP TERM LIFE INSURANCE If applicable. (Attach separate sheet for additional or contingent beneficiaries.)

Life coverage <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, I am applying for <input type="checkbox"/> Life/AD&D \$ _____ <input type="checkbox"/> Dependent Life \$ _____		
Life Beneficiary (Full Name)	Relationship	%
Life Beneficiary (Full Name)	Relationship	%
Life Beneficiary (Full Name)	Relationship	%
Life Beneficiary (Full Name)	Relationship	%

7 DECLINATION OF COVERAGE (complete this section if any coverage is to be declined by you or your eligible dependents.)

- Declining Medical coverage for:** _____ **Reason:** Other group coverage through this employer Individual Coverage
 Self Spouse Domestic Partner Dependent(s) Other group coverage by another group (*i.e. spouse's employer*) Other _____
- Declining Dental coverage for:** _____ **Reason:** Other group coverage through this employer Individual Coverage
 Self Spouse Domestic Partner Dependent(s) Other group coverage by another group (*i.e. spouse's employer*) Other _____
- Declining Vision coverage for:** _____ **Reason:** Other group coverage through this employer Individual Coverage
 Self Spouse Domestic Partner Dependent(s) Other group coverage by another group (*i.e. spouse's employer*) Other _____

STOP AND READ CAREFULLY.

The available coverages have been explained to me by my employer. I have been given the chance to apply for the available coverages. I have decided not to enroll myself and/or my dependent(s).
By declining coverage I acknowledge that my dependents and I may have to wait to be enrolled until the next Open Enrollment period or qualifying event. Additionally, by signing below I certify that the reason I am declining coverage is accurate as indicated by the check marks above.

Employee Signature _____ Date _____

(SIGN ONLY IF DECLINING COVERAGE. IF SIGNED IN ERROR, PLEASE CROSS OUT AND INITIAL.)

8 ACCEPTANCE OF COVERAGE (signature required.)

THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: I acknowledge and understand that health care providers may disclose health information about me or my dependents to the Health Net Entities, the DBP Entities and/or the Fidelity Entities. The Health Net Entities, the DBP Entities and/or the Fidelity Entities use and may disclose this information for purposes of treatment, payment and health plan operations, including but not limited to, utilization management, quality improvement, disease or case management programs. Health Net's Notice of Privacy Practices is included in the evidence of coverage or certificate of insurance for coverage underwritten by the Health Net Entities. I may also obtain a copy of this Notice on the website at www.healthnet.com or through the Health Net Customer Contact Center.

NOTICE: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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

ACKNOWLEDGEMENT AND AGREEMENT: I understand and agree that by enrolling with or accepting services from the Health Net Entities, the DBP Entities and/or the Fidelity Entities, I and any enrolled dependents are obligated to understand and abide by the terms, conditions and provisions of the Plan Contract or Insurance Policy. I have read and understand the terms of this Application and my signature below indicates that the information entered

in this Application is complete, true and correct, and I accept these terms.

BINDING ARBITRATION AGREEMENT: Subject to the terms of the Plan Contract or Insurance Policy (which may prohibit mandatory arbitration of certain disputes if the Plan Contract or Insurance Policy is subject to ERISA, 29 U.S.C. section 1001, et seq.), I, the Employee, understand and agree that any and all disputes or disagreements between me (including any of my enrolled family members or heirs or personal representatives) and the Health Net Entities, the DBP Entities and/or the Fidelity Entities, regarding the construction, interpretation, performance or breach of the Plan Contract or Insurance Policy, or regarding other matters relating to or arising out of the Health Net Entities, the DBP Entities and/or the Fidelity Entities membership, whether stated in tort, contract or otherwise, and whether or not other parties such as health care providers, or their agents or employees, are also involved, must be submitted to final and binding arbitration in lieu of a jury or court trial. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties, including the Health Net Entities, the DBP Entities and/or the Fidelity Entities, are giving up their constitutional right to have their dispute decided in a court of law before a jury. I also understand that disputes that I may have with the Health Net Entities, the DBP Entities and/or the Fidelity Entities involving claims for medical malpractice are also subject to final and binding arbitration. A more detailed arbitration provision is included in the Plan Contract or Insurance Policy. My signature below indicates that I agree to submit any dispute to binding arbitration.

Employee Signature _____ Date _____

"Plan Contract" refers to the Health Net of California, Inc. and/or Dental Benefit Providers of California, Inc. Group Service Agreement and Evidence of Coverage; "Insurance Policy" refers to Health Net Life Insurance Company, Unimerica Insurance Company, and/or Fidelity Security Life Insurance Company Group Policy and Certificate of Insurance.

Please contact the Health Net Customer Contact Center at the toll free numbers below should you need assistance in completing this form or if you have questions about your coverage:

English	1-800-361-3366
Cantonese	1-877-891-9050
Korean	1-877-339-8596
Mandarin	1-877-891-9053
Spanish	1-800-331-1777
Tagalog	1-877-891-9051
Vietnamese	1-877-339-8621

If you have questions about your dental or vision coverage, please call:

Dental	1-866-249-2382
Vision	1-866-392-6058

If you have questions about your physician or physician group, call your physician group directly or contact Health Net Provider Services at 1-800-641-7761.

You can use your copy of the Health Net enrollment form as your temporary ID card until you receive your permanent ID card.

HMO, HMO Silver Network, Salud con Health Net HMO, SELECT (POS), ELECT Open Access, EPO, Dental HMO Enrollees:

Participating Physician Group (PPG), Primary Care Physician (PCP) and Dental Provider Selection.

Please note, if you do not select a Participating Physician Group, Primary Care Physician, or Dental Provider for yourself and each of your eligible dependents, a Participating Physician Group, Primary Care Physician, and Dental Provider will be selected for you.

Emergency and Urgently Needed Care

- **If your situation is life threatening or an emergency:** Call **911** or go to the nearest Hospital.
- If your situation is not so severe: If you cannot call your Primary Care Physician or physician group, or you need medical care right away, go to the nearest hospital or medical center.
- **If you are outside your physician group's service area:** Go to the nearest hospital, medical center or call **911**. In all cases, contact your Primary Care Physician or Participating Physician Group as soon as possible to inform them about your condition.

PPO, FLEX NET Enrollees:

Emergency and Urgently Needed Care

- **If your situation is life threatening or an emergency:** Call **911** or go to the nearest hospital. Please call the appropriate number within 48 hours of being admitted, or as soon as possible.

PRE-CERTIFICATION

You the member are responsible for obtaining certification for certain services. Please check your plan certificate for a list of services requiring pre-certification.

For pre-certification, please call 1-800-977-7282

Pre-existing Conditions and Creditable Coverage

Your coverage under the PPO, EPO and Flex Net benefit plans may be subject to pre-existing condition limitations for a maximum period of six months from the effective date of your enrollment. In accordance with state and federal law, Health Net Life Insurance Company will credit any prior coverage that you document at the time you apply to enroll in PPO, EPO or FLEX NET, provided the prior coverage qualifies as "creditable coverage" as defined under federal and state law. Creditable coverage will be applied to offset (in part or whole) the pre-existing condition limitation, which may apply to your coverage under this policy. If you're unable to provide documentation of bona fide creditable coverage at enrollment time, Health Net Life Insurance Company may provide assistance in obtaining the necessary documentation upon request. Note: Prior coverage, which is interrupted by a period of 63 days (or 180 days if your previous employer terminated the coverage) or more, does not qualify as creditable coverage.

Disabling Conditions:

If you or your family member were disabled as of the date of termination of coverage with a prior health insurer and the loss of coverage was due to the termination of the employer's insurance policy, you may be entitled to an extension of health benefits according to California Insurance Code section 10128. Under this law, the prior insurer retains responsibility until whichever of the following occur first: (a) the member is no longer totally disabled; (b) the maximum benefits of the prior insurer's coverage are paid; or (c) a period of 12 consecutive months has passed since the date coverage ended with prior insurer.

Products/Entities:

Health Net of California, Inc. offers the following products: ELECT Open Access, HMO, Salud HMO and SELECT POS.

Health Net Life Insurance Company offers the following products: Flex Net, PPO, Salud con Health Net EPO & PPO, Life and AD&D insurance.

Dental Benefit Providers of California, Inc. offers the following products: Dental HMO (DHMO).

Unimerica Insurance Company offers the following products: Dental PPO and Dental Indemnity.

Fidelity Security Life Insurance Company offers the following products serviced by EyeMed Vision Care, LLC: PPO Vision.

Declination of Coverage:

If you decline coverage for yourself or an eligible dependent because of coverage under other health insurance and you lose that coverage, or, if you acquire a new dependent due to marriage, birth, adoption, or placement for adoption, you and your dependent may be eligible for special enrollment rights. You must request special enrollment within 30 days of the loss of coverage or acquisition of a new dependent.



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 new applicants please call 1-800-522-0088. For more help call the CA Dept. of Insurance at 1-800-927-4357 if you are enrolling in a PPO or EPO plan.

English

Servicios de Idiomas Sin Costo. Usted puede solicitar un intérprete. Puede solicitar que una persona le lea los documentos y que algunos se envíen en su idioma. Para solicitar ayuda, llámenos al número que aparece en su tarjeta de identificación o, si es un solicitante nuevo, llame al 1-800-522-0088. Para obtener más ayuda llame al Departamento de Seguros de CA al 1-800-927-4357 si se inscribe en un plan PPO o EPO.

Spanish

免費語言服務。您可以取得口譯員服務。我們可以把文件朗讀給您聽，部分文件可以翻譯成您的語言並寄送給您。欲取得協助，請撥您會員卡上所列電話號碼和我們聯絡，新申請人請撥 1-800-522-0088。如果您加入的是 PPO 或 EPO 計畫而想取得更多協助，請致電加州保險部，電話 1-800-927-4357。

Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch và có thể được người khác đọc giúp các tài liệu bằng ngôn ngữ của quý vị. Để được giúp đỡ, xin gọi chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc các đường đơn mới có thể gọi số 1-800-522-0088. Để được giúp đỡ thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357 nếu quý vị muốn tham gia một chương trình PPO hoặc EPO.

Vietnamese

무료 언어 지원 서비스. 무료 통역사 서비스 및 여러분에게 편한 언어로 서류 낭독 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 본인의 ID 카드상의 안내번호로 연락해 주시거나 신규 신청자님의 경우 1-800-522-0088 번으로 문의해 주십시오. PPO 혹은 EPO 플랜에 가입하신 경우 보다 더 많은 도움이 필요하신 분은 캘리포니아 보험 담당국 안내번호 1-800-927-4357 번으로 문의하십시오.

Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa iyong wika ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card, o para sa mga bagong aplikante, mangyaring tumawag sa 1-800-522-0088. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 kung ikaw ay nag-ee-roll sa isang PPO o EPO plan.

Tagalog

Անվճար Լեզվական Ծառայություններ: Կարող եք թարգմանիչ ձեռք բերել և փաստաթղթերը ձեր լեզվով ընթերցել սալ: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) սոմսի վրա գտնվող համարով, կամ եթե նոր դիմորդ եք՝ 1-800-522-0088 համարով: Լրացուցիչ օգնության համար զանգահարեք Կալիֆոռնիայի Ապահովագրության Բաժանմունք 1-800-927-4357 համարով, եթե գրանցվում եք PPO կամ EPO ծրագրում:

Armenian

CA56407 (1/09)

Health Net of California, Inc. and Health Net Life Insurance Company are subsidiaries of Health Net, Inc. Health Net® is a registered service mark of Health Net, Inc. All rights reserved.

Бесплатные услуги перевода. Вы можете воспользоваться услугами устного переводчика, который прочитает вам документы на вашем родном языке. Если вам требуется помощь, звоните нам по номеру телефона, указанному в вашей карточке-удостоверении. Если вы являетесь новым участником, пожалуйста, звоните по номеру 1-800-522-0088. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (CA Dept. of Insurance) по номеру 1-800-927-4357, если вы регистрируетесь как участник плана PPO или EPO.

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場合、ID カード記載の番号までお問い合わせください。新規お申し込みの方は、1-800-522-0088 までご連絡ください。更なるお問い合わせは、PPO または EPO プラン会員の方に限り、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 برخوردار شده و بگوئید مدارک به زبان خودتان برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا متقاضیان جدید لطفاً با شماره 1-800-522-0088 تماس بگیرید. برای دریافت کمک بیشتر یا اگر در یک طرح PPO یا EPO ثبت نام می کنید، به اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تلفن کنید.

Farsi

ਮੁਫਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ, ਅਤੇ ਨਵੇਂ ਮੈਂਬਰ ਕਿਰਪਾ ਕਰਕੇ 1-800-522-0088 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰਨ। ਜੇ ਤੁਸੀਂ PPO ਜਾਂ EPO ਪਲਾਨ ਲਈ ਨਾਂ ਲਿਖਵਾ ਰਹੇ ਹੋ ਤਾਂ ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ ਇਨਸੂਰੈਂਸ ਨੂੰ 1-800-927-4357 ਤੇ ਫੋਨ ਕਰੋ।

Punjabi

សេវាភាសាដែលឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែម្នាក់ និងអាចឱ្យគេអានឯកសារផ្សេងៗឱ្យអ្នក ស្តាប់ជា ភាសារបស់អ្នក ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក ឬបេក្ខជនថ្មីសូមទូរស័ព្ទទៅលេខ 1-800-522-0088 ។ សម្រាប់ព័ត៌មានបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រង នៃរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 ប្រសិនបើអ្នកកំពុងចុះឈ្មោះនៅក្នុងគម្រោង PPO ឬ EPO ។

Cambodian

Cov Kev Pab Txhais Lus Uas Tsis Tau Them Nqi. Yuav muaj ib tug neeg txhais lus thiab nyeem cov ntwav ua koj hom lus rau koj. Yog xav tau kev pab, hu rau peb ntwam tus xov tooj nyob hauv koj daim yuaj ID los sis cov neeg thov kev pab tshiab thov hu rau 1-800-522-0088. Yog xav tau kev pab ntxiv hu rau CA Lub Caj Meem Fai Saib Xyuas Txog Kev Tuav Pov Hwm ntwam 1-800-927-4357 yog hais tias koj koom rau hauv qhov kev pab them nqi los ntwam PPO los sis EPO.

Hmong

ບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າ. ທ່ານສາມາດໄດ້ຮັບບໍລິການແປພາສາແລະມີຜູ້ອ່ານເອກກະສານໃຫ້ທ່ານຟັງເປັນພາສາຂອງທ່ານເຊັ່ນ ເພື່ອຈະໄດ້ຮັບຄວາມຊ່ວຍເຫລືອ, ໃຫ້ໂທຫາພວກເຮົາຕາມພາຍເລກທີ່ລະບຸໄວ້ໃນບັດປະກັນໄພຂອງທ່ານ ຫລືຜູ້ທີ່ຈະຂໍເອົາ ແຜນການໃໝ່ໃຫ້ໂທຕາມພາຍເລກ 1-800-522-0088. ຖ້າຫາກທ່ານກຳລັງຈະລົງທະບຽນແຜນການ PPO ຫລື EPO ໃຫ້ໂທໄປ ຫາກົມປະກັນໄພແຫ່ງລັດຄາລິຟໍເນຍຕາມພາຍເລກ 1-800-927-4357 ເພື່ອຈະໄດ້ຮັບຄວາມຊ່ວຍເຫລືອເພີ່ມຕື່ມ.

Lao

خدمات لغوية بدون تكلفة. يمكنك الاستعانة بمترجم وطلب قراءة الوثائق لك بلغتك. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك. بالنسبة للأعضاء الجدد، رجاء الاتصال بالرقم 1-800-522-0088. للحصول على المساعدة الإضافية، يرجى الاتصال بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357 إذا كنت منضمًا لبرنامج PPO أو EPO.

Arabic