34329

Independence MedigapFreedom

INDIVIDUAL COVERAGE APPLICATION FORM

Benefits underwritten by QCC Insurance Company, a subsidiary of Independence Blue Cross – independent Licensees of the Blue Cross and Blue Shield Association

A To apply for MedigapFreedom

Please reference the enclosed MedigapFreedom Outline of Coverage for the monthly premium based on your plan.

Check the ONE plan for which you are enrolling:

☐ Plan A ☐ Plan B ☐ Plan F ☐ High Deductible Plan F ☐ Plan G ☐ Plan N

Please see Section D for Open Enrollment/Guaranteed Issue Period information.

Desired effective date: ☐☐-0 1-☐☐☐☐
MM DD YYYY

Please check desired billing cycle:

☐ Monthly
☐ Bi-monthly
☐ Quarterly
☐ Annually

LAST Name: FIRST Name: Middle Initial: S.S.#: ☐☐☐-☐☐-☐☐☐☐

Birth Date: ☐☐-☐☐-☐☐☐☐ MM DD YYYY

Sex: ☐ M ☐ F

Home Phone Number: ☐☐☐-☐☐☐-☐☐☐☐

Permanent Residence Street Address:

City: State: ☐☐ ZIP Code: ☐☐☐☐☐

Mailing Address (only if different from your Permanent Residence Address):

Street Address: City: State: ☐☐ ZIP Code: ☐☐☐☐☐

Emergency Contact: _____

Phone Number: ☐☐☐-☐☐☐-☐☐☐☐ **Relationship to You:**

Email Address:

B Please provide your Medicare insurance information

Please take out your Medicare card to complete this section.

- Please fill in these blank boxes so they match your red, white, and blue Medicare card.

– OR –

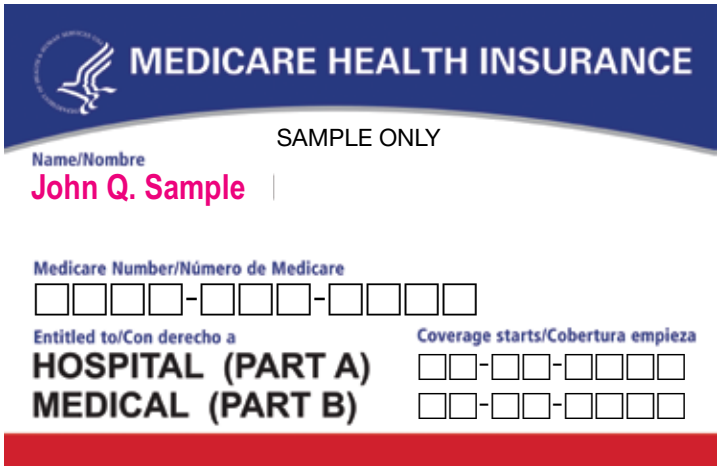
- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A and Part B to join MedigapFreedom.

Underwriting Risk Classification Question

Have you used any form of tobacco at any time within the last 12 months? ..... ☐ Yes ☐ No

(You do not have to answer this question if you are applying during an Open Enrollment or a Guaranteed Issue period.)



C – Part 1 MEDICAL COVERAGE REPLACEMENT (Must be completed)

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you are eligible for guaranteed issue of a Medicare supplement insurance policy, or that you have certain rights to buy such a policy, you may be guaranteed acceptance in one of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

Please mark Yes or No below with an X.

To the best of your knowledge:

1. Did you turn age 65 in the last 6 months? ☐ Yes ☐ No

2. Did you enroll in Medicare Part B in the last 6 months? ☐ Yes ☐ No

   If yes, what is the effective date? ☐☐-☐☐-☐☐☐☐ (MM DD YYYY)

3. Are you covered for medical assistance through the state Medicaid program? ☐ Yes ☐ No
   NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.

   If yes, will Medicaid pay your premiums for this Medicare supplement policy? ☐ Yes ☐ No

   Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ☐ Yes ☐ No

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

   START ☐☐-☐☐-☐☐☐☐ (MM DD YYYY) **END** ☐☐-☐☐-☐☐☐☐ (MM DD YYYY)

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

   Was this your first time in this type of Medicare plan? ☐ Yes ☐ No

   Did you drop a Medicare supplement policy to enroll in the Medicare Plan? ☐ Yes ☐ No

   If currently enrolled in a Medicare Advantage plan, your Medigap Plan effective date should start upon the date your Medicare Advantage plan coverage will end.

5. Do you have another Medicare supplement policy in force? ☐ Yes ☐ No

   If yes, with what company and what plan do you have? _____

   If yes, do you intend to replace your current Medicare supplement policy with this policy? ☐ Yes ☐ No

6. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)? ☐ Yes ☐ No

   If yes, with what company and what kind of policy? _____

   What are your dates of coverage under the policy? (If you are still covered under the policy, leave "END" blank.)

   START ☐☐-☐☐-☐☐☐☐ (MM DD YYYY) **END** ☐☐-☐☐-☐☐☐☐ (MM DD YYYY)

C – Part 2 GUARANTEED ACCEPTANCE/OPEN ENROLLMENT DETERMINATION

For a description of guaranteed issue and open enrollment, please see section D.
PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

1. Are you applying for coverage during your Medicare Supplement Open Enrollment Period? ..... ☐ Yes ☐ No
   If yes, please go to section D. If no, continue to the next section.

2. Have you lost, or are you losing, other health coverage which would qualify you for guaranteed acceptance? ..... ☐ Yes ☐ No
   If yes, please go to section D. If no, continue to the next section.

C – Part 3 HEALTH QUESTIONS

You are *not required* to answer health questions 1-10 if you are in an Open Enrollment or a Guaranteed Issue period. Please see Section D for an explanation of Open Enrollment/Guaranteed Issue period information. If you answer "yes" to any of the health questions 1-10, you are not eligible for coverage.

Please mark Yes or No below with an X.

1. Are you dependent on a wheelchair or any motorized mobility device? ..... ☐ Yes ☐ No

2. Do any of the following apply to you?
   Currently hospitalized, confined to a bed, in a nursing facility or assisted living facility, receiving home health care or physical therapy ..... ☐ Yes ☐ No

3. At any time, have you been medically diagnosed, treated, hospitalized, or had surgery for any of the following?
   A. congestive heart failure, unoperated aneurysm, defibrillator ..... ☐ Yes ☐ No
   B. leukemia, lymphoma, multiple myeloma, cirrhosis ..... ☐ Yes ☐ No
   C. Parkinson's Disease, Lou Gehrig's Disease, Alzheimer's Disease, dementia, multiple sclerosis, muscular dystrophy, cerebral palsy ..... ☐ Yes ☐ No
   D. chronic kidney disease, kidney failure, kidney disease requiring dialysis, renal insufficiency, Addison's Disease ..... ☐ Yes ☐ No
   E. any condition requiring a bone marrow transplant or stem cell transplant, any condition requiring an organ transplant ..... ☐ Yes ☐ No
   F. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), tested positive for the Human Immunodeficiency Virus (HIV) ..... ☐ Yes ☐ No

4. Do you have diabetes?
   A. that requires use of insulin ..... ☐ Yes ☐ No
   B. with complications, including retinopathy, neuropathy, peripheral vascular or arterial disease, or heart artery blockage ..... ☐ Yes ☐ No
   C. with history of heart attack or stroke (at any time) ..... ☐ Yes ☐ No
   D. treated with medication that has been changed or adjusted in the past 12 months because of uncontrolled blood sugar ..... ☐ Yes ☐ No

5. Within the past 36 months, have you been medically diagnosed, treated, hospitalized, or had surgery for any of the following?
   A. alcoholism, drug abuse ..... ☐ Yes ☐ No
   B. cardiomyopathy, atrial fibrillation, anemia requiring repeated blood transfusions, or any other blood disorder ..... ☐ Yes ☐ No
   C. internal cancer, melanoma, Hodgkin's Disease ..... ☐ Yes ☐ No
   D. hepatitis, disorder of the pancreas ..... ☐ Yes ☐ No

C – Part 3 HEALTH QUESTIONS (continued)

6. Within the past 24 months, have you been medically diagnosed, treated, hospitalized, or had surgery for any of the following?
   - A. enlarged heart, transient ischemic attack (TIA), stroke, peripheral vascular or arterial disease, neuropathy, amputation caused by disease ☐ Yes ☐ No
   - B. myasthenia gravis, systemic lupus or connective tissue disorder ☐ Yes ☐ No
   - C. osteoporosis with fractures, Paget's Disease, arthritis that restricts mobility or the activities of daily living ☐ Yes ☐ No
   - D. any lung or respiratory disorder requiring the use of a nebulizer or oxygen, or 3 or more medications for lung or respiratory disorder ☐ Yes ☐ No
   - E. any lung or respiratory disorder and currently use tobacco products ☐ Yes ☐ No

7. Within the past 12 months, have you been advised by a medical professional to have treatment, further evaluation, diagnostic testing, or any surgery that has not been performed? ☐ Yes ☐ No

8. Within the past 12 months, have you been medically diagnosed, treated, hospitalized, or had surgery for a heart attack, artery blockage, or heart valve disorder? ☐ Yes ☐ No

9. Within the past 12 months, do any of the following apply to you?
   - A. had a pacemaker implanted ☐ Yes ☐ No
   - B. had a PSA blood test greater than 4.5, under age 70, with no history of prostate cancer ☐ Yes ☐ No
   - C. had a PSA blood test greater than 6.5, age 70 or older, with no history of prostate cancer ☐ Yes ☐ No
   - D. had a seizure ☐ Yes ☐ No

10. Was your last blood pressure reading higher than 175 Systolic or higher than 100 Diastolic? ☐ Yes ☐ No
    Systolic is the upper number and Diastolic is the bottom number of a blood pressure reading.

D IMPORTANT NOTICE — please read carefully

You do not need more than one Medicare supplement policy.

If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

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

If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

D IMPORTANT NOTICE (continued)

OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION

Open Enrollment: You are eligible for Open Enrollment and will not need to answer Health Questions 1-10 on pages 3 and 4 of this application if (a) you are within 6 months of purchasing Medicare Part B coverage for the first time; or (b) you were eligible for early Medicare and you are within 6 months of turning age 65.

Guaranteed Issue For Eligible Persons Under the Balanced Budget Act of 1997: The following are definitions of the categories of individuals who are eligible for Guaranteed Issue under the Balanced Budget Act of 1997:

(a) Enrolled under an employee welfare benefit plan that either: (1) supplements Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits; or (2) is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan; or

(b) Enrolled in a Medicare Advantage plan or Program of All-Inclusive Care for the Elderly (PACE) and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or

(c) Enrolled in a Medicare risk contract, health care prepayment plan, cost contract or Medicare Select plan, or similar organization, and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material police provision, or a material misrepresentation was made to the individual; or

(d) Enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency or other involuntary termination of coverage under the policy, substantial violation of material policy provision, or material misrepresentation; or

(e) Enrolled under a Medicare Supplement policy, terminates and enrolls for the first time in a Medicare Advantage plan, a risk or cost contract, a Medicare Select plan, or a PACE provider, and then the insured person terminates coverage within 12 months of enrollment; or

(f) Upon first becoming eligible for benefits under Part A at age 65, you enrolled in a Medicare Advantage plan or PACE provider and then you disenroll within 12 months; or

(g) Enrolled in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under Medicare Supplement policy that covers outpatient prescription drugs and terminated enrollment in the Medicare Supplement policy and submits evidence of enrollment in Medicare Part D along with the application for Plan A, B, F, High Deductible Plan F, G or N.

Documentation of these events must be submitted with the application. You must apply within 63 days of the date of termination of previous coverage in order to qualify as an eligible person.

E AUTHORIZATION AND CONFIRMATION

I hereby apply for the Policy coverage specified below. I understand that this application is subject to your acceptance and to the conditions and exclusions contained in the agreement. I agree to pay charges for these coverages as billed. I am covered by Medicare Part A and Part B. I acknowledge and agree that any personally identifiable health information about me ("Protected Health Information") is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, QCC Insurance Company may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Independence Blue Cross Notice of Privacy Practices is available at www.ibxmedicare.com. I understand that the QCC Insurance Company MedigapFreedom policy that I am applying for has a pre-existing condition provision. Under this provision, benefits related to any pre-existing condition will not be provided for six months after I enroll in MedigapFreedom. I also understand, however, that the pre-existing condition provision will not apply to these benefits if, when I enroll in MedigapFreedom, I have already satisfied a pre-existing condition provision for the benefits under another Medicare supplement policy or the pre-existing condition provision is waived because I am an "eligible person" as defined by federal and Pennsylvania laws and regulations.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically

E AUTHORIZATION AND CONFIRMATION (continued)

related facility, insurance company or other organization, institution or person including Medicare, that has any records or knowledge of me or my health or having any non-medical information concerning me to give QCC Insurance Company, or its reinsurers, any such information. I understand that I am authorizing QCC Insurance Company to receive my health information, prescription drug usage history, and my non-medical information. I understand that prescription drug usage may be used to verify the presence of certain medical conditions and that such history will not be used to decline coverage. These medical conditions will be confirmed by a telephone interview prior to being used in the underwriting process. The released information received by QCC Insurance Company will remain protected by federal and/or state regulations as long as it is maintained by the health plan. Medical information will not be used to decline coverage if I am applying during an Open Enrollment or Guaranteed Issue period. If I was previously enrolled under another Blue Cross® policy or a Medicare supplement policy with another company with a pre-existing condition limitation, coverage under this policy for a pre-existing condition limitation will only be excluded to the extent of the time that I did not satisfy the pre-existing condition exclusion period under the previous policy and in no event shall such pre-existing condition exclusion exceed six (6) consecutive months from the effective date of my coverage under this policy. "Pre-existing Condition" means a disease or physical condition for which medical advice or treatment has been received by me within one hundred eighty (180) days immediately prior to my initial effective date under this agreement or any endorsement made part of this policy. I understand that I can find complete details of the program(s) in the Policy which I will receive after I return this Application Form. I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual, this signature acknowledges that:
1)this person is authorized under State law to complete this application and 2) documentation of this authority is available upon request by QCC Insurance Company or by Medicare.
I understand that the information requested is necessary for evaluation and underwriting of my application for the Medicare Supplement Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with QCC Insurance Company. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to QCC Insurance Company will result in the rejection of the Medicare Supplement Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying QCC Insurance Company in writing at Independence Blue Cross, 1901 Market Street, Philadelphia, PA 19103. I understand that such revocation will not have any effect on actions QCC Insurance Company took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, change in policy benefits; or for the duration of a claim if used for the purpose of collecting information with a claim for benefits under a policy. A photocopy of this authorization will be treated in the same manner as the original.
To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete and I understand and agree that: (a) the insurance shall not take effect unless and until the application has been accepted and approved by the Company, the full first premium has been paid, and the policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing. The undersigned applicant acknowledges that the applicant has read, or had read to him, the completed application and that he realizes that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part. Any person who knowningly and with intent to defraud any insurance company or other person files an application for insurance or statment of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
I acknowledge receiving: (a) an Outline of Coverage for the policy applied for, and (b) a "Guide to Health Insurance for People with Medicare."

Signed at: _____
(City/State)

Dated: _____ Applicant's Signature: _____
(Month/Day/Year)

F AGENT'S CERTIFICATION

The undersigned Agent certifies that the Applicant has read, or had read to the Applicant, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)

1. List any other health insurance policy you have sold the Applicant that is still in force.

_____

_____

_____

_____

2. List any other health insurance policy you have sold to the Applicant in the past five (5) years that is no longer in force.

_____

_____

_____

_____

I certify that:

1. I have accurately recorded the information supplied by the Applicant; and
2. I have given an Outline of Coverage for the policy applied for and a Guide to Health Insurance for People with Medicare to the Applicant.

_____ _____

Agent's Signature: Date:

_____ _____

Agent's Printed Name: Agent No:

MedigapFreedom
1901 Market Street
Philadelphia, PA 19103

Independence

Not connected with or endorsed by the U.S. Government or the federal Medicare program.

8694(04/18)IAPP

Independence

MedigapFreedom

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage and replace it with a policy to be issued by QCC Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, PRODUCER (OR OTHER REPRESENTATIVE):

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) (check one):

- ☐ **Additional benefits.**
- ☐ **No change in benefits, but lower premium.**
- ☐ **Fewer benefits and lower premiums.**
- ☐ **My plan has outpatient prescription drug coverage and I am enrolling in Part D.**
- ☐ **Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment:**
- ☐ **Other. (please specify)** _____

_____

_____**: Signature of Producer or other representative**

_____**: Applicant Signature & Date**

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all medical information on an application may provide a basis for the company to dent future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. (If the policy or certificate is in a Guaranteed Issue period, this paragraph will not apply to you.)
4. Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al número

telefónico de Servicio al Cliente que figura en el reverso de su tarjeta de identificación.

Chinese: 注意：如果您讲中文，您可以得到免费的语言协助服务。请致电您ID卡背面的客户服务电话号码.

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드 뒷면에 있는 고객 서비스 번호로 전화해 주십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para telefone do Atendimento ao Cliente que está no verso do seu cartão de identificação.

Gujarati: ◆◆ના: જો તમે ◆◆રાતી બોલતા હો, તો િન: ◆◆ ભાષા સહાય સેવાઓ તમારા માટ ઉપલ ધ છે. ૃપયા તમારા આઇડ કાડ ની પાછળ ાહક સેવા નબર પર કોલ કર.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi số Dịch Vụ Chăm Sóc Khách Hàng ở mặt sau thẻ ID của bạn.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Позвоните в службу поддержки клиентов по номеру телефона, указанном на обратной стороне вашей идентификационной карты.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer Obsługi klienta znajdujący się na odwrocie Twojego identyfikatora.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiami il numero dell'Assistenza clienti che troverà sul retro della sua tessera identificativa.

Arabic:
ملحوظة :إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية
متاحة لك بالمجان الرجاء االتصال برقم " "العمالء الموجود خدمة
على ظهر بطاقة هويتك.

French Creole: ATANSYON : Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Tanpri rele nimewo Sèvis Kliyantèl ki sou do kat idantifikasyon ou a.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Mangyaring tawagan ang numero ng Customer Service na nasa likod ng iyong ID card.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Veuillez composer le numéro du service clientèle indiqué au dos de votre carte d'identité Médicale.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Number uff die hinnerscht Seit vun dei ID Card uff fer schwetze mit ebber as dich helfe kann.

Hindi: □□□ □: □□□ □□ □□□□ □□□□□ □ □□ □□□□ □□□ □□ □ □ □□□□ □□□□□□ □□□□□□ □□□ □ □ □ □□ □□□ □□□□ □□□□ □□□□□ □□ □□□□ □□□ □□□□□□ □□□□ □□□□ □□ □□□ □□ □

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Bitte rufen Sie unsere Kundendienstnummer auf der Rückseite Ihrer Identifikationskarte an.

Japanese: 備考：母国語が日本語の方は、言語アシスタンスサービス（無料）をご利用いただけます。ご自分のIDカードの裏面に記載されているカスタマーサービスの番号へお電話ください。

Persian (Farsi):
توجه: اگر ،فارسی صحبت می کنید خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. لطفاً با شماره خدمات مشتریان که در پشت کارت شناسایی شما درج شده است تماس بگیرید.

Navajo: D77 baa ak0 n7n7zin: D77 saad bee y1n7[ti'go Diné Bizaad, saad bee 1k1'1n7da'1wo'd66', t'11 jiik'eh. T'11 sh--d7 h0d77lnih koj8'!k1'an7daalwo'j8 47 binumber naaltsoos nit['izgo nantin7g77 bine'd66' bik11'.

Urdu:

کے پیچھے دئیےگئے صارف خدمات نمبر پر برائے کرم کال مفت میں زبان معاون خدمات دستیاب ہیں۔ آپ کے شناختی کارڈ توجہ درکارہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے کریں.

Mon-Khmer, Cambodian: សូមេមតុ ចបា់-fរមមណ៍ ៖ ប្រសិនេបើអនកនិយយភ មន-ែខមរ ឬភ ែខមរ េនះ ជំនួយែផនកភ និងមនផ្តល់ជូនដល់េ កអនកេ យឥត គិតែថ្លៃ។ សូមទូរសពទេទេលខេស សមជិក ែដលមេនេ ែផនកខងេ្រកៃនបណ្ណសមគ ល់ខ្លួនរបស់េ កអនក ។

Discrimination is Against the Law

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

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and 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 and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan 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 our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA, 19103; By phone: 1-888-377-3933 (TTY: 711), By fax: 215-761-0245, By email: civilrightscoordinator@1901market.com. If you need help filing a grievance, our 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, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.