OMB No. 0938-1378 Expires:7/31/2024

Enrollment Request Form

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Who can use this form?

People with Medicare who want to join a Medicare Prescription Drug Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Prescription Drug Plan, you must also have either, or both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit **Medicare.gov** to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:

Blue MedicareRx
P.O. Box 269029
Weston, FL 33326-9029

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call Blue MedicareRx Medicare Solutions Specialists at **1-888-274-1568.** TTY users can call **711**.

Or, call Medicare at **1-800-MEDICARE (1-800-633-4227).** TTY users can call **1-877-486-2048.**

En español: Llame a los especialistas de Blue MedicareRx Medicare Solutions al **1-888-274-1568, TTY: 711** o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

Blue MedicareRx℠ Medicare Prescription Drug Plan (PDP)
Individual Enrollment Form Instructions

BlueCross BlueShield Arizona
An Independent Licensee of the Blue Cross Blue Shield Association

Please complete the application using a black ballpoint pen.
All sections must be filled out and submitted for enrollment.

Blue MedicareRx℠ Medicare Prescription Drug Plan (PDP)
Individual Enrollment Form

BlueCross BlueShield Arizona
An Independent Licensee of the Blue Cross Blue Shield Association

To enroll, please provide all the information requested below.

REQUIRED: Please mark an "X" in the box next to the plan you wish to enroll in:

Blue MedicareRx: ☐ Value **$52.70** monthly premium ☐ Enhanced **$158.60** monthly premium

Please Provide Your Medicare Insurance Information

Please take out your red, white, and blue Medicare I.D. card to complete this section.

- Fill out this information as it appears on your Medicare card.

OR

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

Name: Jane L. Smith
(as it appears on your Medicare card)

Medicare Number X X X X - X X X - X X X X

Is Entitled To	Effective Date (MM/DD/YYYY):
HOSPITAL (Part A)	01 / 01 / 2000
MEDICAL (Part B)	01 / 01 / 2000

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

LAST Name:	FIRST Name:	Middle Initial:	☐ Mr. ☒ Mrs. ☐ Ms.
Smith	Jane	L.	

Birth Date: (MM/DD/YYYY)	Sex:
06/03/1933	☐ M ☒ F

Phone Number:	Alternate Phone Number (optional):
(602) 000 - 0000	(602) 000 - 0000

Email Address: jane.smith@yahoo.com

Permanent Residence Street Address (P.O. Box is not allowed): 1234 West Street

City:	State:	ZIP Code:
Phoenix	Arizona	85000

Mailing Address (only if different from your Permanent Residence Street Address): P.O. Box 56789

City:	State:	ZIP Code:
Phoenix	Arizona	85000

STEPS:

A. Select the plan you wish to enroll in.

B. Provide your Medicare Insurance Information as it appears on your red, white, and blue Medicare I.D. card.

C. Provide all personal information.

Blue MedicareRx℠ Medicare Prescription Drug Plan (PDP)

Individual Enrollment Form

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

To enroll, please provide all the information requested below.

REQUIRED: Please mark an "X" in the box next to the plan you wish to enroll in:

Blue MedicareRx: ☐ Value **$52.70** monthly premium ☐ Enhanced **$158.60** monthly premium

Please Provide Your Medicare Insurance Information

Please take out your red, white, and blue Medicare I.D. card to complete this section.

- Fill out this information as it appears on your Medicare card.

OR

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

Name: _____

(as it appears on your Medicare card)

Medicare Number ___ ___ ___ ___-___ ___ ___-___ ___ ___ ___

Is Entitled To	Effective Date (MM/DD/YYYY):
HOSPITAL (Part A)	_____ / _____ / _____
MEDICAL (Part B)	_____ / _____ / _____

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

LAST Name:	FIRST Name:	Middle Initial:	☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: ___ ___/___ ___/___ ___ ___ ___ (M M / D D / Y Y Y Y)		Sex: ☐ M ☐ F	
Phone Number: ( ) –		Alternate Phone Number (optional): ( ) –	
Email Address:			
Permanent Residence Street Address (P.O. Box is not allowed):			
City:		State:	ZIP Code:
Mailing Address (only if different from your Permanent Residence Street Address):			
City:		State:	ZIP Code:

Enrollee Name: _____ Plan Effective Date: _____

PLEASE READ AND ANSWER THESE IMPORTANT QUESTIONS

1. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.
   Will you have other prescription drug coverage in addition to Blue MedicareRx? ☐ Yes ☐ No
   If "yes," please list your other coverage and your identification (ID) number(s) for this coverage.
   Name of other coverage: _____
   ID # for this coverage: _____ Group # for this coverage: _____

2. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
   If "yes," please provide the following information:
   Name of Institution: _____
   Phone Number of Institution: _____
   Address (number and street): _____

Blue Cross® Blue Shield® of Arizona (BCBSAZ) is contracted with Medicare to offer HMO and PPO Medicare Advantage plans and PDP plans. Enrollment in BCBSAZ plans depends on contract renewal. Coverage is available to residents of Arizona.

Enrollee Name: _____ Plan Effective Date: _____

Typically, you may enroll in a Medicare Prescription Drug Plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Prescription Drug Plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

☐ I am new to Medicare.

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) _____.

☐ I was recently released from incarceration. I was released on (insert) _____.

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.

☐ I recently obtained lawful presence status in the U.S. I got this status on (insert date) _____.

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.

☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.

☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) _____.

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's) or was notified of the loss (whichever is later). I lost my drug coverage on (insert date) _____.

☐ I am leaving employer or union coverage on (insert date) _____.

Enrollee Name: _____ Plan Effective Date: _____

☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.

☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.

☐ I was affected by a Government Entity-Declared Disaster or Other Emergency (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements applies to you or you're not sure, please contact Blue MedicareRx Medicare Solutions specialists at **1-888-274-1568,** TTY: **711.** We are open October 1- March 31, seven days a week, 8 a.m. to 8 p.m., April 1- September 30, Monday through Friday, 8 a.m. to 8 p.m. Or, visit our website at **azblue.com/medicare.**

Do you currently have a Medicare Advantage-Prescription Drug (MAPD) plan? ☐ Yes ☐ No

☐ I understand I am signing up for a Medicare prescription drug plan. I understand I cannot combine a Medicare Advantage-Prescription Drug (MAPD) plan with a stand-alone prescription drug plan (PDP).

All fields in this section are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

☐ No, not of Hispanic, Latino/a, or Spanish origin
☐ Yes, Mexican, Mexican American, Chicano/a
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, another Hispanic, Latino/a, or Spanish origin
☐ I choose not to answer.

What's your race? Select all that apply.

☐ American Indian or Alaska Native
☐ Asian Indian
☐ Black or African American
☐ Chinese
☐ Filipino
☐ Guamanian or Chamorro
☐ Japanese
☐ Korean
☐ Native Hawaiian
☐ Other Asian
☐ Other Pacific Islander
☐ Samoan
☐ Vietnamese
☐ White
☐ I choose not to answer.

Select one if you want us to send you information in a language other than English.
☐ Spanish

Select one if you want us to send you information in an accessible format.
☐ Braille ☐ Large Print ☐ Audio CD

Enrollee Name: _____ Plan Effective Date: _____

PAYING YOUR PLAN PREMIUM AND/ OR LATE ENROLLMENT PENALTY

You can pay your monthly plan premium (including any late enrollment penalty you may owe) by mail or "Electronic Funds Transfer (EFT)" each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount (IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security or RRB benefit check or be billed directly by Medicare. **DO NOT pay Blue MedicareRx the Part D-IRMAA.**

People with limited incomes may qualify for *Extra Help* to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this *Extra Help,* contact your local Social Security office, or call Social Security at **1-800-772-1213,** 7 a.m. to 7 p.m. Monday through Friday. TTY users should call **1-800-325-0778.** You can also apply for *Extra Help* online at **www.ssa.gov/medicare/part-d-extra-help.**

If you qualify for *Extra Help* with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover. If you don't select a payment option, you will receive a bill each month.

Please select a premium payment option:

☐ Receive a paper bill. **Do not send a premium payment with this application.**

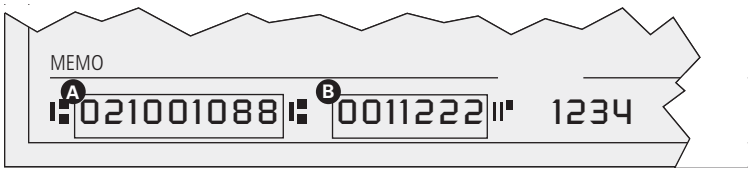
☐ Electronic funds transfer (EFT) from your bank account each month. Please provide the following:

Account holder name: _____

Financial institution: _____

Bank routing number: _____ Bank account number: _____

Account type: ☐ Checking ☐ Saving



Ⓐ The bank routing number is nine characters long and appears between the ⑆ symbols, usually at the bottom left corner of your check.

Ⓑ Your account number is 5 to 17 characters long and appears next to the ⑈ symbol at the bottom of your check, usually to the right of your bank routing number.

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

The Social Security/RRB/EFT deduction may take two or more months to begin. In most cases, if the Social Security/RRB accepts your request for automatic deduction, we will send you an invoice until the deductions from Social Security or RRB are approved, which can take 2-3 months. If Social Security/RRB does not approve your request for automatic deduction, we will continue to send you an invoice for your monthly premiums. If you do not pay your premium for the months before the deduction takes effect, you may be disenrolled from the plan.

PLEASE READ THIS IMPORTANT INFORMATION & SIGN BELOW

If you currently have health coverage from an employer or union, joining Blue MedicareRx could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Blue MedicareRx. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help. After carefully reading all statements in this section, please sign. Keep the copy marked "Enrollee" for your records.

1. Blue MedicareRx is a Medicare drug plan and has a contract with the Federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. It is my responsibility to inform Blue MedicareRx of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time – if I am currently in a Medicare Prescription Drug Plan, my enrollment in Blue MedicareRx will end that enrollment.
2. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (October 15–December 7), unless I qualify for certain special circumstances.
3. Blue MedicareRx serves a specific service area. If I move out of the area that Blue MedicareRx serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies except in an emergency when I cannot reasonably use Blue MedicareRx network pharmacies. Once I am a member of Blue MedicareRx, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Blue MedicareRx when I get it to know which rules I must follow to get coverage.
4. I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.
5. I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Blue Cross Blue Shield of Arizona, he/she may be paid based on my enrollment in Blue MedicareRx.
6. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.
7. **Release of Information:** By joining this Medicare prescription drug plan, I acknowledge that Blue MedicareRx will release my information to Medicare and other plans as is necessary for treatment, payment, and healthcare operations. I also acknowledge that Blue MedicareRx will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes that follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand that my signature (or the signature of the person authorized to act on my behalf under State law where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Medicare.

Signature: **X** _____ Today's Date: _____

If you are the authorized representative, you must sign above and provide the following information:

Name: _____ Address: _____

Phone Number: (____)_____ Relationship to Enrollee: _____

Office Use Only:

Member ID #: _____ Plan Effective Date: _____ ICEP/IEP: _____ AEP: _____ OEP: _____

SEP: _____ /SEP Reason: _____ Not Eligible: _____ Enrollment Rep: _____ Completed Date: _____

For Use by Agent/Broker:

Certified Agent Name (Print): _____ Agent/Broker #: _____

Broker of Record*: _____ Requested Effective Date: _____

Agent/Broker Signature: _____

Date Received: _____ Phone Number: _____

**Enter the name of the Entity contracted with BCBSAZ*

Enrollee Name: _____

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

2024 Enrollment Receipt

Please use this as your temporary proof of coverage until Medicare has confirmed your enrollment, and you receive your member ID card. **This receipt is not a guarantee of enrollment.**

This copy is for your records only. Please do not resubmit enrollment.

Fill out this plan recap with your licensed sales representative (if applicable). It will take you through some plan details to help you better understand your new plan.

Here are some details about your new plan:

Enrollee Name:	
Application Date:	My plan coverage begins (effective date):
My new plan name is: ☐ Blue MedicareRx Value **$52.70** monthly premium ☐ Blue MedicareRx Enhanced **$158.60** monthly premium	My plan type is: ☒ PDP
Premium Information: My plan has a: $_____ monthly premium. I understand I must remain enrolled in Medicare Part A and/or Part B and must continue to pay my Medicare Part B premium, unless the state or another third party pays it for me. If I owe a late enrollment penalty (LEP), it is not included in my premium and I will need to add it to my premium each month.	
I must live in the plan's service area. If I move out of the plan's service area for more than 6 months in a row, I will need to choose a new plan.	
I can cancel my enrollment in this plan before my coverage starts by calling Blue MedicareRx Medicare Solutions specialists at **1-844-883-8524** (TTY: **711**). We are open 24 hours a day, seven days a week. Once my coverage starts, I may have to wait until the Annual Enrollment Period (Oct 15- Dec 7) to make a plan change, unless I qualify for a Special Election Period.	
Call your licensed sales representative if you have any questions:	
Licensed Sales Representative Name and ID Number	Licensed Sales Representative Phone No.

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-844-883-8524. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-844-883-8524. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-844-883-8524。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-844-883-8524。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-844-883-8524. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-844-883-8524. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-844-883-8524 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-844-883-8524. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-844-883-8524 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-844-883-8524. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-844-883-8524. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-844-883-8524 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-844-883-8524. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-844-883-8524. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-844-883-8524. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-844-883-8524. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-844-883-8524 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。

Navajo: T'áá hait'éego da ats'íís baa'áhayą́ doodago azee' aanídaa'nił́ nihinaaltsoos bee hadadít'éhígíí bąąh na'ídikid nee hóló̧go da nihi éí ata' halne'í bee áka'anída'awo'í t'áá jíík'eh nihee hóló̧. Ata' halne'í ła' yíníkeedg kohjį' 1-844-883-8524 nihich'į' hodíilnih. T'áá háida Bilagáana Bizaad yee yáłti'ígíí ła' niká'iilyeed dooleeł. Díí t'áá jiik'eh bee niká'iilyeed dooleeł.

This page intentionally left blank

This page intentionally left blank

NOTES:

NOTES:

An Independent Licensee of the Blue Cross Blue Shield Association