



# California Small Group Employee Enrollment/Change Form (1 - 100 employees)

The following entities provide coverage: 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. For Vision coverage, First American Administrators, Inc. provides certain claims administration services. EyeMed Vision Care LLC ("EyeMed") provides certain network administration services.

PSUID or account number (if available)

Aetna member ID number (if available)

<b>Company name</b>		<b>INSTRUCTIONS:</b> You, the employee, must complete this enrollment form in full. If you do not, we will return it to you or your employer, and that can delay its processing. You alone are responsible for its accuracy and completeness. <b>If you are enrolling, please be sure to sign and date Employee signature on page 6. If you are declining coverage, you must complete section F on page 6.</b> Please use only black ink to complete this form.	
<b>Effective date</b>	<input type="checkbox"/> New hire <input type="checkbox"/> Rehire/reinstatement <input type="checkbox"/> New group enrollment	<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
<b>Date of hire</b>	<input type="checkbox"/> Late enrollment <input type="checkbox"/> Open enrollment <input type="checkbox"/> Waiver	Wherever the term "spouse" appears, it will be interpreted to include domestic partner.	Wherever the term "spouse" appears, it will be interpreted to include domestic partner.
<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 months <input type="checkbox"/> 36 months <input type="checkbox"/> Other _____			
Qualifying event _____ Original qualifying event date _____ Loss of coverage date _____			

## A. Employee information – You must complete this section. Please print clearly.

Member Social Security number or tax ID number*		Last name, first name, middle initial	
Home address (PO box not acceptable)		Apt. number	City, state
Work address (PO box not acceptable)		City, state	
Home/cell telephone (   )   -		Work telephone (   )   -	Primary language spoken (optional)
Number of hours worked a 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	Number of dependents enrolling for medical coverage including spouse
		Job title	

\*Social Security number is optional; tax identification number is acceptable. Please provide either Social Security number or tax identification number.

**B. Coverage selection – Please print clearly.**

Control/Group number	Suffix	Account	Plan number
<b>1. Medical coverage selection:</b> Select a medical plan by checking the appropriate box below. (The plan must be offered by your employer.)			
<b>HMO Plans</b>			
<input type="checkbox"/> CA Platinum HMO \$20/40 0	<input type="checkbox"/> CA Gold HMO AVN \$35/65 0		
<input type="checkbox"/> CA Gold HMO \$25/50 500	<input type="checkbox"/> CA Silver HMO AVN \$50/70 0		
<input type="checkbox"/> CA Gold HMO \$25/65 1250	<input type="checkbox"/> CA Silver HMO AVN \$55/90 2500 M		
<input type="checkbox"/> CA Gold HMO \$30/60 0	<input type="checkbox"/> CA Silver HMO AVN \$60/100 2500		
<input type="checkbox"/> CA Gold HMO \$35/65 0	<input type="checkbox"/> CA Platinum HMO AWH SoCA \$20/30 0 M		
<input type="checkbox"/> CA Silver HMO \$50/70 0	<input type="checkbox"/> CA Platinum HMO AWH SoCA \$20/40 0		
<input type="checkbox"/> CA Silver HMO \$60/100 2500	<input type="checkbox"/> CA Gold HMO AWH SoCA \$25/50 500		
<input type="checkbox"/> CA Bronze HMO \$60/95 6300 M	<input type="checkbox"/> CA Gold HMO AWH SoCA \$25/65 1250		
<input type="checkbox"/> CA Bronze HMO \$75/125 8550	<input type="checkbox"/> CA Gold HMO AWH SoCA \$30/60 0		
<input type="checkbox"/> CA Platinum HMO AVN \$20/30 0 M	<input type="checkbox"/> CA Gold HMO AWH SoCA \$35/55 250 M		
<input type="checkbox"/> CA Platinum HMO AVN \$20/40 0	<input type="checkbox"/> CA Gold HMO AWH SoCA \$35/65 0		
<input type="checkbox"/> CA Gold HMO AVN \$25/50 500	<input type="checkbox"/> CA Silver HMO AWH SoCA \$50/70 0		
<input type="checkbox"/> CA Gold HMO AVN \$25/65 1250	<input type="checkbox"/> CA Silver HMO AWH SoCA \$55/90 2500 M		
<input type="checkbox"/> CA Gold HMO AVN \$30/60 0	<input type="checkbox"/> CA Silver HMO AWH SoCA \$60/100 2500		
<input type="checkbox"/> CA Gold HMO AVN \$35/55 250 M			
<b>Open Access Managed Choice Plans</b>			
<input type="checkbox"/> CA Platinum MC 90/50 0 M	<input type="checkbox"/> CA Platinum MC Savings Plus 90/50 0 M		
<input type="checkbox"/> CA Platinum MC 80/50 250	<input type="checkbox"/> CA Platinum MC Savings Plus 80/50 250		
<input type="checkbox"/> CA Gold MC 90/50 3300 HSA	<input type="checkbox"/> CA Gold MC Savings Plus 90/50 3300 HSA		
<input type="checkbox"/> CA Gold MC 80/50 350 M	<input type="checkbox"/> CA Gold MC Savings Plus 80/50 350 M		
<input type="checkbox"/> CA Gold MC 80/50 1500	<input type="checkbox"/> CA Gold MC Savings Plus 80/50 1500		
<input type="checkbox"/> CA Gold MC 75/50 500	<input type="checkbox"/> CA Gold MC Savings Plus 75/50 500		
<input type="checkbox"/> CA Gold MC 70/50 1250	<input type="checkbox"/> CA Gold MC Savings Plus 70/50 1250		
<input type="checkbox"/> CA Silver MC 65/50 2500 M	<input type="checkbox"/> CA Silver MC Savings Plus 65/50 2500 M		
<input type="checkbox"/> CA Silver MC 65/50 2600	<input type="checkbox"/> CA Silver MC Savings Plus 65/50 2600		
<input type="checkbox"/> CA Silver MC 60/50 2100	<input type="checkbox"/> CA Silver MC Savings Plus 60/50 2100		
<input type="checkbox"/> CA Bronze MC 100 6650 HSA M	<input type="checkbox"/> CA Bronze MC Savings Plus 100 6650 HSA M		
<input type="checkbox"/> CA Bronze MC 50/50 8300	<input type="checkbox"/> CA Bronze MC Savings Plus 50/50 8300		
<b>Open Choice PPO Plan</b>			
<input type="checkbox"/> CA Gold PPO 80/50 1000	<input type="checkbox"/> CA Bronze PPO 55/50 5500		
<input type="checkbox"/> CA Silver PPO 60/50 2100	<input type="checkbox"/> CA Bronze PPO 50/50 8300		

Continued on next page

**B. Coverage selection – Please print clearly. (Continued)**

Control/Group number	Suffix	Account	Plan number
----------------------	--------	---------	-------------

**2. Dental – Check one (if applicable).**

**Non-voluntary 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

Creditable coverage is allowed for new members enrolling in voluntary takeover groups. New hires please see below if applicable:  
 New Hire selecting a Voluntary plan **and your Aetna plan is a takeover group:** Were you covered for 12 months **under** a dental plan within the last 90 days that included both Preventive and Basic coverage? Discount dental and preventive only plans do not apply. ☐ Yes ☐ No

**Employees in AZ, CA, GA, MA, MD, MO, NC, NJ and TX must either live or work within the approved DMO® service area to be eligible to enroll in the DMO®.**

Control number	Suffix	Account	Plan number
----------------	--------	---------	-------------

**3. Aetna Vision<sup>SM</sup> Preferred** ☐ Yes ☐ No

*You may only select a vision plan if your employer offers vision coverage.*

**C. Individuals Covered – List individuals for whom you are enrolling or adding/changing/removing coverage. Add more sheets if needed.**  
**For dependents with different last names or living at another address, complete Section D below. NOTE FOR MEDICAL COVERAGE:** While the 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. Please refer to your plan documents or contact your benefits administrator.

<b>1</b>	Employee name (last, first, middle initial)	Sex (M/F)	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		Choosing coverage for: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Primary care physician (PCP) provider office ID number	Current patient <input type="checkbox"/> Yes	Dental office ID number (if applicable) <input type="checkbox"/> Yes

<b>2</b>	Spouse name (last, first, middle initial)	Sex (M/F)	Social Security number	Birthdate (MM/DD/YYYY) / /	
Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner <input type="checkbox"/> Other _____		Choosing coverage for: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	PCP provider office ID number	Current patient <input type="checkbox"/> Yes	Dental office ID number (if applicable) <input type="checkbox"/> Yes

<b>3</b>	Child name (last, first, middle initial)	Sex (M/F)	Social Security number	Birthdate (MM/DD/YYYY) / /	
Relationship <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____		Choosing coverage for: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	PCP provider office ID number	Current patient <input type="checkbox"/> Yes	Dental office ID number (if applicable) <input type="checkbox"/> Yes

<b>4</b>	Child name (last, first, middle initial)	Sex (M/F)	Social Security number	Birthdate (MM/DD/YYYY) / /	
Relationship <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____		Choosing coverage for: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	PCP provider office ID number	Current patient <input type="checkbox"/> Yes	Dental office ID number (if applicable) <input type="checkbox"/> Yes

<b>5</b>	Child name (last, first, middle initial)	Sex (M/F)	Social Security number	Birthdate (MM/DD/YYYY) / /	
Relationship <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____		Choosing coverage for: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	PCP provider office ID number	Current patient <input type="checkbox"/> Yes	Dental office ID number (if applicable) <input type="checkbox"/> Yes

Continued on next page

**C. Individuals Covered (Continued)**

<b>6</b>	<b>Child name</b> (last, first, middle initial)	<b>Sex (M/F)</b>	<b>Social Security number</b>	<b>Birthdate (MM/DD/YYYY)</b> / /	
<b>Relationship</b> <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____		<b>Choosing coverage for:</b> <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		<b>PCP provider office ID number</b>	<b>Current patient</b> <input type="checkbox"/> Yes
				<b>Dental office ID number (if applicable)</b>	<b>Current patient</b> <input type="checkbox"/> Yes

  

<b>7</b>	<b>Child name</b> (last, first, middle initial)	<b>Sex (M/F)</b>	<b>Social Security number</b>	<b>Birthdate (MM/DD/YYYY)</b> / /	
<b>Relationship</b> <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____		<b>Choosing coverage for:</b> <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		<b>PCP provider office ID number</b>	<b>Current patient</b> <input type="checkbox"/> Yes
				<b>Dental office ID number (if applicable)</b>	<b>Current patient</b> <input type="checkbox"/> Yes

**D. Dependent information**

List any dependent in section <b>C</b> with a different last name or living at another address.	
<b>Name</b>	<b>Address</b>

**E. Coordination of benefits**

Will you have other health insurance at the same time as this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If <b>yes</b> , will the Aetna coverage you're applying for replace the coverage you have now? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Name of person</b>	<b>Carrier name</b>	<b>Name of person</b>	<b>Carrier name</b>

**Conditions of enrollment**

<p><b>NOTICE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.</b></p> <p>I understand that the following legal entities (collectively referred to as "Aetna") underwrite the plans I apply for:</p> <ul style="list-style-type: none"> <li>• Aetna Health of California Inc. underwrites HMO plans.</li> <li>• Aetna Life Insurance Company underwrites Aetna Vision plans, Elect Choice EPO plans, and Managed Choice POS plans.</li> <li>• Aetna Dental of California Inc. and Aetna Life Insurance Company underwrite Aetna Dental plans.</li> </ul> <p>1. My employer's application determines coverage. I don't have coverage until Aetna approves my employee enrollment form and the employer application. Even if Aetna approves the employer application, any fraud, intentional misstatement or omissions of material facts may result in denial of future claims and Aetna may rescind or reevaluate my coverage under the policy, as of the effective date, for eligibility and rating purposes. If Aetna voids or rescinds coverage, I may be entitled to a refund of any paid premiums from the effective date of coverage. Aetna will give at least 30 days prior notice by certified mail to any covered person affected by the proposed rescission. 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 for medical, dental or vision on any of the following factors:</p> <ul style="list-style-type: none"> <li>A. Health status</li> <li>B. Medical condition, including physical and mental illnesses</li> <li>C. Claims experience</li> <li>D. Receipt of health care</li> <li>E. Medical history</li> <li>F. Genetic information</li> <li>G. Evidence of insurability, including conditions arising out of acts of domestic violence</li> <li>H. Any other health status-related factor as determined by any federal regulations, rules, or guidance issued pursuant to Section 2705 of the federal Public Safety Act</li> </ul>
--

*Continued on next page*

**Conditions of enrollment (Continued)**

2. The Group Agreement/Group Policy determines the rights and responsibilities of members and will govern in the event they conflict with any:
- Benefits comparison
  - Summary
  - Other description of the plan
3. Participating physicians, hospitals and other health care providers are independent contractors. They are not Aetna agents or employees. We cannot guarantee the availability of any particular provider. Any provider network is subject to change. We will provide a notice of the change in accordance with applicable state law.
4. You may keep your medical information private by requesting a confidential communication.
5. I understand that, with certain exceptions described in the plan documents, HMO and DMO® plans only provide coverage for network covered benefits. The plan documents also describe if I need a referral for certain procedures, and who can provide care. Covered services must be performed by:
- Participating primary care physicians
  - Participating primary care dentists
  - Participating specialists
  - Participating hospitals
  - Participating pharmacies
  - Participating dentists
  - Other participating providers 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 enrollment/change form. I understand in the event I fail to sign and return this form within 31 days of my eligibility date or Aetna does not receive the request within a reasonable time, my eligibility may be affected. I am employed by the employer shown on page 1. I am working full time at least 30 hours a week (or 20-29 hours a week if elected by my employer) for this employer at the regular place of business. I authorize deductions from my earnings for any contributions required for coverage. I agree to make any necessary payments as required for coverage.

To receive documents online, please visit your secure member account at [Aetna.com](https://www.aetna.com).

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

**Please sign here ONLY if you are enrolling in coverage for yourself and/or dependents.**

**Employee email**

**Date (Month/Day/Year)**

☐ **I AM ENROLLING FOR COVERAGE:**

**Employee signature** **X**

**If an Insurance Agent or Broker helped you complete this application, please obtain their signature below.**

☐ **I did not use an Insurance Agent or Broker.**

**Agent or broker certification and attestation:**

I, \_\_\_\_\_ (print name), attest to the following:

1. The information on the enrollment/change form is complete and accurate; and
2. I explained to the employee, in easy-to-understand language, the risk to the employee of providing inaccurate information and that the employee understood the explanation.

If you, as the agent or broker, willfully state as true any material fact(s) that you know to be false, you will, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to ten thousand dollars (\$10,000).

**Agent or broker signature:** \_\_\_\_\_

**F. Declining coverage – Check all that apply.**

I understand I am eligible to apply for this coverage through my employer. However, I am declining the coverage I checked below.

<input type="checkbox"/> <b>Employee:</b>	<b>Reason for declining coverage</b>	
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Spouse group coverage	<input type="checkbox"/> COBRA coverage
<input type="checkbox"/> <b>Spouse:</b>	<input type="checkbox"/> Parental group coverage	<input type="checkbox"/> Insurance through another job
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Medicare	<input type="checkbox"/> TRICARE Military coverage
<input type="checkbox"/> <b>Children:</b>	<input type="checkbox"/> Medi-Cal	<input type="checkbox"/> Individual coverage – On Exchange
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Retiree coverage	<input type="checkbox"/> Individual coverage – Off Exchange
	<input type="checkbox"/> Another group plan provided by my employer	<input type="checkbox"/> I have no other coverage
		<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 declining coverage as noted above. 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 dependents.**

**Date (Month/Day/Year)**

**X I AM DECLINING COVERAGE:** **Employee signature**

## Nondiscrimination Notice – California

Aetna does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Aetna provides free aids and services to people with disabilities and free language services to people whose primary language is not English.

These aids and services include:

- Qualified language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Qualified interpreters
- Information written in other languages

If you need these services, have questions about our non-discrimination policy, or have a discrimination-related concern that you would like to discuss, contact the number on your ID card. Not an Aetna member? Call us at **1-800-872-3862**.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance with our Civil Rights Coordinator at:

- Address: P.O. Box 14462, Lexington, KY 40512 (HMO customers: P.O. Box 24030 Fresno, CA 93779)
- Email: [CRCoordinator@aetna.com](mailto:CRCoordinator@aetna.com)

Please visit <https://www.aetna.com/individuals-families/member-rights-resources/complaints-grievances-appeals.html#california> for information about how to file a complaint or grievance with the California Department of Insurance or California Department of Managed Health Care (for HMO enrollees).

You can also file a discrimination complaint with the United States Department of Health and Human Services Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, age, disability, or sex by following the instructions on the Department's website: <https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

1076950-01-01 (4/22)

## Language accessibility statement

Interpreter services are available for free.

TTY: 711

To access language services at no cost to you, call **1-800-385-4104**.

Para acceder a los servicios de idiomas sin costo, llame al **1-800-385-4104** (Spanish)

如欲使用免費語言服務，請致電 **1-800-385-4104**。(Chinese)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số **1-800-385-4104**. (Vietnamese)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa **1-800-385-4104**. (Tagalog)

무료 언어 서비스를 이용하려면 **1-800-385-4104** 번으로 전화해 주십시오. (Korean)

Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք **1-800-385-4104** հեռախոսահամարով: (Armenian)

برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-800-385-4104 تماس بگیرید (Persian-Farsi)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону **1-800-385-4104**. (Russian)

言語サービスを無料でご利用いただくには、**1-800-385-4104** までお電話ください。(Japanese)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم

**1-800-385-4104**. (Arabic)

ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, **1-800-385-4104** 'ਤੇ ਫ਼ੋਨ ਕਰੋ। (Punjabi)

ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ **1-800-385-4104** ។ (Mon-Khmer, Cambodian)

1076950-01-01 (4/22)

Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu **1-800-385-4104**. (Hmong)

आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, **1-800-385-4104** पर कॉल करें। (Hindi)

หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร **1-800-385-4104** (Thai)

## Notice 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

1076950-01-01 (4/22)



TTY: 711

To access language services at no cost to you, call 1-888-238-6201.

Para acceder a los servicios de idiomas sin costo, llame al 1-888-238-6201. (Spanish)

如欲使用免費語言服務，請致電 1-888-238-6201。 (Chinese)

Afin d'accéder aux services langagiers sans frais, composez le 1-888-238-6201. (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-888-238-6201. (Tagalog)

T'áá ni nizaad k'ehjí bee níká a'doowoł doo bááh ílínígóó koji' hólne' 1-888-238-6201. (Navajo)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-888-238-6201 an. (German)

Për shërbime përkthimi falas për ju, telefononi 1-888-238-6201. (Albanian)

የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-888-238-6201 ይደውሉ። (Amharic)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-888-238-6201. (Arabic)

Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-888-238-6201 հեռախոսահամարով: (Armenian)

Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-888-238-6201 (Bantu)

আপনাকে বিনামূল্যে ভাষা পরিষেবা পেতে হলে এই নম্বরে টেলিফোন করুন: 1-888-238-6201। (Bengali)

Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-888-238-6201. (Bisayan-Visayan)

သင့်အနေဖြင့် အခကြေးငွေ မပေးရပဲ ဘာသာစကားဝန်ဆောင်မှုများ ရရှိနိုင်ရန် 1-888-238-6201 သို့ ဖုန်းခေါ်ဆိုပါ။ (Burmese)

Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-888-238-6201. (Catalan)

Para un hago' i setbision lengguãhi ni dibátde para hãgu, ágang 1-888-238-6201. (Chamorro)

ᎠᎵᏍᎦᎵ ᎠᎵᏍᎦᎵ ᎠᎵᏍᎦᎵ ᎠᎵᏍᎦᎵ ᎠᎵᏍᎦᎵ ᎠᎵᏍᎦᎵ ᎠᎵᏍᎦᎵ 1-888-238-6201. (Cherokee)

Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-888-238-6201. (Choctaw)

Tajaajiloota afaanii garuu bilisaa ati argaachuuf, bilibili 1-888-238-6201. (Cushite-Oromo)

Voor gratis toegang tot taaldiensten, bell 1-888-238-6201. (Dutch)

Pou jwenn sèvis lang gratis, rele 1-888-238-6201. (French Creole-Haitian)

Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-888-238-6201. (Greek)

તમારે કોઇ જાતના ખર્ચ વિના ભાષાની સેવાઓની પહોંચ માટે, કોલ કરો 1-888-238-6201. (Gujarati)

No ka wala'au 'ana me ka lawelawe 'ōlelo e kahea aku i kēia helu kelepona 1-888-238-6201. Kāki 'ole 'ia kēia kōkua nei. (Hawaiian)

आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, 1-888-238-6201 पर कॉल करें। (Hindi)

Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-888-238-6201. (Hmong)

Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 1-888-238-6201. (Ibo)

Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-888-238-6201. (Ilocano)

Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-888-238-6201. (Indonesian)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-888-238-6201 (Italian)

言語サービスを無料でご利用いただくには、1-888-238-6201 までお電話ください。 (Japanese)

လၢတၢ်ကမၤန့ၢ်ကိၣ်အတၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖၣ်လၢတၢ်အိၣ်ဒီးအပူၤလၢကတၢၢ်ဟ့ၣ်အိၣ်အိၣ်တၢ်န့ၣ် ကိး 1-888-238-6201 တက့ၢ်. (Karen)

무료 언어 서비스를 이용하려면 1-888-238-6201 번으로 전화해 주십시오. (Korean)

M̈dyi wuḍu-dù kà kò dò bë d̈yi múuñ nì Pídyi ní, n̈í, dá nòbà n̈ià kɛ: 1-888-238-6201. (Kru-Bassa)

بو دەسپێر اگەشتن بە خزمەتگوزاری زمان بەبێ تیچوون بو تو، پەیوەندی بکە بە ژمارەی 1-888-238-6201. (Kurdish)

ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-888-238-6201. (Laotian)

कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-888-238-6201 वर फोन करा. (Marathi)

Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirløk 1-888-238-6201. (Marshallese)

Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-888-238-6201. (Micronesia-Pohnpeian)

ដើម្បីទទួលបានសេវាភាសាដោយឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-888-238-6201។ (Mon-Khmer, Cambodian)

निःशुल्क भाषा सेवा प्राप्त गर्न 1-888-238-6201 मा टेलिफोन गर्नुहोस् । (Nepali)

Të koor yin wëër de thokic ke cîn wëu kor keek tënɔŋ yîn. Ke cɔl kɔc ye kɔc kuony ne nɔmba 1-888-238-6201. (Nilotic-Dinka)

For tilgang til kostnadsfri språktjenester, ring 1-888-238-6201. (Norwegian)

Um Schprooch Services zu griege mitaus Koscht, ruff 1-888-238-6201. (Pennsylvania Dutch)

برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-888-238-6201 تماس بگیرید. (Persian-Farsi)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonić 1-888-238-6201 (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para 1-888-238-6201. (Portuguese)

ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-888-238-6201 'ਤੇ ਫ਼ੋਨ ਕਰੋ। (Punjabi)

Pentru a accesa gratuit serviciile de limbă, apălați 1-888-238-6201. (Romanian)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-888-238-6201. (Russian)

Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-888-238-6201. (Samoan)

Za besplatne prevodilačke usluge pozovite 1-888-238-6201. (Serbo-Croatian)

Heeba a nasta jangirde djeɣ wolde wola chede bo apelou lamba 1-888-238-6201. (Sudanic-Fulfulde)

Kupata huduma za lugha bila malipo kwako, piga 1-888-238-6201. (Swahili)

ܡܝ ܫܪܝܩܐ، ܕܗ ܟܠ ܝܠܒܝܬܝܢ ܐܚܝܢܝܬܝܢ ܥܠܝܬܝܢ ܕܝܬܝܢܝܬܝܢ، ܡܢ ܦܨܚܐ:  
 (Syriac-Assyrian) 1-888-238-6201

మీరు భాష సేవలను ఉచితంగా అందుకునేందుకు, 1-888-238-6201 కు కాల్ చేయండి. (Telugu)

หากท่านต้องการเข้าถึงบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-888-238-6201 (Thai)

Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-888-238-6201.  
(Tongan)

Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-888-238-6201. (Trukese)

Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-888-238-6201 numarayı arayın. (Turkish)

Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-888-238-6201. (Ukrainian)

بلا قیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-888-238-6201 پر بات کریں۔ (Urdu)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-888-238-6201. (Vietnamese)

צו צוטריט שפראך באדינונגען אין קיין פרייז צו איר, רופן 1-888-238-6201. (Yiddish)

Lati wọnú awọn isẹ èdè l'ọfẹ fun ọ, pe 1-888-238-6201. (Yoruba)