blue california

Small Business Master Group Application

Effective April 1, 2021

Blue Shield of California and
Blue Shield of California Life & Health Insurance Company

Requested Coverage Effective Date: _____

Use this form if you currently don't have any Blue Shield Small Business coverage, or to add medical to existing specialty coverage. Please type or print clearly in black ink.

1A EMPLOYER INFORMATION

Group legal name			Federal Tax ID (TID) number
Doing business as (DBA), if applicable:			Standard Industry Classification (SIC) and industry description
Principal business address in California – number and street (no P.O. box)*			
City		State	ZIP code
Billing address (if different from above)			
City		State	ZIP code
Location of group headquarters (if different from "Principal business address in California" above) – number and street (no P.O. box)*			
City	State	ZIP code	County

* The principal business address means the principal business address registered with the Secretary of the State of California. If a principal business address is not registered with the State or is registered solely for purposes of service of process and is not a substantial worksite for the group's business, then provide the business address within the State where the greatest number of employees work.

1B GROUP CONTACT INFORMATION

Only the primary contact can access group information.

Primary contact	Name	Title
	Phone	Email
Secondary contact	Name	Title
	Phone	Email

☐ **Check here to register the primary contact for online account access to view and/or manage the group account.**

Once registered, the primary group contact can delegate account access to the group's producer or other individuals within the company. To sign up or make account changes, please visit **blueshieldca.com/employer**.

1C LEGAL ENTITY TYPE

Choose one legal entity type:

☐ S-Corporation ☐ C-Corporation ☐ Partnership or LP ☐ Sole proprietor ☐ LLC ☐ Non-profit

☐ Other (specify) _____

1D AFFILIATED COMPANIES AND SUBSIDIARIES

When counting the number of employees or eligible employees to determine if the group is a "small employer", companies that are affiliated companies and that are eligible to file a combined tax return for purposes of state taxation are considered one employer.

Reset

Does the group have any subsidiary or affiliated companies? ☐ Yes ☐ No

Subsidiary or affiliated company name(s)	Include in coverage?	Eligible to file a combined state tax return?
	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No

2A PREVIOUS AND CURRENT COVERAGE

If the group has had or currently has medical coverage, who was/is the most recent carrier(s)? _____

Is the group intending to offer Blue Shield alongside another carrier? ☐ Yes ☐ No

If yes, carrier name _____ Number of employees enrolled _____

2B CONTINUATION COVERAGE

If the group is subject to continuation coverage, choose one option below:

Reset

☐ **Federal COBRA, OR**	20+ total employees, employed 50% working days in previous calendar year.
☐ **Cal-COBRA**	2-19 eligible employees, employed 50% working days in previous calendar year; or if not in the business during the previous calendar year, during the previous calendar quarter.

Provide information below for all Federal COBRA and/or Cal-COBRA employees:

Reset

	Number of current enrollees	Number of employees and/or family members in election period	Enrollment forms submitted for all enrolling participants?
Federal COBRA			☐ Yes ☐ No
Cal-COBRA			☐ Yes ☐ No

3A EMPLOYEE COUNTS

_____	**Total number of employees** – count all full-time and part-time employees, regardless of eligibility for coverage, including employed owners and officers
_____	**Eligible employees*** Total number of eligible full-time employees
☐ Yes ☐ No	Is the group offering coverage to part-time employees? See definition of part-time employee below.
If yes, _____	Total number of eligible part-time employees

Total number of eligible enrolling/refusing employees – the counts of enrolling and refusing should equal the total number of eligible employees entered above.

ENROLLING	Medical coverage _____	Dental coverage _____	Vision coverage _____	Life coverage _____
REFUSING	Medical coverage _____	Dental coverage _____	Vision coverage _____	Life coverage _____

* **Eligible Employee** – use this definition to determine which employees are eligible to enroll, and remain enrolled, in coverage. An eligible employee is an employee who:

- **(Full-time)** Is a permanent employee who works on a full-time basis in the conduct of the business of the employer, whose duties are performed at the employer's regular place(s) of business, working an average of 30 hours per work week, and who has met any statutorily authorized waiting period; or
- **(Part-time)** Meets all the conditions set forth in the first bullet except works at least 20 hours but no more than 29 hours at least 50% of the weeks in the previous calendar quarter, the group offers such employees health coverage and all similarly situated employees are offered such coverage; and
- Receives monetary compensation in the course of employment (shown through W-2); and
- Is a bona fide employee and a bona-fide employee/employer relationship exists.
- An eligible employee also includes a sole proprietor, spouse, or Domestic Partner of a sole proprietor, or partners of a partnership, or the spouse or Domestic Partner of a partner of a partnership working on a full-time basis at the employer's regular place(s) of business, working an average of 30 hours per work week, when the group meets all small employer eligibility requirements.
- An eligible employee does not include individuals working on a temporary or substitute basis.

3B GROUP ELIGIBILITY

☐ Yes ☐ No	Is the group actively engaged in business or service? A "Yes" answer means the business currently provides goods or services. A "No" answer means the business does not currently provide goods or services.
☐ Yes ☐ No	Was the group formed primarily for the purpose of buying health coverage? A "Yes" answer means the business was established solely to obtain healthcare coverage, not to provide goods or services. A "No" answer means the business was established solely to provide goods or services.
☐ Yes ☐ No	Did the group employ 1-100 employees on at least 50% of its working days during the preceding calendar quarter or preceding calendar year (unless the group is a startup), the majority of whom reside within the state of CA, and in which a bona fide employer-employee relationship exists?
☐ Yes ☐ No	Does your group employ at least one W-2 ("common law") employee listed on the employer's DE 9C, who meets the definition of an "eligible employee", who isn't the sole proprietor, a partner of the partnership, or their spouse or registered domestic partner?

Use the method for counting full time employees (FTE) and FTE Equivalents described in Section 4980H(c)(2) of the Internal Revenue Code to determine if the group is a "small employer" under the Small Group Act. A group must employ 1-100 total FTEs, including FTE Equivalents, (not including sole proprietors, partners of a partnership, their spouses or legal domestic partners), to be eligible for a small group health plan at issuance and renewal, in addition to meeting any applicable underwriting criteria such as contribution and participation requirements.

To calculate the number of FTEs and FTE Equivalents:

- **FTE**: an FTE is an employee who has on average at least 30 hours of service per week, or at least 130 hours of service total, during a calendar month.
- **FTE Equivalent**: this calculation is to account for employees who average fewer than 30 hours of service per week, who, in combination, are counted as the equivalent of a full-time employee.
- **FTE Equivalent employee calculation**: combine the number of hours of service of all non-full-time employees for the month (do not include more than 120 hours of service per employee). Divide the total number by 120. If the result is a fraction, round down.

Total current FTE and FTE Equivalent _____	If current count is larger than 100, how many employed in prior calendar quarter?	_____
	If prior calendar quarter count is larger than 100, how many employed in prior calendar year?	_____
Total current FTE and FTE Equivalent employed out of state _____	Total FTE and FTE Equivalent employed out of state during the prior calendar quarter	_____
	Total FTE and FTE Equivalent employed out of state during the prior calendar year	_____

4 ADDITIONAL GROUP INFORMATION

☐ Yes ☐ No	Are all eligible employees being offered health coverage? (Employees who waive coverage on the grounds that they have group coverage through another employer are not counted as eligible employees).
☐ Yes ☐ No	Do all employees and their dependents who are to be covered by the plan contract work or reside in the service area in which the plan provides or otherwise arranges for the provision of health services?
☐ Yes ☐ No	Are all employees covered by workers' compensation to the extent required by law?
☐ Yes ☐ No	Does the group employ both union and non-union employees?
☐ Yes ☐ No	Has the group used employees leased from a Professional Employer Organization (PEO) within the past six weeks? A leased employee is employed and paid by the PEO. When the PEO performs administrative services only, such as payroll processing, the employees are not leased.
☐ Yes ☐ No	If yes, are you canceling this leasing arrangement and hiring employees?
☐ Yes ☐ No	Is the group a spinoff?*
☐ Yes ☐ No	Is the group a startup?†

* **Spinoff Group** – a newly formed business in which a majority of the employees of the new business have left an established business ("former business") which had been offering Blue Shield coverage to its employees. At least 50% of the employees in the spin-off group must have been enrolled in Blue Shield through the former business. The new group must not have shared ownership with the former business. Contact your sales representative for more information.

† **Startup Group** – has been in business and has employed at least one eligible common-law employee for less than six weeks and otherwise meets all small employer requirements.

5 EMPLOYER ORIENTATION AND WAITING PERIODS

An employer may impose a bona fide employment-based orientation (affiliation) period for new employees which cannot exceed 30 days. If the employer imposes an orientation period when completing an enrollment form for a new employee, the "date of hire" is the first day after completion of the orientation period.

A waiting period may also be imposed before coverage becomes effective, beginning the first day after any orientation period and not to exceed 90 days.

Choose one of the following options. Coverage for eligible employees will become effective following completion of the waiting period on the day specified.

☐	Effective first of the month following date of hire (if hired on the first of the month, coverage will be effective the first of the following month)
☐	Effective first of the month following 30 days from date of hire
☐	Effective first of the month following 60 days from date of hire
☐	Effective on the 91st day following date of hire (a group may be partially billed when electing the 91st day waiting period)
☐ Yes ☐ No	Does the group intend to offer coverage to employees currently in the employer waiting period for the original effective date of the group contract (i.e. one-time waiver of employer waiting period)?

6 NOTICES AND ELECTRONIC DISTRIBUTION OF MATERIALS

- Summary of Benefits and Coverage (SBC) forms are available for all health plans. These forms summarize coverage and benefits for all plans in a uniform manner. Log in to **blueshieldca.com/policies** to review SBC forms for any plan prior to submitting an application. Once the group's application for coverage is approved, download the SBC form(s) for benefit plans specific to your group at **bscadocs.com/sbc** to distribute to employees.
- The group is responsible for the prompt distribution of the *Evidence of Coverage* booklets and other required coverage notices ("required materials") to covered employees. Electronic versions of required materials are emailed directly to the group administrator. For printed versions of required materials, please contact us at **(800) 559-5905**.

7A MEDICAL PLANS

For groups with one or more enrolling employee, choose plans from either the Off-Exchange or Mirror plan packages, but not both. Plan packages cannot be combined. Within a plan package, HMO and PPO can be offered together.

Off-Exchange Package	May be offered with another carrier's HMO plan
Mirror Package	Cannot be offered alongside Off-Exchange plans or any other carrier's plans. These plans "mirror" standardized plans offered through Covered California

Blue Shield of California Off-Exchange Package for Small Business

PPO Plans Full PPO and Tandem PPO have different provider networks. Full PPO and Full HSA-compatible High Deductible Health Plan (HDHP) plans share a full Blue Shield provider network. Tandem PPO and Tandem HSA-compatible HDHP plans share a select Blue Shield provider network. Choose any combination of Full PPO Network and Tandem PPO Network plans.

☐ Choose ALL PPO plans, OR Reset

☐ Individually choose any number of the plan(s) below:

PPO plans – Full PPO Network
- ☐ Platinum Full PPO 0/0 OffEx
- ☐ Platinum Full PPO 0/10 OffEx
- ☐ Platinum Full PPO 250/10 OffEx
- ☐ Platinum Full PPO 250/15 OffEx
- ☐ Gold Full PPO 0/25 OffEx
- ☐ Gold Full PPO 500/30 OffEx
- ☐ Gold Full PPO 750/30 OffEx
- ☐ Gold Full PPO 1200/35 OffEx
- ☐ Silver Full PPO 1950/50 OffEx
- ☐ Silver Full PPO 2225/50 OffEx*
- ☐ Silver Full PPO 2400/55 OffEx
- ☐ Bronze Full PPO 6250/70 OffEx
- ☐ Bronze Full PPO 6850/65 OffEx
- ☐ Bronze Full PPO 7500/50 OffEx

HSA-compatible HDHP plans – Full PPO Network
- ☐ Gold Full PPO Savings 1750/15% OffEx
- ☐ Silver Full PPO Savings 2100/25% OffEx
- ☐ Silver Full PPO Savings 2600/35% OffEx
- ☐ Bronze Full PPO Savings 5700/40% OffEx
- ☐ Bronze Full PPO Savings 7000 OffEx

HSA-compatible HDHP plans – Tandem PPO Network
- ☐ Gold Tandem PPO Savings 1750/15% OffEx
- ☐ Silver Tandem PPO Savings 2100/25% OffEx
- ☐ Silver Tandem PPO Savings 2600/35% OffEx
- ☐ Bronze Tandem PPO Savings 5700/40% OffEx
- ☐ Bronze Tandem PPO Savings 7000 OffEx

Tandem PPO plans – Tandem PPO Network
- ☐ Platinum Tandem PPO 0/0 OffEx
- ☐ Platinum Tandem PPO 0/10 OffEx
- ☐ Platinum Tandem PPO 250/10 OffEx
- ☐ Platinum Tandem PPO 250/15 OffEx
- ☐ Gold Tandem PPO 0/25 OffEx
- ☐ Gold Tandem PPO 500/30 OffEx
- ☐ Gold Tandem PPO 750/30 OffEx
- ☐ Gold Tandem PPO 1200/35 OffEx
- ☐ Silver Tandem PPO 1950/50 OffEx
- ☐ Silver Tandem PPO 2225/50 OffEx*
- ☐ Silver Tandem PPO 2400/55 OffEx
- ☐ Bronze Tandem PPO 6250/70 OffEx
- ☐ Bronze Tandem PPO 6850/65 OffEx
- ☐ Bronze Tandem PPO 7500/50 OffEx

* The Silver Full PPO 2225/50 OffEx and Silver Tandem PPO 2225/50 OffEx offer enhanced coverage for members diagnosed with diabetes, asthma, COPD, and CAD.

HMO Plans Access+ HMO plans, Local Access+ HMO plans, and Trio HMO plans have different provider networks. Local Access+ and Trio are select networks and Access+ is a full network. Access+ and Local Access+ networks may not be offered together. Reset

☐ Choose ALL Trio and Local Access+ plans, OR

☐ Choose ALL Trio and Access+ plans, OR

☐ Individually choose any number of plan(s) below from Trio/Access+ or Trio/Local Access+:

Access+ HMO plans – Access+ HMO Network
- ☐ Platinum Access+ HMO® 0/20 OffEx
- ☐ Platinum Access+ HMO® 0/25 OffEx
- ☐ Platinum Access+ HMO® 0/30 OffEx
- ☐ Gold Access+ HMO® 0/30 OffEx
- ☐ Gold Access+ HMO® 500/35 OffEx
- ☐ Gold Access+ HMO® 1000/35 OffEx
- ☐ Gold Access+ HMO® 1500/35 OffEx
- ☐ Silver Access+ HMO® 2350/65 OffEx

Trio HMO plans – Trio ACO HMO Network
- ☐ Platinum Trio HMO 0/20 OffEx
- ☐ Platinum Trio HMO 0/25 OffEx
- ☐ Platinum Trio HMO 0/30 OffEx
- ☐ Gold Trio HMO 0/30 OffEx
- ☐ Gold Trio HMO 500/35 OffEx
- ☐ Gold Trio HMO 1000/35 OffEx
- ☐ Gold Trio HMO 1500/35 OffEx
- ☐ Silver Trio HMO 2350/65 OffEx

Local Access+ HMO plans – Local Access+ HMO Network
- ☐ Platinum Local Access+ HMO® 0/20 OffEx
- ☐ Platinum Local Access+ HMO® 0/25 OffEx
- ☐ Platinum Local Access+ HMO® 0/30 OffEx
- ☐ Gold Local Access+ HMO® 0/30 OffEx
- ☐ Gold Local Access+ HMO® 500/35 OffEx
- ☐ Gold Local Access+ HMO® 1000/35 OffEx
- ☐ Gold Local Access+ HMO® 1500/35 OffEx
- ☐ Silver Local Access+ HMO® 2350/65 OffEx

Blue Shield of California Mirror Package for Small Business

☐ Choose ALL Trio HMO and Full PPO plans, OR Reset

☐ Individually choose any number of plan(s) below from Trio HMO and/or Full PPO

Platinum Mirror plans
- ☐ Blue Shield Trio Platinum 90 HMO 0/20 + Child Dental
- ☐ Blue Shield Platinum 90 PPO 0/15 + Child Dental

Gold Mirror plans
- ☐ Blue Shield Trio Gold 80 HMO 250/35 + Child Dental
- ☐ Blue Shield Gold 80 PPO 350/25 + Child Dental

Silver Mirror plans
- ☐ Blue Shield Trio Silver 70 HMO 2250/55 + Child Dental
- ☐ Blue Shield Silver 70 PPO 2250/50 + Child Dental

Bronze Mirror plans
- ☐ Blue Shield Bronze 60 PPO 6300/65 + Child Dental

7B ADDITIONAL SELECTIONS

Choose any additional selections, as applicable.

☐ **Yes, HealthEquity**	If you selected an HDHP plan, you may choose to make HealthEquity your HSA administrator. **Choosing HealthEquity means Blue Shield shares eligibility and claims data for a seamless experience.** If you do not select HealthEquity, please work directly with your own HSA administrator.
☐ **Yes, Infertility Rider**	If selected, a rider for infertility benefits will be added to all medical plans for the entire group. This rider can be offered with either an off-exchange or a mirror plan package, HMO and PPO.

8A SPECIALTY BENEFITS – DENTAL

Choose one dental plan option below:

☐ **Single dental plan option** – choose any ONE plan below (HMO or PPO), OR

☐ **Dual Choice dental plan option** – choose any TWO plans below (any combination of HMO or PPO), OR

☐ **Triple Choice dental plan option** – choose THREE plans below in one of these combinations:

- ☐ 2 Dental HMO and 1 Dental PPO, OR
- ☐ 3 Dental HMO plans, OR
- ☐ 2 Dental PPO plans and 1 Dental HMO plan – This option requires you to offer Blue Shield medical plans. The 2 Dental PPO plans must have the same Ortho benefit.

Dental HMO plans

☐ DHMO Basic ☐ DHMO Standard ☐ DHMO Plus ☐ DHMO Deluxe ☐ DHMO Voluntary

Dental PPO plans

☐ Smile℠ Value 50/1500/No Ortho/MAC/NR
☐ Smile℠ 50/1500/No Ortho/MAC/NR
☐ Smile℠ Plus 50/1500/Ortho/MAC/NR
☐ Smile℠ Basic 75/1000/No Ortho/MAC/NR
☐ Smile℠ Basic 50/1000/No Ortho/MAC
☐ Smile℠ Basic 50/1000/Ortho/U85
☐ Smile℠ Plus 50/1500/No Ortho/MAC
☐ Smile℠ Plus 50/1500/No Ortho/MAC/WP*
☐ Smile℠ Deluxe 50/1500/Ortho/MAC/NR
☐ Smile℠ Deluxe 2000 50/2000/No Ortho/MAC/NR
☐ Smile℠ Deluxe Plus 2000 50/2000/Ortho/MAC/NR
☐ Smile℠ Deluxe Gold 50/1500/Ortho/U85/NR
☐ Smile℠ Plus Gold 50/1500/Ortho/U85/NR
☐ Smile℠ Plus Gold 50/1500/Ortho/U80
☐ Smile℠ Plus Gold 50/1500/No Ortho/U80
☐ Smile℠ Plus Gold 50/1500/Ortho/U80/ADV
☐ Smile℠ Plus Gold 50/1500/Ortho/U90/ADV
☐ Smile℠ Plus Gold 50/1500/No Ortho/U90/ADV
☐ Smile℠ Plus Gold 50/2500/Ortho/U90/ADV
☐ Smile℠ Plus Gold 50/2500/No Ortho/U90/ADV
☐ Ultimate Dental PPO for Small Business 50/2000/No Ortho/MAC/NR
☐ Ultimate Dental Plus PPO for Small Business 50/2000/Ortho/MAC/NR
☐ Ultimate Dental PPO for Small Business 50/2000/No Ortho/U80
☐ Ultimate Dental PPO for Small Business 50/2000/Lifetime Ortho/U90
☐ Ultimate Dental PPO for Small Business 50/2000/No Ortho/U90

Voluntary Dental PPO plans*

☐ Smile℠ Basic Voluntary 75/1000/No Ortho/MAC/NR
☐ Smile℠ Basic Voluntary 50/1000/No Ortho/MAC
☐ Smile℠ Basic Voluntary 50/1500/Ortho/U80
☐ Smile℠ Basic Voluntary 50/1000/No Ortho/U80 (No Wait)†

* Voluntary Dental plans require one eligible, enrolling employee.

† This Voluntary plan does not include Waiting Periods. Submission of proof of any prior coverage is not required.

ADV stands for Advantage. ADV plans incentivize members to use in-network providers.

NR stands for No Rollover.

8B SPECIALTY BENEFITS – VISION*

Choose one vision plan option below:

☐ Single vision plan option – choose any ONE plan below, OR

☐ Dual Choice vision plan option – choose any TWO plan options below:

Ultimate Vision for Small Business (12-12-12)	Preferred Vision for Small Business (12-12-24)	Basic Vision for Small Business (12-24-24)
☐ Ultimate Vision Plus 0/0/150/120	☐ Preferred Vision Plus 0/0/150/120	☐ Basic Vision Plus 0/0/150/120
☐ Ultimate Vision 0/0/150	☐ Preferred Vision 0/0/150	☐ Basic Vision 0/0/150
☐ Ultimate Vision Plus 10/25/150/120	☐ Preferred Vision Plus 10/25/150/120	☐ Basic Vision Plus 10/25/150/120
☐ Ultimate Vision 10/25/150	☐ Preferred Vision 10/25/150	☐ Basic Vision 10/25/150
☐ Ultimate Vision 0/0/120	☐ Preferred Vision 0/0/120	☐ Basic Vision 0/0/120
☐ Ultimate Vision 10/25/120	☐ Preferred Vision 10/25/120	☐ Basic Vision 10/25/120
☐ Ultimate Vision Voluntary 10/25/150	☐ Preferred Vision Voluntary 10/25/120	☐ Basic Vision Voluntary 10/25/120

Voluntary Vision plans require one eligible, enrolling employee.

* Vision plans are underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

8C SPECIALTY BENEFITS – LIFE/AD&D*

Choose the life plan design and coverage amount from the options below:

1. **Select plans** – Choose one employee plan option: Flat, Multiple of salary, or Graded. Determine if you also want to offer dependent life. If offering dependent life, the group must also offer Employee Life/AD&D.
2. **Provide benefit details** – Use the "Benefit amounts table" at the bottom of this section to find available amounts for each plan type.

Reset	1. Select plan(s)	2. Provide benefit details	Description
Employee	☐ Flat	Benefit amount: $ _____	All employees are covered at the same flat amount (up to the maximum amount).
	☐ Multiple of salary	☐ 1x salary or ☐ 2x salary Up to a maximum benefit of: $ _____	All employees are covered for the same multiple of salary at one or two times annual salary (up to the maximum amount). Benefit amounts are rounded to the next highest $1,000.
	☐ Graded	Make selections in the "Graded life table" below	Employees are covered by class (up to four), defined with different levels of benefits. Classes can be either flat or multiple of salary, and this selection can vary for each class.
☐ **Dependent**		Benefit amount: $ _____	Only available to employees electing Life/AD&D. Benefits for children ages 14 days to six months are 10% of total benefit, with no coverage for infants from birth to 14 days. AD&D is not available for dependents.

Graded life table (use only if choosing a graded plan). Provide a class description and choose one plan option, Flat or Multiple of Salary, for each class. Plan choices may vary by class. The benefit amount for each class must be no more than 2.5 times that of the next lower class.

	Provide class description	Flat	Multiple of salary	Reset
	Up to four classes	Provide benefit amount	Select salary multiplier	Provide maximum benefit amount
Class 1		$ _____	☐ 1x or ☐ 2x	$ _____
Class 2		$ _____	☐ 1x or ☐ 2x	$ _____
Class 3		$ _____	☐ 1x or ☐ 2x	$ _____
Class 4		$ _____	☐ 1x or ☐ 2x	$ _____

Benefit amount table (use to find benefit amount or maximum benefit for your plan type)

Number of eligible employees	Flat	Multiple of salary	Basic dependent life
	If benefit is within a range, pick any increment of $5,000.	Minimum benefit always $15,000. 1x or 2x annual salary up to the below maximums.	Dependent life benefit must not be more than 50% of the employee benefit. spouse/domestic partner and children must be covered for the same benefit amount.
2-9	$15,000 – $50,000	$30,000 or $50,000	$1,000 or $2,000 or $3,000 or $4,000 or $5,000
10-24	$15,000 – $100,000	$50,000 – $300,000 for 1x annual salary and $50,000 – $500,000 for 2x annual salary	$1,000 or $2,000 or $3,000 or $4,000 or $5,000 or $7,500 or $10,000 or $20,000
25-50	$15,000 – $150,000	$50,000 – $300,000 for 1x annual salary and $50,000 – $500,000 for 2x annual salary	
51-100	$15,000 – $150,000 or $175,000 or $200,000	$50,000 – $300,000 for 1x annual salary and $50,000 – $600,000 for 2x annual salary	

Employee Life/AD&D requires two eligible, enrolling employees.

* Life/AD&D Insurance is underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

9 EMPLOYER CONTRIBUTIONS

How much will the group contribute for each product selected?

Medical	Employee:	_____ % or $ _____	Employer must contribute either (1) at least 50% of employee's total premium, or (2) a defined contribution minimum of $100 per employee (or the cost of total employee premiums, whichever is less). If employer pays 100% employee premium, all eligible employees must enroll in coverage.
	Dependent:	_____ % or $ _____	
Dental	Employee:	_____ % or $ _____	Employer must contribute at least 50% of employee's total premium (except for voluntary plans). If 100% is paid by the employer, all eligible employees must enroll in coverage.
	Dependent:	_____ % or $ _____	
Vision	Employee:	_____ % or $ _____	Employer must contribute at least 25% of employee's total premium (except for voluntary plans). If 100% is paid by the employer, all eligible employees must enroll in coverage.
	Dependent:	_____ % or $ _____	
Basic Term Life and AD&D	Employee:	_____ % or $ _____	Employer must contribute at least 25% of employee's total premium. If 100% is paid by the employer (non-contributory), all eligible employees must enroll in coverage. Voluntary life is not an option.
	Dependent:	_____ % or $ _____	

10A PRODUCER INFORMATION (to be completed by producer or general agent)

Producer agency name (as associated to Tax ID Number)	Producer Tax ID number (for commission payments)
Producer name (agent who wrote the group)	Producer CDI license number
Producer email	Producer phone number
Producer address – number and street (no P.O. Box)	
City	State ZIP code
Does the producer have a delegate contact? ☐ Yes ☐ No	
If yes, delegate name	Delegate email
Is there a split commission? ☐ Yes ☐ No	If yes, 1st Producer _____% 2nd Producer _____%
2nd producer name	2nd producer Tax ID

10B GENERAL AGENT INFORMATION (to be completed by producer or general agent, if applicable)

General agency name (as associated to Tax ID Number)	General agency Tax ID number (for commission payments)
General agency contact name	General agency contact email

10C PRODUCER SIGNATURE (to be completed by producer or general agent)

☐ I assisted the applicant in completing and submitting this application. I certify that, to the best of my knowledge and belief, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information, and the applicant understood the explanation.

Date (required)	**Producer signature** (required)	**Producer printed name** (required)
_____	**X**_____	_____

11 EMPLOYER ATTESTATIONS AND SIGNATURE

☐ The group representative attests to the following:

1. Each employee to whom coverage is being offered meets the definition of an eligible employee (see Section 3A of this application for reference).
2. This is an application for coverage. The group understands that no contract for coverage will exist until Blue Shield has completed its review and communicated to the applicant or the applicant's broker that the application has been accepted, required premium payments have been made, and a group health service contract has been issued. The group representative certifies that, to the best of his/her knowledge and belief, all of the responses provided in this application are true, correct, and complete.
3. By signing below, the group also understand that if it has committed fraud or made an intentional misrepresentation of any material fact in conjunction with this application within the first 24 months of issuance of coverage, Blue Shield may pursue one of the following remedies: Coverage may be cancelled or the applicable dues/premiums may be adjusted, or following notice, the health service contract may be rescinded.

_____ _____

Authorized group representative signature | Date

_____

Authorized group representative printed name

_____

Authorized group representative printed title

Blue Shield of California

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

Blue Shield of California complies with applicable state laws and federal civil rights laws, and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Blue Shield of California:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats, and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California 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:

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711)
Fax: (844) 696-6070
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax, or email. 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
(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

Notice of the Availability of Language Assistance Services
Blue Shield of California

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 help at no cost, please call right away at the Member/Customer Service telephone number on the back of your Blue Shield ID card, or (866) 346-7198.

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda sin cargo, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Blue Shield o al (866) 346-7198. (Spanish)

重要通知：您能讀懂這封信嗎？如果不能，我們可以請人幫您閱讀。這封信也可以 用您所講的語言書寫。如需免费幫助，請立即撥打登列在您的Blue Shield ID卡背面上的 會員/客戶服務部的電話，或者撥打電話 (866) 346-7198。(Chinese)

QUAN TRỌNG: Quý vị có thể đọc lá thư này không? Nếu không, chúng tôi có thể nhờ người giúp quý vị đọc thư. Quý vị cũng có thể nhận lá thư này được viết bằng ngôn ngữ của quý vị. Để được hỗ trợ miễn phí, vui lòng gọi ngay đến Ban Dịch vụ Hội viên/Khách hàng theo số ở mặt sau thẻ ID Blue Shield của quý vị hoặc theo số (866) 346-7198. (Vietnamese)

MAHALAGA: Nababasa mo ba ang sulat na ito? Kung hindi, maari kaming kumuha ng isang tao upang matulungan ka upang mabasa ito. Maari ka ring makakuha ng sulat na ito na nakasulat sa iyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa numerong telepono ng Miyembro/Customer Service sa likod ng iyong Blue Shield ID kard, o (866) 346-7198. (Tagalog)

Baa' ákohwiindzindooígí: Díí naaltsoosísh yíiníłta'go bíiníghah? Doo bíiníghahgóó éí, naaltsoos nich'į' yiidóołtahígíí ła' nihee hóló. Díí naaltsoos ałdó' t'áá Diné k'ehjí ádoolníił nínízingo bíighah. Doo bąąh ílínígó shíká' adoowoł nínízingó nihich'į' béésh bee hodíilnih dóó námboo éí díí Blue Shield bee néího'dílzinígí bine'déé' bikáá' éí doodagó éí (866) 346-7198 jį' hodíilnih. (Navajo)

중요: 이 서신을 읽을 수 있으세요? 읽으실 수 경우, 도움을 드릴 수 있는 사람이 있습니다. 또한 다른 언어로 작성된 이 서신을 받으실 수도 있습니다. 무료로 도움을 받으시려면 Blue Shield ID 카드 뒷면의 회원/고객 서비스 전화번호 또는 (866) 346-7198로 지금 전환하세요. (Korean)

ԿԱՐԵՎՈՐ Է. Կարողանում է՞ք կարդալ այս նամակը: Եթե ոչ, ապա մենք կօգնենք ձեզ: Դուք պետք է նաև կարողանաք ստանալ այս նամակը ձեր լեզվով: Ծառայությունն անվճար է: Խնդրում ենք անմիջապես զանգահարել Հաճախորդների սպասարկման բաժնի հեռախոսահամարով, որը նշված է ձեր Blue Shield ID քարտի ետևի մասում, կամ (866) 346-7198 համարով: (Armenian)

ВАЖНО: Не можете прочесть данное письмо? Мы поможем вам, если необходимо. Вы также можете получить это письмо написанное на вашем родном языке. Позвоните в Службу клиентской/членской поддержки прямо сейчас по телефону, указанному сзади идентификационной карты Blue Shield, или по телефону (866) 346-7198, и вам помогут совершенно бесплатно. (Russian)

重要：お客様は、この手紙を読むことができますか？ もし読むことができない場合、弊社が、お客様をサポートする人物を手配いたします。 また、お客様の母国語で書かれた手紙をお送りすることも可能です。 無料のサポートを希望される場合は、Blue Shield IDカードの裏面に記載されている会員/お客様サービスの電話番号、または、(866) 346-7198にお電話をおかけください。 (Japanese)

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر پاسختان منفی است، می‌توانیم کسی را برای کمک به شما در اختیارتان قرار دهیم. حتی می‌توانید نسخه مکتوب این نامه را به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، لطفاً بدون فوت وقت از طریق شماره تلفنی که در پشت کارت شناسی Blue Shield تان درج شده است و یا از طریق شماره تلفن 346-7198 (866) با خدمات اعضا/مشتری تماس بگیرید. (Persian)

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ ਤਾਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿਚ ਮਦਦ ਲਈ ਅਸੀਂ ਕਿਸੇ ਵਿਅਕਤੀ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਵਿਚ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਤੁਹਾਡੇ Blue Shield ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਮੈਂਬਰ/ਕਸਟਮਰ ਸਰਵਿਸ ਟੈਲੀਫ਼ੋਨ ਨੰਬਰ ਤੇ, ਜਾਂ (866) 346-7198 ਤੇ ਕਾੱਲ ਕਰੋ। (Punjabi)

ប្រការសំខាន់៖ តើអ្នកអាចលិខិតនេះ បានដែរឬទេ? បើមិនអាចទេ យើងអាចឲ្យគេជួយអ្នកក្នុងការអានលិខិតនេះ។ អ្នកក៏អាចទទួលបានលិខិតនេះជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅកាន់លេខទូរស័ព្ទសេវាសមាជិក/អតិថិជនដែលមាននៅលើខ្នងប័ណ្ណសម្គាល់ Blue Shield របស់អ្នក ឬតាមរយៈលេខ (866) 346-7198។ (Khmer)

المهم :هل تستطيع قراءة هذا الخطاب؟ أن لم تستطع قراءته، يمكننا إحضار شخص ما ليساعدك في قراءته. قد تحتاج أيضاً إلى الحصول على هذا الخطاب مكتوباً بلغتك. للحصول على المساعدة بدون تكلفة، يرجى الاتصال الآن على رقم هاتف خدمة العملاء/أحد الأعضاء المدون على الجانب الخلفي من بطاقة الهوية Blue Shield أو على الرقم 346-7198 (866).(Arabic)

TSEEM CEEB: Koj pos tuaj yeem nyeem tau tsab ntawv no? Yog hais tias nyeem tsis tau, peb tuaj yeem nrhiav ib tug neeg los pab nyeem nws rau koj. Tej zaum koj kuj yuav tau txais muab tsab ntawv no sau ua koj hom lus. Rau kev pab txhais dawb, thov hu kiag rau tus xov tooj Kev Pab Cuam Tub Koom Xeeb/Tub Lag Luam uas nyob rau sab nraum nrob qaum ntawm koj daim npav Blue Shield ID, los yog hu rau tus xov tooj (866) 346-7198. (Hmong)

สำคัญ: คุณอ่านจดหมายฉบับนี้ได้หรือไม่ หากไม่ได้ โปรดขอความช่วยจากผู้อ่านได้ คุณอาจได้รับจดหมายฉบับนี้เป็นภาษาของคุณ หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดติดต่อฝ่ายบริการลูกค้า/สมาชิกทางเบอร์โทรศัพท์ในบัตรประจำตัว Blue Shield ของคุณ หรือโทร (866) 346-7198 (Thai)

महत्वपूर्ण: क्या आप इस पत्र को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी मदद के लिए किसी व्यक्ति का प्रबंध कर सकते हैं। आप इस पत्र को अपनी भाषा में भी प्राप्त कर सकते हैं। नि:शुल्क मदद प्राप्त करने के लिए अपने Blue Shield ID कार्ड के पीछे दिए गये मेंबर/कस्टमर सर्विस टेलीफोन नंबर, या (866) 346-7198 पर कॉल करें। (Hindi)

ສິ່ງສຳຄັນ: ທ່ານສາມາດອ່ານຈົດໝາຍນີ້ໄດ້ບໍ? ຖ້າອ່ານບໍ່ໄດ້, ພວກເຮົາສາມາດໃຫ້ບາງຄົນຊ່ວຍອ່ານໃຫ້ທ່ານຟັງໄດ້. ທ່ານຍັງສາມາດຂໍໃຫ້ແປຈົດໝາຍນີ້ເປັນພາສາຂອງທ່ານໄດ້.ສຳລັບຄວາມຊ່ວຍເຫຼືອແບບບໍ່ເສຍຄ່າ, ກະລຸນາ ໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກ/ລູກຄ້າໃນທັນທີເບີໂທລະສັບຢູ່ດ້ານຫຼັງບັດສະມາຊິກ Blue Shield ຂອງທ່ານ, ຫຼືໂທໄປຫາເບີ(866) 346-7198. (Laotian)

Notice of the Availability of Language Assistance Services

Blue Shield of California Life & Health Insurance Company

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 1-866-346-7198. 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 1-866-346-7198. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

免費語言服務。您可獲得口譯員服務。可以用中文把文件唸給您聽，有些文件有中文的版本，也可以把這些文件寄給您。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打 1-866-346-7198 與我們聯絡。欲取得其他協助，請致電 1-800-927-4357 與加州保險部聯絡。Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch. Quý vị có thể được người khác đọc giúp các tài liệu và nhận một số tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-866-346-7198. Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-866-346-7198번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-866-346-7198. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-866-346-7198 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-866-346-7198. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance), по телефону 1-800-927-4357. Russian

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、ＩＤカード記載の番号または1-866-346-7198までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Japanese

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند.برای دریافت کمک،با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره 1-866-346-7198 تماس بگیرید.برای دریافت کمک بیشتر، به CA Dept. of Insurance(اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تلفن کنید.Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-866-346-7198 'ਤੇ ' ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

សេវាកម្មភាសាឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-866-346-7198 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول علي مترجم و قراءة الوثائق لك باللغة العربية. للحصول علي المساعدة، اتصل بنا علي الرقم المبين علي بطاقة عضويتك أو علي الرقم 1-866-346-7198. للحصول علي المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا علي الرقم 1-800-927-4357. Arabic

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-866-346-7198. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

บริการทางภาษาอย่างไม่เสียค่าใช้จ่าย คุณสามารถรับบริการจากล่าม รวมถึงให้เจ้าหน้าที่อ่านเอกสารให้คุณฟัง หรือส่งเอกสารบางส่วนในภาษาของคุณไปหาคุณได้ หากต้องการความช่วยเหลือ กรุณาโทรศัพท์ตามหมายเลขที่ระบุอยู่ด้านหลังบัตรประจำตัวของคุณ หรือ ที่หมายเลข 1-866-346-7198 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรมาที่ กรมการประกันภัยแห่งมลรัฐแคลิฟอร์เนียที่หมายเลข 1-800-927-4357 Thai

निःशुल्क भाषा सेवाएँ। आप एक दुभाषिया की सेवा प्राप्त कर सकते हैं। आप दस्तावेजों को पढ़वा के सुन सकते हैं और कुछ को अपनी भाषा में स्वयं को भिजवा सकते हैं। सहायता के लिए, अपने ID कार्ड पर दिए गए नंबर पर, या 1-866-346-7198 पर हमें फ़ोन करें। अधिक सहायता के लिए कैलीफोर्निया बीमा विभाग (CA Dept. of Insurance) को 1-800-927-4357 पर फ़ोन करें। Hindi

Doo bááh ílínígó saad bee yát'i' bee aná'áwo'. Díí shá ata'halne'dooígí hóló̱o̱doo nínízingo éí bíighah. Naaltsoos naaniná́hájeehígí shich'į' yíidooltah éí doodagó ła' shich'į' ádoolníił nínízingo bíighah. Shíká a'doowoł nínízingo nihich'į' béésh bee hodíilnih dóó námboo éí díí ninaaltsoos dootł'ízhígí bee néího'dílzinígí bine'déé' bikáá' éí doodagó éí (866)346-7198jį' hodíilnih. Hózhó shíká aná́á'doowoł nínízingo éí díí béeso ách'a̱a̱h naa'nil bił haz'á̱a̱jį' 1-800-927-4357jį' hodíilnih. Navajo

ບໍລິການແປພາສາໂດຍບໍ່ເສຍຄ່າ. ທ່ານສາມາດຂໍເອົາຜູ້ແປພາສາໄດ້. ທ່ານສາມາດຂໍໃຫ້ອ່ານເອກະສານໃຫ້ທ່ານຟັງ ແລະ ສົ່ງເອກະສານບາງຢ່າງທີ່ເປັນພາສາຂອງທ່ານ. ສໍາລັບຄວາມຊ່ວຍເຫຼືອ, ໃຫ້ໂທຫາພວກເຮົາຕາມເບີໂທລະສັບທີ່ມີໃນບັດປະຈໍາຕົວຂອງທ່ານ ຫຼື ໂທຫາເບີ1-866-346-7198. ສໍາລັບຄວາມຊ່ວຍເຫຼືອເພີ່ມເຕີມໂທຫາ ພະແນກ ປະກັນໄພຂອງ ລັດຄາລິຟໍເນຍໄດ້ທີ່ເບີ1-800-927-4357. Laotian