ACCIDENT CLAIM FORM

CHECK LIST

Step 1 – Insured's Statement of Claim
- ☐ Must be completed each time you file a claim.
- ☐ Be sure to answer every question.

Step 2 – Authorization
- ☐ Claimant or Authorized Representative must sign and date Authorization on Page 2 to allow physicians to release medical records to Companion Life.

Step 3 – Physicians Statement
- ☐ To be completed by the medical provider.

Important Note Regarding Accident Medical Expenses Claims:

Your accident medical expense coverage requires that all other insurance coverage you hold- whether individual, self-funded, group, or governmental health coverage – first process and pay their portion of the accident expenses. Once these payments are made, the corresponding Explanation of Benefits (EOBs) must be submitted with the claim form.

For Accident Medical Expense and optional Sickness Indemnity Claims:

Attach both paid and unpaid itemized bills to the claim form. A UB04 (hospital bill) or HCFA1500 (non-hospital bill) must be included; a balance-due statement alone is not sufficient. All proceeds will be paid to the member. Itemized bills must clearly indicate:

- ☐ Date(s) of treatment
- ☐ Type(s) of service
- ☐ Diagnosis
- ☐ Medical provider's name and address
- ☐ Individual charge for each expense

ALL REQUIRED PORTIONS OF THIS CLAIM FORM MUST BE COMPLETED TO AVOID UNNECESSARY DELAY IN THE PROCESSING OF YOUR REQUESTS FOR BENEFITS.

Return the fully completed claim form and supporting documentation via any of the methods below:

Companion Life

Phone: 866-473-6615
Fax: 610-374-6986
Mail: P.O. Box 13668, Reading, PA 19612-3668
Submit Claim Via Online Portal: https://flexbenefits.loomislive.com/view/login

Companion Life

Administered by The Loomis Company
P.O. Box 13668
Reading, PA 19612-3668

ACCIDENT CLAIM FORM

Failure to complete this form in its entirety may result in a delay in processing this claim.

Complete Policyholder/Patient Information and sign your claim form.
Have the treating physician complete the Physician's Statement and sign the claim form
If hospitalized and/or confined to an intensive care unit/step-down unit, please send a copy of your hospital bill showing charges and the number of days you were confined. These items can be obtained directly from your healthcare provider(s) by requesting a UB04 (hospital bill) or HCFA1500 (non-hospital bill).

INSURED'S STATEMENT OF CLAIM			TO BE COMPLETED BY POLICYHOLDER
Name of Insured	Social Security Number		Policy & Certificate Number
Street Address	City	State	ZIP Code
Phone Number (Area Code First)	Email Address		Insured's Date of Birth
Name of Claimant	Relationship to Insured	Claimant's Date of Birth	Gender ☐ Male ☐ Female

ACCIDENT CLAIMS

Date of Accident:	Describe how the Accident occurred:

Location of the Accident? ☐ On the job ☐ Off the job ☐ Other (please describe): _____

_____

Was a Workers Compensation Claim filed? ☐ Yes ☐ No
If yes, Carrier Name and Phone Number: _____
If no, Reason: _____

Are you self-employed? ☐ Yes ☐ No

Was the patient in a motor vehicle accident? ☐ Yes (Must attach the police report) ☐ No

Identify where treatment was provided. Please identify all the places of treatment if there is more than one. Use additional claim forms if more room is necessary.

Hospital or Medical Provider Name: _____

Provider Address: _____ Phone: _____

Hospital or Medical Provider Name: _____

Provider Address: _____ Phone: _____

Companion Life

Administered by The Loomis Company
P.O. Box 13668
Reading, PA 19612-3668

ACCIDENT CLAIM FORM

ACCIDENT MEDICAL EXPENSE BENEFIT ONLY:

Do you have other coverage for expenses related to this accident? ☐ Yes ☐ No
If yes, provide:

Insured/Member/Owner Name: _____

Carrier Name: _____ Carrier Address: _____

Carrier Phone Number: _____

Group Policy Number: _____ Effective Date: _____

Termination Date (if applicable): _____

ACCIDENTAL DEATH AND DISMEMBERMENT CLAIM INFORMATION SECTION

Please check the box or boxes that best describe your claim. Attach any documentation you may have indicating the provider, patient's name, copy of itemized billing statement, and date of service, including but not limited to a death certificate and/or physicians statement, and beneficiary information in the event of death that ties to the enrollment.

If there is a change in beneficiary, then it is handled through the change in beneficiary form. If there is no one listed at enrollment, the policy holder can update via the change in beneficiary form, otherwise payment will be issued to the estate.

☐ Loss of Life	☐ Loss of two Covered persons/same covered accident	☐ Loss of Both Hands, or Both Feet or Sight of Both Eyes	☐ Loss of One Hand or One Foot and Sight of One Eye	☐ Loss of One Hand and One Foot
☐ Loss of Speech and Hearing	☐ Loss of One Hand or One Foot or Sight of One Eye	☐ Loss of Speech or Hearing	☐ Loss of Thumb and Index Finger on same hand	

OPTIONAL SICKNESS/WELLNESS BENEFITS CLAIM INFORMATION SECTION

(Not available in KS, MI, MT, TN and TX)

☐ Optional Daily In-Hospital Indemnity Benefit Rider (Sickness Only)	☐ Optional Physician's Office and Urgent Care Facility Visit Benefit Rider (Sickness Only)	☐ Optional Emergency Room Benefit Rider (Sickness Only)	☐ Optional Daily Surgical Indemnity Benefit Rider (Sickness Only)	☐ Wellness Benefit

Companion Life
Administered by The Loomis Company
P.O. Box 13668
Reading, PA 19612-3668

PHYSICIAN'S STATEMENT

ALL BENEFITS OTHER THAN DISABILITY & WELLNESS BENEFITS

Failure to complete this form in its entirety may result in a delay in processing this claim.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Group Number: _____ Policyholder Name: _____

Patient Name: _____ Date of Birth: _____

PHYSICIAN'S STATEMENT **Please answer each question COMPLETELY.**

Physician's Name	Phone Number	Fax Number

Address	City	State	ZIP

DATES OF SERVICE	DIAGNOSIS CODE ICD	DIAGNOSIS DESCRIPTION	PROCEDURE CODE	PROCEDURE DESCRIPTION

Date of the incident: _____

Describe where the incident occurred: _____

_____

_____

_____

_____

Companion Life
Administered by The Loomis Company
P.O. Box 13668
Reading, PA 19612-3668

PHYSICIAN'S STATEMENT – CONTINUED

ALL BENEFITS OTHER THAN DISABILITY & WELLNESS

Was the patient referred to you by another physician? ☐ Yes ☐ No

If yes, physician's name? _____

Referring physician's address: _____

Was patient hospitalized as a result of this diagnosis? ☐ Yes ☐ No

Admission Date: _____ Discharge Date: _____

Hospital Name: _____

City: _____ State: _____

_____ _____ _____
Medical Provider's Name (Please Print) Phone Number Fax Number

_____ _____ _____
Medical Provider's Signature Tax ID Number Date

Companion Life
Administered by The Loomis Company
P.O. Box 13668
Reading, PA 19612-3668

OPTIONAL ACCIDENT WEEKLY TOTAL DISABILITY INCOME BENEFITS CLAIM INFORMATION SECTION

On what date did you last work?	Date & Time of the accident?	Where did this accident occur? If the accident occurred while working did you file Workers' Compensation? ☐ Yes ☐ No	Date you were treated by a Physician for this claim?

Names and Contact Information of all people witnessing the accident (if necessary, attach a list to this claim form):

State the cause and circumstances of the accident. Provide a brief description of what occurred.

What bodily injuries did you sustain caused solely by the accident (not pre-existing and not partly due to other causes)?

Physician's Name and Address First Consulted for this condition

List Name and Address of your family physician

Name and Address of Hospital, if confined

Date of Confinement
Admit: Discharge:

Are you entitled to Benefits from any of the following for this disability? ☐ Local, State or Society Disability Income Plan $ _____

☐ Workers' Compensation $ _____ ☐ Salary Continuance $ _____ ☐ No Fault $ _____

☐ Social Security $ _____ ☐ Any Government Agency $ _____

☐ Other (please describe) $ _____

If "Yes" insert policy number, name and address of insurance company or organization providing such benefits or services.

Policy No. _____ Name and Address _____

Policy No. _____ Name and Address _____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such valuation.

_____ _____ _____

Claimant Signature | Family Relationship, if not Policyholder | Date

Companion Life

Administered by The Loomis Company
P.O. Box 13668
Reading, PA 19612-3668

ACCIDENT CLAIM FORM

PHYSICIAN'S STATEMENT

DISABILITY BENEFIT ONLY

Failure to complete this form in its entirety may result in a delay in processing this claim.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Claimant's Name (First, Middle, Last)	Age	☐ Male ☐ Female	Height _____ Weight _____

HISTORY

Has the patient ever had the same or similar condition? ..... ☐ Yes ☐ No If yes, state when and describe.

Is condition due to injury arising out of patient's employment? ..... ☐ Yes ☐ No ☐ Unknown

Names and addresses of other treating physicians.

DIAGNOSIS

Diagnosis (including any complications)

Subjective Systems

Objective Findings (Including current X-rays, EKG's, Laboratory Data, and any clinical findings)

Restrictions, limitations

ENTER DATES FOR THE FOLLOWING	MONTH	DAY	YEAR
Date symptoms first appeared, or accident happened			
Date patient was unable to work because of disability			
Date of first treatment for this disability			
Date of the most recent treatment for this disability			

Frequency of treatment ☐ Weekly ☐ Monthly ☐ Other (Specify) _____

Date claimant will be able to perform usual work (even if considerable question exists, estimate date) ☐ Full-time ☐ Part-time			
For pregnancy disability only, expected date of delivery			

Companion Life
Administered by The Loomis Company
P.O. Box 13668
Reading, PA 19612-3668

PHYSICIAN'S STATEMENT – CONTINUED

DISABILITY BENEFIT ONLY

NATURE OF TREATMENT (including surgery and medications prescribed, if any)
PROGRESS
A. Has patient..... ☐ Recovered? ☐ Improved? ☐ Unchanged? ☐ Retrogressed?
B. Is patient..... ☐ Ambulatory? ☐ House confined? ☐ Bed confined? ☐ Hospital confined?
C. Has patient been hospital confined? ☐ Yes ☐ No If yes, give name and address of hospital _____ Confined from _____ through _____
D. Is patient able to drive? ☐ Yes ☐ No

_____ _____ _____
Medical Provider's Name (Please Print) Phone Number Fax Number

_____ _____ _____
Medical Provider's Signature Tax ID Number Date

Claimant Signature Family Relationship, if not Policyholder Date

AUTHORIZATION

FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize the use and/or disclosure of my protected health information as described below:

1. My authorization applies to that information obtained by all health care professionals. This information may include my medical records, laboratory reports, prescription medication records and radiology reports in the possession of all health care professionals. Only this information may be used and/or disclosed pursuant to this authorization.
2. I authorize all health care professionals to disclose my protected health information.
3. I authorize only designated staff of Companion Life or its contracted third-party administrators to receive, in writing, by photocopy, facsimile, or by telephone, my protected health information.
4. I understand that, if my protected health information is disclosed to someone who is not required to comply with federal privacy protection regulations, such information may be re-disclosed and would no longer be protected.

5. I understand that I have a right to revoke this Authorization at any time. My revocation must be in writing in a letter addressed to Companion Life. This revocation shall become effective on the date it is received by Companion Life. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this Authorization.
6. This Authorization is valid for twelve (12) months from the date of execution hereof.

I CERTIFY THAT I HAVE RECEIVED A COPY OF THIS AUTHORIZATION AND AUTHORIZE THE USE AND/OR DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS CONTEMPLATED HEREIN.

_____	_____	_____
Signature	Print Name	Date

I have legal authority* under the laws of the State of _____ to make health care decisions on behalf of _____, the individual to whom the use and/or disclosure of protected health information above applies, and execute this Authorization in my capacity as Authorized Representative thereof.

_____	_____	_____
Name of Authorized Representative, Parent or Guardian	Relationship to Applicant	Date

* A copy of the legal authority document must be on file with Companion Life.

Companion Life
Administered by The Loomis Company
P.O. Box 13668
Reading, PA 19612-3668

CLAIM FORM FRAUD WARNINGS

GENERAL FRAUD WARNING: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON. The fraud warnings listed below are applicable in the states of AL, AK, AZ, AR, CO, DE, DC, FL, ID, IN, KS, KY, LA, ME, MD, MA, MN, NH, NM, OH, OK, OR, PA, RI, TN, TX, VT, VA, WA, and WV. Please review the appropriate fraud warning relevant to the state that you reside in prior to submitting your claim.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kansas: Any person who knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim

containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Massachusetts: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application or contract for insurance may be found guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: ANY PERSON WHO, WITH A PURPOSE TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS SUBJECT TO PROSECUTION AND PUNISHMENT FOR INSURANCE FRAUD, AS PROVIDED IN R.S.A. 638:20.

New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Vermont: Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information may be guilty of fraud and may be subject to criminal or civil penalties.

Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Companion Life
Administered by The Loomis Company
P.O. Box 13668
Reading, PA 19612-3668

West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice (TDD: 711).

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance by emailing contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥 1-844-396-0188。(Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839. (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険 についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

Ni da doodago t'áá háída bíká'aná nílwo'ígíí díí Béeso Ách'ąąh naa'nilígi háá'ída yí na' ídíł kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'íshíį bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'į' ha desdzih nínízingo, kojį' béésh bee hólne' 1-844-516-6328. (Navajo)

15388

Vann du adda ebbah es du am helfa bisht, ennichi questions hend veyyich *deah health plan*, hend diah's recht fa hilf un information greeya in eiyah aykni shprohch unni kosht. Fa shvetza mitt en interpreter, roof deah nummah oh 1-833-584-1829. (Pennsylvania Dutch)
