blue california

Subscriber Change Request
Blue Shield of California and Blue Shield of California Life & Health Insurance Company

All changes must be received within 31 days of the effective date of change. This form cannot be used for primary care physician changes – subscriber must call the Member Services phone number on the back of their ID card.

Employee identification – this section must be completed.

Subscriber ID number (from ID card)	Social Security number	Group number (from ID card)
Work telephone	Home telephone	
Last name	First name	MI
Home street address – City	State	ZIP code
Group/employer name (if applicable)	Email address	

Changes

☐ Yes ☐ No Is this a change/correction of address?

☐ Yes ☐ No Is the change/correction of address for a dependent? (**Note**: Dependent's address will default to subscriber's address if 'No' is indicated here.)

If yes, please indicate dependent name and address change: _____

☐ Correct my Social Security number to: _____ (Copy of Social Security card, a photo ID, a letter of verification from the Social Security office, and a written statement of why the employee is requesting the change must be attached.)

☐ This is a change made during open enrollment.

☐ Transfer/add my health coverage to: ☐ Access+ HMO® $20 ☐ ~~Access+ HMO® SaveNet℠~~ _____ ☐ ~~Local Access+ HMO®~~ _____
☐ ~~Trio HMO~~ _____ ☐ ~~Added Advantage POS℠~~ _____ ☐ Full PPO $500 ☐ ~~Active Choice®*~~ _____ ☐ ~~Full PPO Savings Plus~~ _____
☐ ~~Tandem PPO~~ _____ ☐ ~~Tandem PPO Savings~~ _____

☐ ~~Transfer my ABHP benefits coverage to:~~
- ~~For Access+ HMO:~~ ☐ ~~HRA~~ ☐ ~~HIA~~ ☐ ~~FSA~~
- ~~For Local Access+ HMO:~~ ☐ ~~HRA~~ ☐ ~~HIA~~ ☐ ~~FSA~~
- ~~For Full PPO~~ ☐ ~~HRA~~ ☐ ~~HIA~~ ☐ ~~FSA~~
- ~~For Full PPO HSA:~~ ☐ ~~HRA~~ ☐ ~~HIA~~ ☐ ~~FSA~~ ☐ ~~HSA~~ ☐ ~~LFSA~~

~~For 51-100 Small Group Transition plans, transfer/add my health coverage to:~~ ☐ ~~HMO~~ ☐ ~~PPO~~ ☐ ~~PPO for HSA~~

☐ ~~Transfer my ABHP benefits coverage to:~~
- ~~For HMO:~~ ☐ ~~HRA~~ ☐ ~~HIA~~ ☐ ~~FSA~~
- ~~For PPO:~~ ☐ ~~HRA~~ ☐ ~~HIA~~ ☐ ~~FSA~~
- ~~For Shield PPO Savings Plus for HSA:~~ ☐ ~~HRA~~ ☐ ~~HIA~~ ☐ ~~FSA~~ ☐ ~~LFSA~~

~~Transfer my specialty benefits coverage to:~~ ☐ ~~DHMO~~ _____ ☐ ~~DPPO~~ _____ ☐ ~~DINO~~ _____
~~From Group # _____ to Group # _____ in my employer group. Note: If transferring coverage to HMO, POS, or DHMO, please complete Section A.~~

☐ ~~Change the amount of Basic Group Term Life or Supplemental Life and Supplemental AD&D insurance coverage: (provide prior coverage amount and new coverage amount)~~
- ~~Prior amount of Basic Group Term Life coverage: $ _____~~ ~~New amount of coverage: $ _____~~
- ~~Prior amount of Supplemental Life and/or Supplemental AD&D coverage: $ _____~~ ~~New amount of coverage: $ _____~~
- ~~(If Supplemental AD&D coverage is purchased, it is always in the same amount as the Supplemental Life coverage)~~

☐ Correct/change name to:

☐ Correct/change email address to:

☐ Correct/change my date of birth from: _____ to: _____

☐ Additional changes/comments: _____
☐ Subscriber cancellation: I decline health plan coverage for myself (and dependents, if any) effective: _____
☐ COBRA participant
☐ Qualifying event: _____
☐ Effective date of above qualifying event: _____
☐ Is this a termination? If yes, list name(s): _____

Subscriber Change Request (continued)

Spouse/domestic partner/dependent child(ren) coverage changes

Add spouse/domestic partner/dependent child(ren) – Complete section A – Requested effective date for additions: _____

☑ Date of marriage if adding spouse: _____ ☑ Domestic partner – date of domestic partnership if adding: _____

☑ If court ordered custody/coverage, enter date and attach copy of legal documents: _____
☑ If adoption, enter date of adoption or date placed for adoption, and attach copy of legal documents: _____
☑ Disabled dependent over the age of 25 (Attach a 'Declaration of disability for over age dependent child' form (C3674) or confirmation that your current health carrier is providing coverage for this disabled dependent.)

☑ Change the Supplemental Group Term Life and AD&D insurance coverage amount of the spouse or domestic partner: (provide prior coverage amount and new coverage amount) Prior amount of coverage: $_____ New amount of coverage: $_____

Cancel dependent(s) – Complete section A – Requested effective date for deletions: _____

For cancellation of spouse or domestic partner: (select appropriate cancellation reason and provide date of event)
☑ Divorce or termination of domestic partnership: Date: _____
☑ Death: Date: _____
☑ Other reason (please specify): _____ Date: _____

For cancellation of dependent children: (select appropriate cancellation reason and provide date of event)
☑ Death: Date: _____ ☑ Other reason (please specify) _____ Date: _____

Note: Newborn/adopted children or children placed for adoption require a completed Subscriber Change Request to be submitted within 31 days from the date of birth/adoption/placement for adoption to be added to your coverage.

Please be sure to return this form as the third page contains your signature, which is necessary to process these changes.

Section A

Complete this section if adding/canceling coverage for yourself or your dependents. Provide primary care physician/dental provider information if the change pertains to HMO/POS/DHMO coverage. Please fill in which benefit the change applies to:

Add	Cancel	Self			
☐ ~~Dental~~ ☑ Medical ☐ ~~Vision~~ ☐ ~~Basic Life/ AD&D~~ ☐ ~~Dep. Life~~ ☐ ~~Supp. Life‡~~ ☐ ~~Supp. Life/ AD&D‡~~	☐ ~~Dental~~ ☑ Medical ☐ ~~Vision~~ ☐ ~~Basic Life/ AD&D~~ ☐ ~~Dep. Life~~ ☐ ~~Supp. Life~~ ☐ ~~Supp. Life/ AD&D~~	Last name	First name	MI	Sex
		Social Security number:		Date of birth (mm/dd/yyyy) _____	
		Job title/classification		Annual earnings (not including bonuses, overtime, etc.) $ _____	
		~~If adding Basic Life and AD&D insurance please indicate amount requested: $ _____~~ ~~If adding Supp. Life and/or Supp. AD&D insurance please indicate amount requested: $ _____~~ ~~If adding Dependent Life, please indicate amount requested: $ _____~~ ~~(Note: Spouse and all children will be covered for the same benefit amount)~~			
		HMO/POS primary care physician name Doctor's name: _____ Provider #: _____ IPA/MG #: _____	Current patient? ☑ Yes ☑ No	~~**Dental HMO only dental provider**~~ ~~Dental provider name:~~ _____ ~~Dental provider #: _____~~	

Add	Cancel	Spouse/domestic partner			
☐ ~~Dental~~ ☑ Medical ☐ ~~Vision~~ ☐ ~~Supp. Life‡~~ ☐ ~~Supp. Life/ AD&D‡~~	☐ ~~Dental~~ ☑ Medical ☐ ~~Vision~~ ☐ ~~Supp. Life~~ ☐ ~~Supp. Life/ AD&D~~	Last name	First name	MI	Sex
		Social Security number:		Date of birth (mm/dd/yyyy) _____	
		~~If adding Supp. Life and/or Supp. AD&D insurance please indicate amount requested: $ _____~~			
		HMO/POS primary care physician name Doctor's name: _____ Provider #: _____ IPA/MG #: _____	Current patient? ☑ Yes ☑ No	~~**Dental HMO only dental provider**~~ ~~Dental provider name:~~ _____ ~~Dental provider #: _____~~	

Add	Cancel	Child			
☐ ~~Dental~~ ☑ Medical ☐ ~~Vision~~ ☐ ~~Supp. Life‡~~ ☐ ~~Supp. Life/ AD&D‡~~	☐ ~~Dental~~ ☑ Medical ☐ ~~Vision~~ ☐ ~~Supp. Life~~ ☐ ~~Supp. Life/ AD&D~~	Last name	First name	MI	Sex
		Social Security number:		Date of birth (mm/dd/yyyy) _____	
		~~If adding Supp. Life and/or Supp AD&D insurance please indicate amount: $ _____ ($5,000 or $10,000)~~ ~~(Note: All children will be covered for the same amount for Supplemental Life and Supplemental AD&D coverage.)~~			
		~~If adding Dependent Life, please indicate amount requested: $ _____~~ ~~(Note: Spouse and all children will be covered for the same benefit amount)~~			
		HMO/POS primary care physician name Doctor's name: _____ Provider #: _____ IPA/MG #: _____	Current patient? ☑ Yes ☑ No	~~**Dental HMO only dental provider**~~ ~~Dental provider name:~~ _____ ~~Dental provider #: _____~~	

Subscriber Change Request (continued)

Add	Cancel	Child			
☐ ~~Dental~~ ☑ Medical ☐ ~~Vision~~ ☐ ~~Supp. Life‡~~ ☐ ~~Supp. Life/ AD&D‡~~	☐ ~~Dental~~ ☑ Medical ☐ ~~Vision~~ ☐ ~~Supp. Life~~ ☐ ~~Supp. Life/ AD&D~~	Last name	First name	MI	Sex
		Social Security number:		Date of birth (mm/dd/yyyy) _____	
		~~If adding Supp. Life and/or Supp AD&D insurance please indicate amount: $ _____ ($5,000 or $10,000)~~ ~~(Note: All children will be covered for the same amount for Supplemental Life and Supplemental AD&D coverage.)~~			
		~~If adding Dependent Life, please indicate amount requested: $ _____~~ ~~(Note: Spouse and all children will be covered for the same benefit amount)~~			
		HMO/POS primary care physician name Doctor's name: _____ Provider #: _____ IPA/MG #: _____	Current patient? ☐ Yes ☐ No	**~~Dental HMO only dental provider~~** ~~Dental provider name:~~ _____ ~~Dental provider No. _____~~	
		Child			
☐ ~~Dental~~ ☐ Medical ☐ ~~Vision~~ ☐ ~~Supp. Life‡~~ ☐ ~~Supp. Life/ AD&D‡~~	☐ ~~Dental~~ ☐ Medical ☐ ~~Vision~~ ☐ ~~Supp. Life~~ ☐ ~~Supp. Life/ AD&D~~	Last name	First name	MI	Sex
		Social Security number:		Date of birth (mm/dd/yyyy) _____	
		~~If adding Supp. Life and/or Supp AD&D insurance please indicate amount: $ _____ ($5,000 or $10,000)~~ ~~(Note: All children will be covered for the same amount for Supplemental Life and Supplemental AD&D coverage.)~~			
		~~If adding Dependent Life, please indicate amount requested: $ _____~~ ~~(Note: Spouse and all children will be covered for the same benefit amount)~~			
		HMO/POS primary care physician name Doctor's name: _____ Provider #: _____ IPA/MG #: _____	Current patient? ☐ Yes ☐ No	**~~Dental HMO only dental provider~~** ~~Dental provider name:~~ _____ ~~Dental provider #: _____~~	

All information I have provided on this form is accurate and complete. I understand that this form, along with any prior enrollment form, the *Evidence of Coverage/Certificate of Insurance* and Health Service Agreement/policy, and any endorsements and attachments thereto, collectively constitutes the entire agreement for coverage.

Employee signature _____ Date _____

If faxing this form, keep this document for your files.

Blue Shield of California/Blue Shield Life protects the confidentiality and privacy of your personal information. Personal and health information which may individually identifiable information, such as your name, address, telephone number, Social Security number, and health information. We will not disclose this information, except as permitted by law.

Please be sure to return this form as the third page contains your signature, which is necessary to process these changes.

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

† Evidence of Insurability form is required for Supplemental Life. Approval must be received for any added Supplemental Life coverage. The effective date of coverage will be the first of the month following approval.

Blue Shield of California Life & Health Insurance Company

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

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

- 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 Life Civil Rights Coordinator.

If you believe that Blue Shield Life 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 Life & Health Insurance Company 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 may also contact the California Department of Insurance if you believe that Blue Shield of California Life & Health Insurance Company 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:

California Department of Insurance
Consumer Communications Bureau
300 S. Spring Street, South Tower
Los Angeles, CA 90013

Phone: 1-800-927-HELP (4357) or TDD 1-800-482-4833

Complaint forms are available at **www.insurance.ca.gov/01-consumers/101-help**

If you believe that you have not been provided these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, 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**.

blue california

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 naanin——áhájeehígí 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. Hózhó̱ shíká anáá'doowoł nínízingo éí díí béeso ách'ą̱ąh naa'nil bił haz'á̱ą̱jį' 1-800-927-4357jį' hodíilnih. Navajo

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