Excellus

A nonprofit independent licensee of the Blue Cross Blue Shield Association

FOR INTERNAL USE ONLY

HIOS ID# _____

EC _____

Commercial Group Health Insurance Application/Change Form

CONFIDENTIAL

Please print clearly and complete all sections that apply. Signatures are required. Additional instructions included on Page 4.

Section 1: Employer Group & Benefit Information

To be completed with your Group Administrator

Monroe Community College

Employer Name

Association/Chamber Name (if applicable)

Check Desired Action
☐ Add ☐ Cancel ☐ Change

_____ _____ _____

Group Administrator's Signature (required) Date

Employee Number

Department Number

Medical Information

00044328

Medical Group Number (8 digits)

Medical Subgroup Number (4 digits)

Medical Class Number (e.g. A001)

If enrolling in a Medical plan, who do you need coverage for?
☐Self Only
☐Self & Child(ren)
☐Self & Spouse, or Self & Domestic Partner
☐Family

Medical Effective Date

Subscriber Status:
☐Actively Working
☐Retired
☐Disabled
☐Canceled
☐COBRA

Dental Information

00089907

Dental Group Number

Dental Subgroup Number

Dental Class

If enrolling in a Dental plan, who do you need coverage for?
☐Self Only
☐Family

Dental Effective Date

Medical Plan Selection

☐ POS B / Enhanced (EB)
☐ POS D / Standard (EC)
☐ PPO Plan (P1)
☐ Signature 1500 HDHP (DAG)

Dental Plan Selection

☐ Faculty/Admin Dental Plan (EIS)
☐ CSEA Dental Plan (EBA)

Section 2: Subscriber's Information

Last Name

First Name

Middle Initial **Title (e.g., Jr, Sr, III, etc.)**

Street Address

City **State**

Zip Code **Phone**

Birthdate: _____ _____ _____

Gender assigned at birth:
☐Male
☐Female

Gender identity (optional):
☐Transgender Male
☐Transgender Female
☐Prefer to self-describe: _____
☐Prefer not to say
☐Non-binary

Social Security Number** _____

Date of Hire/Rehire: _____ _____ _____

Retirement Date: _____ _____ _____

☐Age 65+ ☐Disability
☐End Stage Renal *

_____
Subscriber's Medicare Number (if applicable)

_____ _____ _____ **Medicare Part A** Effective Date

_____ _____ _____ **Medicare Part B** Effective Date

_____ _____ _____
Primary Care Physician's Last Name First Name Zip Code

_____ _____ _____
Ob/Gyn's Last Name First Name Zip Code

Subscriber's Last Name: _____

Section 3: Reason for enrollment or change

To be completed by the Group Administrator **Not required for cancelations**

Enrollment Opportunity: ☐New Hire ☐Rehire ☐Open Enrollment ☐Medicare eligible

Special Enrollment Opportunity: ☐Newly Eligible Dependent: ☐Newborn ☐Marriage ☐Other _____

☐Change in employment status ☐A move in or out of the service area

☐Involuntary loss of coverage ☐Former dependent regains eligibility

Date of Event ___ ___ _____

COBRA Election - Please indicate the reason for COBRA if applicable:

☐Left Employment/Retired ☐Divorce/Legal Separation ☐Loss of Student Status ☐Death of Spouse

☐Disability ☐Dependent Reached Max Age ☐ Other: _____

Demographic Change: ☐Address ☐Birthdate ☐Subscriber Name ☐Dependent Name ☐Phone Number

Section 4: Cancel Information - If canceling coverage, who are you canceling coverage for?

Subscriber

Cancel Code:	Medical Cancel Date:	Dental Cancel Date:

Cancel Codes:

SB02-Left Employment SB05-Per Group Request SB06-Subscriber Request (voluntary) SB07-Deceased SB09-Enrolled in Error

Dependent(s)

Dependent Name:	Cancel Code:	Medical Cancel Date:	Dental Cancel Date:

Cancel Codes:

M001-Per Group Request M004-Enrolled in Error M008-Moved Out of Area M013-Ineligible

M002-Deceased M005-Divorced M010-Overage Dependent M014-YAO Ineligible

M003-Per Subscriber Request M007-Per Member Request (voluntary) M011-No Longer a Student M040-Mx Same Group

Section 5: Information about who you would like coverage for (dependent information)

☐Spouse ☐Domestic Partner ☐Dependent Child ☐Disabled Dependent Child (Separate application form required)

☐Other_____

_____ _____ _____ _____

Last Name (if different) Title **First Name** MI **Social Security Number** **

Gender assigned at birth: ☐Male ☐Female **Birthdate** _____ . _____ . _____

Gender identity (optional): ☐Transgender Male ☐Transgender Female ☐Non-binary ☐Prefer not to say ☐Prefer to self-describe: _____

Is dependent a full-time student over age 19? ☐Yes ☐No Married? ☐Yes ☐No Expected Graduation Date: _____ , _____ , _____

If yes, please provide name of college/university _____ Will dependent further education after graduation? ☐Yes ☐No

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal *

_____ Part A Effective Date: ___ . ___ . ____ Part B Effective Date: ___ . ___ . ____

Medicare Number (if applicable)

_____ _____ _____ _____ _____ _____

Primary Care Physician's Last Name First Name Zip Code Ob/Gyn's Last Name First Name Zip Code

↓ Additional Dependent(s) ↓

☐Dependent Child ☐Disabled Dependent Child (Separate application form required) ☐Other_____

_____ _____ _____ _____

Last Name (if different) Title **First Name** MI **Social Security Number** **

Gender assigned at birth: ☐Male ☐Female **Birthdate** _____ , _____ , _____

Gender identity (optional): ☐Transgender Male ☐Transgender Female ☐Non-binary ☐Prefer not to say ☐Prefer to self-describe: _____

Is dependent a full-time student over age 19? ☐Yes ☐No Married? ☐Yes ☐No Expected Graduation Date: _____ , _____ , _____

If yes, please provide name of college/university _____ Will dependent further education after graduation? ☐Yes ☐No

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal *

_____ Part A Effective Date: ___ ___ ____ Part B Effective Date: ___ . ___ . ____

Medicare Number (if applicable)

_____ _____ _____ _____ _____ _____

Primary Care Physician's Last Name First Name Zip Code Ob/Gyn's Last Name First Name Zip Code

☐Dependent Child ☐Disabled Dependent Child (Separate application form required) ☐Other_____

_____ _____ _____ _____
Last Name (if different) Title **First Name** MI **Social Security Number** **

Gender assigned at birth: ☐Male ☐Female **Birthdate** _____ . _____ . _____
Gender identity (optional): ☐Transgender Male ☐Transgender Female ☐Non-binary ☐Prefer not to say ☐Prefer to self-describe: _____

Is dependent a full-time student over age 19? ☐Yes ☐No Married? ☐Yes ☐No Expected Graduation Date: _____ . _____ . _____
If yes, please provide name of college/university _____ Will dependent further education after graduation? ☐Yes ☐No

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal *

_____ Part A Effective Date: ___ . ___ . ____ Part B Effective Date: ___ . ___ . ____
Medicare Number (if applicable)

_____ _____ _____ _____ _____ _____
Primary Care Physician's Last Name First Name Zip Code Ob/Gyn's Last Name First Name Zip Code

Note: Use an additional application [or addendum] if more than three dependents need coverage.

Section 6: Other coverage information (Required) - You may be contacted for additional information

Have you or any member of your family been enrolled in other medical or dental coverage? ☐Yes ☐No
If yes, what type of coverage? ☐Medical ☐Dental
What is the effective date of the other coverage? ☐Medical: ____ . ____ . _____ ☐Dental: ____ . ____ . _____
What is the name of the other carrier? _____
Are you keeping the coverage? ☐Yes ☐No
If no, when will the coverage end? ☐Medical: ____ . ____ . _____ ☐Dental: ____ . ____ . _____
Policyholder's name _____ ID#(s) _____
Who did the insurance cover? ☐Self Only ☐Self & Spouse/Domestic Partner ☐Self & Child(ren) ☐Family

Section 7: Release - You must sign and date this form to be eligible for health insurance

I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is covered under the contract you issue is bound by the terms and conditions of the contract applicable to my coverage. This includes, without limitation, the terms and conditions regarding the receipt and release of medical records and information. I make this acknowledgment and agreement on behalf of myself and each other person who accepts coverage under the terms of the contract applicable to my coverage (who may include, for example my spouse and my eligible family dependents).

I hereby accept responsibility for payment of any portion of the premium.
I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.
Pediatric dental is an essential health benefit mandated by the ACA. If your employer group does not provide pediatric dental coverage through this Excellus BCBS plan, you agree to enroll in the dental plan offered to you by your employer.

PREFERRED PROVIDER ORGANIZATION (PPO) I understand that the Preferred Provider Organization (PPO) coverage is comprised of an in-network benefit that is dependent on the utilization of medical providers who participate with the PPO and out-of-network benefit that provides coverage for services of medical providers who do not participate with the PPO. I understand that the in-network benefit provides the highest level of coverage under the plan.

POINT OF SERVICE (POS) I understand that the Point of Service (POS) plan provides services on two benefit levels: in-network or out-of-network benefits. I understand that the in-network benefit provides the highest level of coverage under the plan and that I must choose a Primary Care Provider (PCP) to provide my primary care, oversee my other health care services, and, when required, obtain prior approval for certain services such as Inpatient Facility care.

I have thoroughly read, understand and agree to comply with the terms of the release in this section.

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 $5,000 and the stated value of the claim for each such violation.

Subscriber Signature _____ **Date** _____

Please return to P.O. Box 21146 Eagan, MN 55121-0146
If you have questions, please contact your Group Administrator. Or, visit us at: ExcellusBCBS.com

Excellus

A nonprofit independent licensee of the Blue Cross Blue Shield Association

CONFIDENTIAL

Additional Dependent Addendum

This form must be attached to a completed enrollment application/change form. Please print clearly.

For each additional dependent only complete fields below the dotted line if applicable to the product you are enrolling in.

Section 1: Subscriber's Information

00044328//00089907 ______ ______ ______ ______

Group # | **Subscriber's Last Name** | **First Name** | **MI** | **SSN**

Section 2: Additional Dependent(s) Information

☐Dependent Child ☐Disabled Dependent Child (Separate application form required) ☐Other________________________

Last Name (if different) Title | **First Name** | MI | **Social Security Number**

Gender assigned at birth: ☐Male ☐Female **Birthdate** _______ . _______ . __________

[Gender identity (optional): ☐Transgender Male ☐Transgender Female ☐Non-binary ☐Prefer not to say ☐Prefer to self-describe: _________]

Is dependent a full-time student over age 19? ☐Yes ☐No Married? ☐Yes ☐No Expected Graduation Date: _____ _____ ________

If yes, please provide name of college/university ______________________________ Will dependent further education after graduation? ☐Yes ☐No

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal * Separate form required

____________________ Part A Effective Date: ___ ___ ____ Part B Effective Date: ___ ___ ____

Medicare Number (if applicable)

Primary Care Physician's Last Name | First Name | Zip Code | Ob/Gyn's Last Name | First Name | Zip Code

☐Dependent Child ☐Disabled Dependent Child (Separate application form required) ☐Other________________________

Last Name (if different) Title | **First Name** | MI | **Social Security Number**

Gender assigned at birth: ☐Male ☐Female **Birthdate** _______ . _______ . __________

[Gender identity (optional): ☐Transgender Male ☐Transgender Female ☐Non-binary ☐Prefer not to say ☐Prefer to self-describe: __________]

Is dependent a full-time student over age 19? ☐Yes ☐No Married? ☐Yes ☐No Expected Graduation Date: _____ _____ ________

If yes, please provide name of college/university ______________________________ Will dependent further education after graduation? ☐Yes ☐No

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal * Separate form required

____________________ Part A Effective Date: ___ ___ ____ Part B Effective Date: ___ ___ ____

Medicare Number (if applicable)

Primary Care Physician's Last Name | First Name | Zip Code | Ob/Gyn's Last Name | First Name | Zip Code

☐Dependent Child ☐Disabled Dependent Child (Separate application form required) ☐Other________________________

Last Name (if different) Title | **First Name** | MI | **Social Security Number**

Gender assigned at birth: ☐Male ☐Female **Birthdate** _______ . _______ . __________

[Gender identity (optional): ☐Transgender Male ☐Transgender Female ☐Non-binary ☐Prefer not to say ☐Prefer to self-describe: __________]

Is dependent a full-time student over age 19? ☐Yes ☐No Married? ☐Yes ☐No Expected Graduation Date: _____ _____ ________

If yes, please provide name of college/university ______________________________ Will dependent further education after graduation? ☐Yes ☐No

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal * Separate form required

____________________ Part A Effective Date: ___ , ___ , ____ Part B Effective Date: ___ , ___ , ____

Medicare Number (if applicable)

Primary Care Physician's Last Name | First Name | Zip Code | Ob/Gyn's Last Name | First Name | Zip Code

Instructions for completing the Group Health Insurance Application/Change Form

Section 1: Employer Group & Benefit Information
This section should be completed with your Group Administrator. Group Administrator's signature is required. Medical and/or dental group numbers and information must be populated. Select who you need coverage for on the medical and/or dental plan(s) and indicate the subscriber's status. Next, select the medical and/or dental plan(s) you are enrolling in. All products may not be applicable to your employer group. Please check with your Group Administrator.

Section 2: Subscriber's Information
This section should be completed by the Subscriber. **We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act. * There is additional information needed if eligible for Medicare due to ESRD. Please contact your Group Administrator for the appropriate form.

Gender and gender identity: Excellus BlueCross BlueShield does not discriminate on the basis of gender identity, gender expression or behavior. In order to ensure that you are receiving access to high quality, affordable health care based on your individual needs, we ask that you consider completing this **optional gender identity section** of the application. Excellus BlueCross BlueShield will not limit coverage or impose any additional cost-sharing for any otherwise-covered services that are ordinarily available to individuals of one sex, to a transgender individual, based on the fact that an individual's sex assigned at birth, gender identity, gender expression or behavior or gender otherwise recorded is different from the gender for which health care services are ordinarily available.

Section 3: Reason for enrollment or change
Select the box(es) that describe(s) the reason for this enrollment or change regarding health insurance coverage and include the date of the event. An event is a specific occurrence, due to change in status, marriage, divorce, birth or adoption, group's anniversary date, or rate change. Your request must be received within 30 days of the event date. Please see your Group Administrator for events that fall outside the 30-day period. You may be required to provide documentation of certain events.

Section 4: Cancel Information - If canceling coverage, who are you canceling coverage for?
If you are canceling coverage, complete the appropriate section for who you are canceling. List the cancel code and enter the date(s) the coverage is to be canceled. List each applicable dependent to be canceled.

Section 5: Information about who you would like coverage for (dependent information)
Please include information about all the people who you would like coverage for.
Use an additional application or addendum if more than three dependents need coverage.
If your dependents are Medicare eligible, complete the questions regarding Medicare coverage.
Qualified guidelines for coverage include:

- A legal spouse/domestic partner (An ex-spouse no longer qualifies as of the date court documents are stamped and filed with the county clerk)
- Must be under the eligible child age for your employer group including natural, adopted or stepchild(ren)
- Child(ren) Only coverage is available for children up to age 26 or 29 depending on the employer group coverage.
- There are additional eligibility requirements for dependents pending adoption, for which you are the legal guardian, and/or a disabled dependent who is over the maximum dependent age. Please contact your Group Administrator for the appropriate form.

**We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act.
* There is additional information needed if eligible for Medicare due to ESRD. Please contact your Group Administrator for the appropriate form.
A separate Adult Disabled Dependent application form is required for applicable dependents. Please contact your Group Administrator for the appropriate forms.

Section 6: Other coverage information (Required)
Please include accurate information in this section. This could affect the processing of your application and/or claims.

Section 7: Release
Subscriber signature and date are required in this section. The subscriber must sign the application prior to or within 30 days of the effective date or qualifying event date.

Notice of Nondiscrimination

Our Health Plan complies with federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services and are a Child Health Plus or Managed Medicaid member, please call 1-800-650-4359. If you are an Essential Plan member, please call 1-877-626-9298. All others please call 1-800-499-1275.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Advocacy Department
Attn: Civil Rights Coordinator
PO Box 4717
Syracuse, NY 13221
Telephone number: 1-800-614-6575
TTY number: 1-800-421-1220
Fax: 315-671-6656

You can file a grievance in person or by mail or fax. If you need help filing a grievance, the Health Plan's 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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Atención: Si habla español, contamos con ayuda gratuita de idiomas disponible para usted. Si usted es un asegurado de Child Health Plus o Managed Medicaid, llame al número 1-800-650-4359. Si usted es un asegurado de Essential Plan, llame al número 1-877-626-9298. Todos los demás pueden llamar al número 1-800-499-1275.

注意：如果您说中文，您可免费获得语言协助服务。如果您是 Child Health Plus 或 Managed Medicaid 会员，请拨打 1-800-650-4359。如果您是 Essential Plan 会员，请拨打 1-877-626-9298。如非上述会员，请您拨打 1-800-499-1275。

Внимание! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Если вы являетесь участником программы Child Health Plus или Managed Medicaid, позвоните по телефону 1-800-650-4359. Если вы являетесь участником программы Essential Plan, позвоните по телефону 1-877-626-9298. Всех остальных просим звонить по телефону 1-800-499-1275.

Atansyon: Si ou pa pale Kreyòl Ayisyen, gen èd gratis nan lang ki disponib pou ou. Si ou se yon manm Child Health Plus oswa Managed Medicaid, tanpri rele nimewo 1-800-650-4359. Si ou se yon manm Essential Plan, tanpri rele nimewo 1-877-626-9298. Tout lòt moun yo, tanpri rele nimewo 1-800-499-1275.

알려드립니다: 한국어를 사용하시는 경우, 무료 언어 지원을 받으실 수 있습니다. Child Health Plus 또는 Managed Medicaid 회원이신 경우, 1-800-650-4359번으로 전화해 주십시오. Essential Plan 회원이신 경우, 1-877-626-9298번으로 전화해 주십시오. 기타의 경우 1-800-499-1275번으로 전화해 주십시오.

Attenzione: Se la vostra lingua parlata è l'italiano, potete usufruire di assistenza linguistica gratuita. Se siete iscritti a un programma Child Health Plus o Managed Medicaid, chiamate il numero 1-800-650-4359. Se siete iscritti a un programma Essential Plan, chiamate il numero 1-877-626-9298. In tutti gli altri casi, chiamate il numero 1-800-499-1275.

אויפמערקזאם: אויב איר רעדט אידיש, איז אומזיסטע שפראך הילף אוועילעבל פאר אייך. אויב איר זענט א Child Health Plusמעמבער אדער Managed Medicaid, 1-800-650-4359. ביטע רופט מעמבער, ביטע רופט 1-877-626-9298. אלע אנדערע ביטע רופט Essential Plan אויב איר זענט אן 1-800-499-1275.

নজর দিন: যদি আপনি বাংলায় কথা বলেন তাহলে আপনার জন্য বিনামূল্যের সাহায্য উপলভ্য রয়েছে। আপনি Child Health Plus বা Managed Medicaid এর সদস্য হলে অনুগ্রহ করে 1-800-650-4359 নম্বরে ফোন করুন। আপনি Essential Plan এর সদস্য হলে অনুগ্রহ করে 1-877-626-9298 নম্বরে ফোন করুন। অন্যান্য সমস্ত প্রশ্নের জন্য, অনুগ্রহ করে 1-800-499-1275 নম্বরে কল করুন।

Uwaga: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Jeśli jesteś członkiem ubezpieczenia Health Plus lub Managed Medicaid, zadzwoń pod nr 1-800-650-4359. Jeśli jesteś członkiem ubezpieczenia Essential Plan, zadzwoń pod nr 1-877-626-9298. Pozostałe osoby powinny dzwonić pod nr 1-800-499-1275.

تنبيه: إذا كنت تتحدث اللغة العربية، فإن المساعدة اللغوية المجانية متاحة لك. إذا كنت عضوًا في Child Health Plus أو Managed Medicaid ، يرجى الاتصال على الرقم 1-800-650-4359. إذا كنت عضوًا في Essential Plan ، يرجى الاتصال على الرقم 1-877-626-9298. لجميع البرامج الأخرى، يرجى الاتصال على الرقم 1-800-499-1275.

Remarque : si vous parlez français, une assistance linguistique gratuite vous est proposée. Si vous êtes un membre du programme Child Health Plus ou Managed Medicaid, veuillez appeler le 1-800-650-4359. Si vous êtes un membre du programme Essential Plan, veuillez appeler le 1-877-626-9298. Si vous êtes dans une autre situation, veuillez appeler le 1-800-499-1275.

نوٹ: اگر آپ اردو بولتے ہیں تو آپ کے لیے مفت میں زبان کی مدد دستیاب ہے۔ اگر آپ Child Health Plus یا Managed Medicaid اگر آپ 1-800-650-4359 پر کال کریں۔ ممبر ہیں تو براہ کرم Essential Plan1- کے ممبر ہیں تو براہ کریم 1-877-626-9298 پر کال کریں۔ باقی سبھی لوگ براہ کرم 800-499-1275 پر کال کریں۔

Paunawa: Kung nagsasalita ka ng Tagalog, may magagamit kang libreng tulong sa wika. Kung isa kang miyembro ng Child Health Plus o Managed Medicaid, mangyaring tumawag sa 1-800-650-4359. Kung isa kang miyembro ng Essential Plan, mangyaring tumawag sa 1-877-626-9298. Para sa lahat ng iba pa, mangyaring tumawag sa 1-800-499-1275.

Προσοχή: Αν μιλάτε Ελληνικά μπορούμε να σας προσφέρουμε βοήθεια στη γλώσσα σας δωρεάν. Αν είστε μέλος των προγραμμάτων Child Health Plus ή Managed Medicaid, καλέστε στο 1-800-650-4359. Αν είστε μέλος του προγράμματος Essential Plan, καλέστε στο 1-877-626-9298. Διαφορετικά, καλέστε στο 1-800-499-1275.

Vini re: Nëse flisni shqip, ju ofrohet ndihmë gjuhësore falas. Nëse jeni anëtar i "Child Health Plus" ose "Managed Medicaid", ju lutemi të telefononi numrin 1-800-650-4359. Nëse jeni anëtar i planit bazë, ju lutemi të telefononi numrin 1-877-626-9298. Të gjithë personave të tjerë iu lutemi që të telefonojnë numrin 1-800-499-1275.