Mississippi Farm Bureau Health Plan Change Form

READ ALL INSTRUCTIONS BEFORE COMPLETING THIS CHANGE FORM. THE CHANGE FORM MUST BE COMPLETED IN ITS ENTIRETY AND ALL PAGES MUST BE SUBMITTED IN ORDER TO BE PROCESSED.

- This form is a legal document. If you are approved for coverage, it will become a part of your contract. Therefore, all information provided must be accurate and legible.
- This form must be completed in dark blue or black ink. Forms completed in **pencil** will not be accepted.
- If you make a mistake, mark through the incorrect information, initial it, date it, and provide the correct information.
- **What changes would you like to make?**
  - **Contact information** ➡ Complete sections 1, 2 and 3
  - **Address change** ➡ Complete sections 1, 2, 3 and 4
  - **Name change** ➡ Complete sections 1, 2, 3 and 5
  - **Add a spouse or dependents to a policy** ➡ Complete sections 1, 2, 3 and 6
  - **Delete person from policy** ➡ Complete sections 1, 2, 3 and 7
  - **Make someone else the primary policyholder** ➡ Complete sections 1, 2, 3 and 8
  - **Split my policy into two or more policies** ➡ Complete sections 1, 2, 3 and 9
  - **Delete / change benefits** ➡ Complete sections 1, 2, 3 and 10; subject to underwriting review
  - **Review surcharge** ➡ Complete sections 1, 2, 3, 6 and 11; subject to underwriting review

The Mississippi Farm Bureau Health Plan is sponsored by Mississippi Farm Bureau Federation, and provided through its wholly-owned subsidiary, Mississippi Farm Bureau Health Plans. The Plan is generally administered, to include medical underwriting of this application, by Arkansas Blue Cross and Blue Shield, an independent licensee of the Blue Cross Blue Shield Association.

The Mississippi Farm Bureau health plan has designated, with the approval of the Mississippi Insurance Department, a Plan Ombudsman who possesses the authority, along with the Mississippi Farm Bureau health plan or its designee, to investigate and make determinations on Grievances and Appeals filed according to its Policy. This individual is also responsible for reviewing all Member complaints filed against the Mississippi Farm Bureau health plan with the Mississippi Insurance Department pursuant to Miss. Code § 83-1-111. The Ombudsman is available by phone at **(601) 369-0842** and by email at **ombudsman@msfb.org**.

INSTRUCTIONS

When you are completing this form, please refer to your Mississippi Farm Bureau Health Plan identification card for your **Member ID** and Group Number. This information must be entered correctly under Section 1 in order to process your request.

Effective Date: Approved changes become effective on the 1st of the month. The effective date for any changes will be the next available effective date following approval, unless otherwise requested.

Section 6

- For any applicant who is not a U.S. citizen, a copy of his/her Permanent Resident VISA or Green Card issued by the U.S. Citizenship and Immigration Services must be submitted with the application.
- Applicants must reside in the U.S. at least one year and must have a primary care physician in the U.S. prior to being eligible to apply for coverage.

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Arkansas
BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

IMPORTANT NOTE: We cannot process your Change Form without this completed form.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

As a condition of coverage and of my enrollment in the policy, I authorize any medical professional, medical care institution, pharmacy related service organization, pharmacy benefit manager, or other provider of healthcare services or supplies, as well as any individual, company or prior insurance carrier possessing relevant medical, health, treatment or payment information, to provide Arkansas Blue Cross and Blue Shield and its affiliate or agents information concerning services, supplies, benefit or payments provided or denied to me or to any family member listed in my application, including but not limited to any and all protected health information related to treatments where a restriction was requested for any healthcare item or service in relation to the healthcare provider having been paid in full out-of-pocket. I understand that information obtained as a result of this authorization will be used for the purpose of determining eligibility for coverage. This information may also be used by Arkansas Blue Cross and Blue Shield in investigating and adjudicating claims for benefits. I understand that in the course of its business operations, Arkansas Blue Cross and Blue Shield may disclose this information to others as required or permitted by law and as set out in the Arkansas Blue Cross and Blue Shield Notice of Privacy Practices.

I understand that information re-disclosed may no longer be protected by federal privacy regulations. This authorization does not provide for the disclosure of psychotherapy notes as define in 45 CFR §164.501. I understand that I may terminate this authorization by sending a written revocation to Arkansas Blue Cross and Blue Shield, PO Box 2181, Little Rock, AR 72203-2181. However, if I revoke this authorization before I am enrolled in the policy(ies), my application for coverage will be denied. Unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with investigation of claims. Both the federal government and the State of Arkansas have enacted electronic signature laws, which allow the use of electronic signatures in all areas of commerce. See the Electronic Signatures in Global and National Commerce Act 15 USC §§ 7001 et seq., the Arkansas Electronic Records and Signatures Act A.C.A. §§25-31-101 et seq. and the Uniform Electronic Transaction Act, A.C.A. §§25-31-101 et seq. Electronic signatures are specifically authorized in the business of insurance. See 15 USC §§ 7001(i).

This authorization includes authorization to release information on the diagnosis and treatment of mental illness, alcohol, and drug use, as well as authorization to release information on the diagnosis, treatment, and testing results related to HIV-AIDS, and sexually transmitted diseases, unless otherwise restricted by applicable law.

Please note the following consequences if you decline to sign this authorization for release of your medical information, or if you later revoke it: in that event, we may be unable to process your application or evaluate a claim for coverage and would then deny your application or your claim for policy benefits.

This authorization must be signed by each applicant age 18 or older.

Applicants age 18 and older

Print Name(s)	Signature	Date

Applicants under age 18

List applicants under age 18 (Print Name).

	Parent/Legal Guardian's Signature (if policy for a minor)	Date

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Mississippi Farm Bureau Health Plan Change Form For Current Policy

Return To: Arkansas Blue Cross and Blue Shield
Attn: CRM Operations and Service
P.O. Box 2181
Little Rock, AR 72203-2181

OR Fax to: 501-378-3752
E-mail: CRMCustomerService@arkbluecross.com

SECTION 1 | CURRENT POLICYHOLDER INFORMATION

Member ID	Group Number	Date of Birth:

First Name	M.I.	Last Name

SECTION 2 | CONTACT INFORMATION

Primary Phone Number	Alternate Phone Number	E-mail Address	How do you prefer we communicate with you during this process?
			☐ E-mail ☐ Phone

Note: By selecting your preferred contact method, you agree that all communication during the application process will be sent based on your selection; however, the alternate method(s) may be used if needed to reach you for purposes related to your application.

☐ **Important Opt-In Consent for Electronic Document Access and Delivery:** By providing your email address or by checking this box, you agree that after enrollment we may communicate with you and provide your policy information to you electronically for your convenience, such as your health insurance plan documents, benefits, ID cards, explanation of benefits, claim status, and legal notices regarding your financial, privacy and healthcare rights under federal law. Opting into electronic delivery also allows us to communicate with you electronically, either directly or through one of our contracted business associates, regarding your plan, identification of healthcare providers participating in our networks, disease management, health education and health promotion, preventive care options, wellness programs, treatment options, care coordination, and case management assistance for you in connection with your plan through Arkansas Blue Cross and Blue Shield. Please note that you are responsible for updating your contact information. This electronic delivery will continue through any policy renewals or other changes. Once you are an enrolled member of a plan, if you want to change your communication preferences, including to opt-out of electronic delivery, you may:

- Update your communication preferences and/or contact information at **blueprintportal.com**

OR

- Call the Customer Service number located on your member ID card

If you register for Blueprint portal access after enrollment, this allows you to access your documents and information electronically through your own password-protected account. With the Blueprint portal, your documents can be viewed or printed using your computer or mobile device. The website may be accessed with most versions of Chrome, Firefox, Microsoft Edge, or Safari. You may also set your preferences at **blueprintportal.com**.

Consent to electronic delivery is not a condition of purchase, enrollment, or coverage. At no cost to you, you also may request a paper copy of a document, regardless of whether it is or has been delivered electronically.

By providing your mobile phone number, you agree that automated, informational text messages may be sent to you by or on behalf of your Plan to update you about new plan products and programs. Standard mobile phone and/or text message charges may apply from your wireless provider. Frequency will vary. You can opt-out of receiving such text messages at any time by responding STOP in a response text message.

SECTION 3 | REQUESTED EFFECTIVE DATE

Please write the month and year you would like this change to be effective. **Note**: Changes can only become effective on the 1st of the month, unless change is due to adoption.

Month	Day	Year
	01	

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CHANGES TO BE MADE

You may skip section(s) that do not apply to the change(s) you are making. However, you must return all pages — even if blank.

SECTION 4 | ADDRESS CHANGES

Any change to your current address information can be completed in this section. We have provided three separate listings for this information. Only complete for addresses that are changing.

Residential – This address will be noted as your physical place of residence.
Mailing – Correspondence such as letters and Personal Health Statement (PHS) will be mailed to this address.
Billing – All billing invoices will be mailed to this address.

Residential (Must be permanent address – No P.O. box, please)

Street	City	State	County	Zip

Mailing

Street	City	State	County	Zip

Billing

Street	City	State	County	Zip

SECTION 5 | NAME CHANGE

Documentation is required for any name change request. Please complete this section and attach appropriate documentation, such as a copy of your marriage license, divorce decree, adoption papers or other court papers to support the change.

	First Name	M.I.	Last Name
From:			
To:			

SECTION 6 | ADD PERSON(S) TO POLICY

Please complete all sections below with information about the individual(s) you would like to add to your policy. Individual(s) requested to be added to the policy are subject to underwriting. **When adding a spouse, the individual must be age 17 or older. All dependent additions – including adoptions, must be at least 6 months or older.**

First Name	M.I.	Last Name	Suffix	Relationship	Sex	Date of Birth	Social Security No.	Height	Weight
								ft. in.	lbs.
								ft. in.	lbs.
								ft. in.	lbs.

OTHER INSURANCE

☐ Yes ☐ No a. Are any added individual(s) covered by Medicaid (including CHIP)? If "Yes," please provide name(s):

Applicant Name:	
Applicant Name:	

☐ Yes ☐ No b. Are any added individual(s) covered by Medicare? If "Yes," please provide name(s):

Applicant Name:	
Applicant Name:	

☐ Yes ☐ No c. Are any added individual(s) Medicare disabled? If "Yes," please provide name(s):

Applicant Name:	
Applicant Name:	

ELIGIBILITY

☐ Yes ☐ No d. Is any female applying for coverage pregnant or a potential adoptive mother? If "Yes", please provide name(s):

Applicant Name:	

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SECTION 6 | ADD PERSON(S) TO POLICY (continued)

☐ Yes ☐ No e. Has any added individual(s) ever consumed alcohol to excess, received treatment, or joined an organization for alcoholism or drug addictions? If "Yes," please provide name(s):

Applicant Name:	

☐ Yes ☐ No f. Has any added individual(s) ever used any addictive drug or substance for purposes other than recommended by your physician? If "Yes," please provide name(s):

Applicant Name:	

☐ Yes ☐ No g. Does any applicant have a valid Medical Marijuana Card?

Applicant Name:	

☐ Yes ☐ No h. Has any added individual(s) ever been treated for, diagnosed by or consulted a physician, psychotherapist, counselor or any other provider, or had any indication(s) of having a drug dependency/habit? If "Yes," please provide name(s):

Applicant Name:	Reason for Treatment

☐ Yes ☐ No i. Has any added individual(s) required the assistance of any other individual to perform any activities of daily living? If "Yes," please provide name(s):

Applicant Name:	

☐ Yes ☐ No j. Is any applicant currently a patient in a hospital or nursing home? If "Yes", please provide name(s):

Applicant Name:	

HOUSEHOLD/RESIDENCY

☐ Yes ☐ No a. Do all the added individual(s) under the age of 18 reside in the same household? If "no," please provide reason and his/her name and address:

Name	
Address	
Reason	

☐ Yes ☐ No b. Are all the added individual(s) permanent, legal residents of Mississippi? If "no," please provide reason and his/her name and address:

Name	
Address	
Reason	

Applicants who are not U.S. citizens may be contacted by Mississippi Farm Bureau or Arkansas Blue Cross to request additional information that is relevant to and may be needed for completion of the application.

☐ Yes ☐ No Are all applicants U.S. citizens? If "No", please provide the name(s) of the applicant(s) who are not U.S. citizens.

Name	

Type of Permanent Visa or Permanent Green Card

USCIS Category	Registration No.	Issue Date (Mo. Day Yr.)	Expiration Date (Mo. Day Yr.)

☐ Yes ☐ No Have all applicants applying for coverage resided in the U.S. for at least 12 continuous months? If "No", please provide the name(s) of the applicant(s) who have not resided in the U.S. for at least 12 continuous months.

Name	

(Continued on page 6)

TOBACCO USE

☐ Yes ☐ No c. Has any applicants to be covered used any form of tobacco or nicotine supplements/cessation products within the last 12 months? If "Yes," please provide the following:

Name:	Date Last Used:

MATERNITY RIDER

☐ Yes ☐ No Would you like to add an optional maternity rider?

Note: Must be prior to conception - cannot be pregnant prior to the effective date of maternity coverage. There is a six-month waiting period before the maternity benefits will be covered.

☐ Yes ☐ No Would you like to remove the optional maternity rider?

MEDICAL CONDITIONS

ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED FOR EACH PERSON APPLYING FOR COVERAGE.

Per the field underwriting guidelines and training, the soliciting agent is required to send additional information for any selected condition through the Blueprint for Agents portal after submitting the application.

- ☐ Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related Complex (ARC) or Immune Deficiency Disorder or HIV
- ☐ Adrenal disorders
- ☐ Alzheimer's Disease or senile dementia
- ☐ Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)
- ☐ Anemia
- ☐ Angina, heart attack, myocardial infarction
- ☐ Arteriosclerosis, atherosclerosis, Coronary Artery Disease, stent placement or angioplasty
- ☐ Attempted suicide
- ☐ Brain and nervous system disorders
- ☐ Cancer, Leukemia, or malignancy of any kind
- ☐ Cardiomyopathy, Enlarged Heart, Congestive Heart Failure
- ☐ Cerebral Palsy
- ☐ Cerebrovascular accident (stroke), including Transient Ischemic Attack (TIA)
- ☐ Chronic fatigue
- ☐ Chronic Obstructive Pulmonary Disease, emphysema, lung disease or Respiratory Syncytial Virus (RSV), sleep apnea
- ☐ Cirrhosis
- ☐ Connective Tissue disorder
- ☐ Crohn's Disease or ulcerative colitis
- ☐ Diabetes, abnormal glucose
- ☐ Dialysis
- ☐ Fibromyalgia
- ☐ Gastric bypass surgery or other weight loss procedure
- ☐ Gastric or duodenal ulcer
- ☐ Glandular disorders
- ☐ Heart bypass surgery, pacemaker implant
- ☐ Heart or vein/artery surgery
  - ☐ Congenital ☐ Disease
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Hodgkin's or Non-Hodgkin's Disease
- ☐ Hypertension
- ☐ Kidney, urinary or reproductive disorders
- ☐ Lupus, systemic
- ☐ Meniere's Disease
- ☐ Mental disorders
- ☐ Multiple Sclerosis, Muscular Dystrophy, or Myasthenia Gravis
- ☐ Musculoskeletal disorders
- ☐ Nephritis
- ☐ Nephrotic Syndrome, renal disease or failure
- ☐ Pancreatitis
- ☐ Parkinson's Disease
- ☐ Pending surgery
- ☐ Polyneuritis
- ☐ Respiratory, digestive, or circulatory condition
- ☐ Sarcoidosis
- ☐ Silicone breast implants
- ☐ Sugar, blood, or protein in urine
- ☐ Thyroid disorders
- ☐ Transplant recipient (except cornea/lens)
- ☐ Valve repair/replacement/shunts or stents/retained hardware
  - ☐ Congenital ☐ Disease
- ☐ Any injury, deformity, incapacitation, disease or condition not listed elsewhere
- ☐ Any symptoms, ailments or concerns needing medical evaluation

☐ **None of the above apply to any applicant(s)**

(Continued on page 7)

SECTION 7 | DELETE PERSON(S) FROM THE POLICY

In the event you would like to **terminate coverage** for a covered person, including the primary policyholder, you can do so by completing this section, **OR** you have the option to **maintain coverage on the person you would like to delete from your policy** by splitting him/her off onto a new individual policy with identical coverage. This will completely remove him/her from your coverage and create a new policy for the covered person. You can make this change by completing **Section 9 – Split Policy.** A signature is **required** by **both** the current policyholder and the person maintaining their coverage and moving to a new policy of their own.

Important Note: Complete one change form for each new policy you are requesting.

First Name	M.I.	Last Name	Suffix	Reason	Date of Event

SECTION 8 | OWNERSHIP CHANGE

Complete this section only when the primary policyholder is being removed. **Except for death of the primary policyholder, both the primary policyholder and the covered person maintaining the policy coverage and being moved to the new primary policyholder must sign the change form.**

	First Name	M.I.	Last Name
From:			
To:			

SECTION 9 | SPLIT POLICY

Indicate the name of the covered person(s) you want covered on a separate policy with identical coverage.

First Name	M.I.	Last Name	Suffix	Reason	Date of Event

Primary Phone Number	Alternate Phone Number	E-mail Address

Please provide address information for new Policyholder ONLY:

Residential (Must be permanent address – No P.O. box, please)

Street	City	State	County	Zip

Mailing

Street	City	State	County	Zip

Billing

Street	City	State	County	Zip

SECTION 10 | BENEFIT CHANGES

Policies **CAN INCREASE** deductibles at any time and **CAN DECREASE** deductibles after 12 months.

Deductible:

☐ $250 ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $10,000

IMPORTANT NOTE: Increasing the deductible means that any claims processed by Arkansas Blue Cross after the effective date of change, regardless of the date of the service(s), will be applied to the new higher deductible.

SECTION 11 | POLICY SURCHARGE REVIEW

	Name of Insured	Date Last Used
☐ Review Tobacco Surcharge		
☐ Review Other Surcharge	Name of Insured	

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PLEASE READ BEFORE SIGNING

I understand: (1) This application may be rejected if the applicant is age 18 or older. (2) This application will be medically underwritten in order to assess the potential financial risk of each individual on the application. As the result of the assessment, my application may be approved with no changes, approved but charged a higher premium, or I may be declined for coverage. (3) If accepted, the insurance applied for shall not become effective until the date shown on my schedule of benefits and the adjusted premium, if applicable, is paid in full. (4) If my application is accepted relying on my representations in this document, any coverage which may be issued to me shall be invalid if based on intentional misrepresentations of material fact or fraud. (5) My signature authorizes Arkansas Blue Cross and Blue Shield to coordinate benefits under this policy with other insurance I have which is subject to coordination. (6) Arkansas Blue Cross and Blue Shield may phone me for additional information that may help with the timely processing of my application. In signing below, I represent that the statements and answers given in this application and any signed and dated addendum to this application (both front and back) are true, complete and correctly recorded.

You may review our privacy and non-discrimination notices at **arkbluecross.com/privacy**, **arkbluecross.com/financial-privacy** and **arkbluecross.com/notice**.

Arkansas Blue Cross and Blue Shield, its affiliates and partners may contact you, either directly or through a business associate, using your email address or telephone number regarding your health insurance plan or other promotional opportunities. You can manage your preferences or unsubscribe in Blueprint Portal at **blueprintportal.com**.

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

I certify that I signed this change form in the state of Mississippi. I also understand maintaining Mississippi Farm Bureau membership is a requirement.

SIGNATURE SECTION | (Please sign appropriate line only)

Primary Applicant OR Parent/Legal Guardian **(if policy for a minor)**	Date Signed
Spouse **(required if applying)**	Date Signed
Dependent age 18 or older **(required if applying)**	Date Signed
Dependent age 18 or older **(required if applying)**	Date Signed

CUSTODIAL PARENT SECTION

If any applicant under age 18 (primary applicant or dependent), named on this application, does NOT reside with the policyholder indicated in Section 2, the custodial parent's signature is also required.

Custodial parent's name (please print)		**Phone number**	
Custodial parent's address (Street or PO box)	**City**	**State**	**ZIP**
Custodial parent's signature		**Date signed**	

THIS APPLICATION IS VALID FOR 45 DAYS ONLY WHEN COMPLETED AND SIGNED.

RETURN INSTRUCTIONS

- Any **attachments** submitted with the change form must be signed and dated.
- Do not send any money with this change form.
- **Please ensure all required parties have signed and dated the change form prior to submission.**
- We strongly recommend you make a copy of this completed change form for your records.

NOTICE OF LANGUAGE ASSISTANCE, AUXILIARY AIDS/SERVICES AND NON-DISCRIMINATION NOTICE

We provide free language assistance, appropriate auxiliary aids and services, and reasonable modifications to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, written information in various formats (large print, audio, accessible electronic formats, other formats), and language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call or contact Customer Service at 1-800-238-8379 (TTY:771) or Civil Rights Coordinator.

ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in assessable formats are available free of charge. Call 1-800-238-8379 (TTY: 711) or speak to your provider.

Spanish: ATENCIÓN: Disponemos de servicios gratuitos de asistencia lingüística. También hay disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-800-238-8379 (TTY: 711) o hable con su proveedor.

Chinese Simplified: 注意：提供免费语言服务。此外，免费提供适合残障人士使用的辅助和支持服务。请致电 1-800-238-8379 (TTY: 711)或联系您的服务提供商。

Chinese Traditional: 注意：我們提供免費的語言協助服務，以及免費的適當輔助工具和其他服務，讓您能夠獲得無障礙格式的資訊。請撥打 1-800-238-8379 (TTY: 711)或諮詢您的服務提供者。

Tagalog: PAUNAWA: Available para sa iyo ang mga libreng serbisyo sa tulong sa wika. Available rin nang walang bayad ang mga naaangkop na auxiliary na tulong at serbisyo para magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-238-8379 (TTY: 711) o makipag-usap sa iyong provider.

French: ATTENTION : Des services d'assistance linguistique sont gratuitement mis à votre disposition. Des aides et services auxiliaires appropriés visant à vous informer dans des formats accessibles sont également mis à votre disposition gratuitement. Appelez le 1 800 238 8379 (TTY : 711) ou discutez avec votre prestataire.

Vietnamese: CHÚ Ý: Các dịch vụ hỗ trợ ngôn ngữ sẽ được cung cấp miễn phí cho quý vị. Các dịch vụ và hỗ trợ giao tiếp phù hợp nhằm cung cấp thông tin ở các định dạng dễ tiếp cận cũng được cung cấp hoàn toàn miễn phí. Hãy gọi 1-800-238-8379 (TTY: 711) hoặc trao đổi với nhà cung cấp của quý vị.

German: HINWEIS: Ihnen stehen kostenlose Sprachmittlungsdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zum barrierefreien Zugang zu Informationen stehen ebenfalls kostenfrei zur Verfügung. Rufen Sie 1-800-238-8379 (TTY: 711) an oder sprechen Sie mit Ihrem Leistungserbringer.

Korean: 주의: 무료 언어 지원 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 도구와 서비스도 무료로 제공됩니다. 1-800-238-8379 (TTY: 711)번으로 전화하거나 담당 서비스 제공자에게 문의하십시오.

Russian: ВНИМАНИЕ! Вам доступны бесплатные услуги языковой поддержки. Приемлемые вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-238-8379 (TTY: 711) или обратитесь к своему поставщику услуг.

Arabic: ملاحظة: خدمات المساعدة اللغوية متاحة لك مجاناً، كما أن وسائل وخدمات المساعدة الإضافية المناسبة لتوفير المعلومات بصيغ يسهل عليك الوصول إليها متاحة مجاناً أيضاً. يرجى الاتصال على الرقم: 1-800-238-8379 (TTY: 711) أو التحدث إلى مقدم الرعاية

Hindi: ध्यान दें: आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। आसान फ़ॉर्मैट में सूचना उपलब्ध कराने के लिए उचित सहायक साधन और सेवाएं भी निःशुल्क उपलब्ध हैं। 1-800-238-8379 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

Italian: ATTENZIONE: Ha a disposizione servizi di assistenza linguistica gratuiti. Potrà usufruire gratuitamente anche di sussidi e servizi ausiliari appropriati per ottenere le informazioni in formati accessibili. Chiami il numero 1-800-238-8379 (TTY: 711) o chieda al suo operatore sanitario.

Portuguese: ATENÇÃO: Serviços gratuitos de assistência linguística estão disponíveis para você. Ajudas e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-238-8379 (TTY: 711) ou fale com seu provedor.

French Creole: ATANSYON: Genyen sèvis asistans lang gratis disponib pou ou. Epitou, genyen lòt èd ak sèvis apwopriye disponib gratis pou ede moun jwenn enfòmasyon nan yon fòma ki aksesib. Rele 1-800-238-8379 (TTY: 711) oswa pale ak founisè w la.

Polish: UWAGA: może Pan/Pani skorzystać z bezpłatnych usług pomocy językowej. Odpowiednie dodatkowe pomoce i usługi w zakresie zapewniania dostępu do informacji w przystępnym formacie również są dostępne bezpłatnie. Prosimy dzwonić pod numer 1-800-238-8379 (TTY: 711) lub porozmawiać z lekarzem.

Japanese: 注意：無料の言語サポートサービスをご利用いただけます。アクセシブルなフォーマットで情報を提供するための適切な援助やサービスも無料でご利用いただけます。1-800-238-8379（TTY：711）にお電話いただくか、医療提供者にご相談ください

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Our Company complies with applicable federal and state civil rights laws and does not discriminate, exclude, or treat people differently on the basis of race, color, national origin, age, disability, or sex.

If you believe that we have failed to provide these language assistance or auxiliary aids and services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex.

Civil Rights Coordinator
601 Gaines Street, Little Rock, AR 72201
Phone: 1-844-662-2276 (TTY: 711)
You can file a grievance in person, by mail, or by 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
Phone: 1-800-368-1019; TDD: 1-800-537-7697

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