Horizon Blue Cross Blue Shield of New Jersey

NON-GROUP ENROLLMENT/CHANGE REQUEST

Mail to: Horizon BCBSNJ
Attn: Consumer Enrollment Dept.
P.O. Box 1330
Newark, NJ 07101-1330
Email to: individualapplication@**HorizonBlue.com**
Fax to: 973-274-4413
HorizonBlue.com

A. Type of Activity – to be completed by Applicant *Refer to instructions before completing this form. (Check all that apply)*

1. ADD

	Date of Event	Reason		Date of Event	Reason
☐ Enrollment of a new Subscriber	____/____/____	__________	☐ Add Domestic Partner	____/____/____	__________
☐ Add Spouse	____/____/____	__________	☐ Add Dependent Child	____/____/____	__________
☐ Add Civil Union Partner	____/____/____	__________			

2. REMOVE

	Date of Event	Reason		Date of Event	Reason
☐ Remove Spouse	____/____/____	__________	☐ Remove Domestic Partner	____/____/____	__________
☐ Remove Civil Union Partner	____/____/____	__________	☐ Remove Dependent Child	____/____/____	__________

3. OTHER CHANGE

	Date of Event	Reason		Date of Event	Reason
☐ Name Change	____/____/____	__________	☐ Add/Change Office ID Numbers: Primary Care Provider	____/____/____	__________
☐ Change Plan	____/____/____	__________	☐ Other	____/____/____	__________
☐ Special Enrollment Period (Check triggering event below and attach proof)	____/____/____				

- ☐ Loss of minimum essential coverage
- ☐ Dependent attained age 26 or 31 and lost coverage
- ☐ Marriage/birth/adoption/foster care
- ☐ Child support order or other court order
- ☐ Access to new plan due to permanent move
- ☐ Marketplace changed subsidy determination

B. Applicant Information ☐ Add ☐ Other Change ☐ Continue *If a name change, indicate prior name:* ____________________

Last Name: __________ First Name: __________ MI: ___

Social Security #: __________ Date of Birth: ____ (MM DD YYYY) Sex: ☐ M ☐ F

Are you a resident of New Jersey? ☐ Yes ☐ No

Email: __________

Primary Residence: Street __________ Apt.: ____

City: __________ State: ____ Zip Code + 4: _____ — ____ Phone: __________

Do you maintain a home in any other state/country? ☐ Yes ☐ No *If yes:* Name of state/country: ________________ Number of months you live there each year: ______

Other Residence: Street __________ Apt.: ____

City: __________ State: ____ Zip Code + 4: _____ — ____ Phone: __________

Your billing address: ☐ Primary residence ☐ Other residence ☐ P.O. Box or Other *(specify)*: ____________________

Are you eligible for Medicare? ☐ Yes ☐ No **Are you covered under Medicare Part A or Part B?** ☐ Yes ☐ No

Please note: If you are eligible for Medicare, the individual policy will coordinate as secondary payor to what Medicare paid or would have paid. Individual polices do not operate as Medicare supplement polices.

Are you covered under Other Health Coverage? ☐ Yes ☐ No *If yes,* why are you applying for individual coverage and what is your intended termination date? __________

Horizon Blue Cross Blue Shield of New Jersey is an independent licensee of the Blue Cross and Blue Shield Association.

APPLICANT'S LAST NAME ______________________ FIRST NAME ______________________ MI ________

C. Plan Options

Please select desired medical plan option. We cannot issue you a medical plan without a pediatric dental plan.

Medical *(check one)*

Horizon Advantage Plans We encourage you to select a Primary Care Provider (PCP) in Section F to maximize your benefits.

☐ Horizon Advantage EPO Silver

☐ Horizon Advantage EPO Bronze

☐ Horizon Advantage EPO Essentials. You must be under age 30 or provide a Certificate of Exemption from the Marketplace if you are age 30 or older.

OMNIA Health Plans

☐ OMNIA Gold
☐ OMNIA Silver
☐ OMNIA Silver HSA
☐ OMNIA Bronze

Medical Unit *(check one):* ☐ Single ☐ Family ☐ Two Adults ☐ Adult & Child(ren)

Pediatric Dental and Family Pediatric Dental *(required)*

Stand Alone Pediatric Dental (SAPD) Plan options: Federal law requires all ten categories of essential health benefits which includes pediatric dental benefits to be made available to you, whether or not you have dependents under age 19. Because the above medical plan options do not contain pediatric dental benefits, you must provide assurance that you have, or will obtain a Marketplace-certified SAPD plan. **We will automatically enroll you and your covered dependents in the Horizon Young Grins SAPD plan, unless you have Horizon Young Grins, Horizon Family Grins, Horizon Family Grins Plus or select one of the options below.**

☐ I want to purchase a family pediatric dental plan which provides Marketplace-certified SAPD coverage for individuals under age 19 plus dental coverage for covered persons age 19 and older instead of the Horizon Young Grins SAPD plan.

Plan *(check one):* ☐ Horizon Family Grins ☐ Horizon Family Grins Plus

☐ I have purchased a Marketplace-certified SAPD plan with another carrier. I agree to provide information demonstrating this coverage immediately to Horizon BCBSNJ if requested, that may include the evidence of coverage, the name of the issuer and applicable policy number. I attest that this information is accurate and agree to hold Horizon BCBSNJ harmless from any harm, monetary loss, or liability in connection with reliance on your representation.

D. Other Individuals Covered

Identify individuals other than yourself for whom you are adding/changing/removing coverage. Attach additional pages if necessary, dated and signed by you. Attach proof of disability.

1. SPOUSE/CIVIL UNION PARTNER/DOMESTIC PARTNER ☐ Add ☐ Remove ☐ Other

Last Name (If last name is different from applicant's attach proof): First Name: MI:

Social Security #: Date of Birth: MM DD YYYY Sex: M F

Home address same as applicant? ☐ Yes ☐ No

If no, provide home address and explain why the address is different: ______________________

Home Address: Street Apt.:

City: State: Zip Code + 4:

Are you eligible for Medicare? ☐ Yes ☐ No **Are you covered under Medicare Part A or Part B?** ☐ Yes ☐ No

Are you covered under Other Health Coverage? ☐ Yes ☐ No *If yes,* why are you applying for individual coverage and what is your termination date? ______________

2. CHILD ☐ Add ☐ Remove ☐ Other

Last Name (If last name is different from applicant's attach proof): First Name: MI:

Social Security #: Date of Birth: MM DD YYYY Sex: M F

Living with applicant? ☐ Yes ☐ No **If No, complete Section E**

Are you eligible for Medicare? ☐ Yes ☐ No **Are you covered under Medicare Part A or Part B?** ☐ Yes ☐ No

Are you covered under Other Health Coverage? ☐ Yes ☐ No *If yes,* why are you applying for individual coverage and what is your termination date? ______________

3. CHILD ☐ Add ☐ Remove ☐ Other

Last Name (If last name is different from applicant's attach proof): First Name: MI:

Social Security #: Date of Birth: MM DD YYYY Sex: M F

Living with applicant? ☐ Yes ☐ No **If No, complete Section E**

Are you eligible for Medicare? ☐ Yes ☐ No **Are you covered under Medicare Part A or Part B?** ☐ Yes ☐ No

Are you covered under Other Health Coverage? ☐ Yes ☐ No *If yes,* why are you applying for individual coverage and what is your termination date? ______________

E. Additional Child Information

Provide information below about children listed in Section D, if they have a different address. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.

Name:

Address: Street Apt:

City: State: Zip Code + 4:

Reason: ______________________

Name:

Address: Street Apt:

City: State: Zip Code + 4:

Reason: ______________________

F. Horizon Advantage Plans Primary Care Provider (PCP) Selection - Selecting a PCP for you and each covered dependent is not required but will help maximize your benefits. Attach additional pages if necessary, signed and dated by you.

1. Applicant

Last Name: ______ First Name: ______ MI: ______

Primary Care Provider Name: ______ Current Patient: Yes: ☐ No: ☐

Primary Care Provider Address: ______

City: ______ State: ______ Zip Code +4: ______

NPI #: ______ Loc Code: ______

2. Spouse/Civil Union Partner/Domestic Partner

Last Name: ______ First Name: ______ MI: ______

Primary Care Provider Name: ______ Current Patient: Yes: ☐ No: ☐

Primary Care Provider Address: ______

City: ______ State: ______ Zip Code +4: ______

NPI #: ______ Loc Code: ______

3. Child

Last Name: ______ First Name: ______ MI: ______

Primary Care Provider Name: ______ Current Patient: Yes: ☐ No: ☐

Primary Care Provider Address: ______

City: ______ State: ______ Zip Code +4: ______

NPI #: ______ Loc Code: ______

4. Child

Last Name: ______ First Name: ______ MI: ______

Primary Care Provider Name: ______ Current Patient: Yes: ☐ No: ☐

Primary Care Provider Address: ______

City: ______ State: ______ Zip Code +4: ______

NPI #: ______ Loc Code: ______

G Race/Ethnicity *Your response is appreciated but NOT required. Choose a category that most closely describes you:*

☐ American Indian or Alaskan Native ☐ Black, not of Hispanic origin ☐ Hispanic
☐ Asian or Pacific Islander ☐ White, not of Hispanic origin

H. Payment Information *Indicate how you would like to make payment.*

☐ Check ☐ Money Order ☐ One time Automatic Bank Draft (used for initial premium payment only)

Provide Bank Information for Automatic Bank Draft: Routing # ______ Account # ______

☐ Credit or Debit Card Type: ☐ Visa ☐ MasterCard

Credit or Debit Card No.: ______ Exp. Date: ______/______

Cardholder Name: ______

I. Applicant's Signature

I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form.

Signature: ______ Date: ______/______/______

J. Broker/General Agent Signature

Signature of Preparer: ______ Date: ______/______/______ NJ Producer License #: ______

Print Agent Name: ______

General Agent/Broker: ______ Agent/Vendor ID# ______

Instructions

INSTRUCTIONS AND ELIGIBILITY REQUIREMENTS

Instructions

- Except for section G, you must complete sections A through I, and sign and date this form, as well as any additional pages you may need to submit with it to provide further requested information.
- Please PRINT except when a signature is requested.
- For Section A-Type of Activity:
  - ➢ If you are applying to add a spouse, civil union partner, domestic partner, or child, use the "Add" section and check the applicable box. If the member being added is due to a triggering event, also use the "Other Change" section, check the box "Special Enrollment Period" and check the applicable reason.
  - ➢ If you are applying due to a triggering event that resulted in a Special Enrollment Period, use the "Other Change" section, check the box "Special Enrollment Period", check the applicable reason and attach proof of the triggering event.
    - Loss of eligibility for minimum essential coverage but not if lost due to non-payment of premium.
    - Dependent attained age 26 or 31 and lost coverage.
    - New dependent due to marriage, birth, adoption or placement for adoption, placement in foster care.
    - Child support order or other court order requiring coverage.
    - Gained access to New Jersey plans as a result of a permanent move to New Jersey.
    - Marketplace changed your subsidy determination.
  - ➢ If a dependent child is disabled and you want to continue his or her coverage beyond age 26, use the "Other Change" section, check the box "Other", describe the reason and attach proof of disability.
- Eligible for Medicare means the person satisfies the requirements for Medicare but has not yet enrolled for Medicare. Covered under Medicare Parts A or B means you have Medicare and CANNOT enroll for an individual plan.
- For the Horizon Advantage plans, selecting a Primary Care Provider (PCP) for you and each covered dependent is not required but will help maximize your benefits. You can obtain the providers' correct names and addresses from the appropriate provider directory. You may also obtain each provider's NPI number and LOC Code from the provider directory or at **HorizonBlue.com/doctorfinder**. Providers with multiple office locations and individual providers who belong to more than one practice or provider entity may have more than one NPI number. You should confirm the correct NPI number for the specific provider and office location where you will be seen by contacting that office directly.
- For provider addresses, include the zip code plus the four-digit extension (9 digits).
- IF YOU HAVE ANY QUESTIONS concerning the benefits and services provided by or excluded under this policy, contact a Horizon Blue Cross Blue Shield of New Jersey Sales Representative at **1-888-425-5611** or your broker before signing this form.
- MAKE A COPY OF THIS COMPLETED APPLICATION! A copy of this application may be used as a temporary ID card for 30 days from the effective date if authorized by Horizon BCBSNJ. Coverage must be verified with Horizon BCBSNJ prior to visiting with a physician or admission to a hospital.
- You may submit this form to us by mail, email or fax:

  Mail to: Horizon BCBSNJ
  Attn: Consumer Enrollment Dept.
  P.O. Box 1330
  Newark, NJ 07101-1330
  Email to: individualapplication@**HorizonBlue.com**
  Fax to: 973-274-4413

Medical Eligibility

A. Eligibility requirements are set forth under the Individual Health Coverage Reform Act of 1992, P.L. 1992, c. 161 (N.J.S.A. 17B: 27A-2 et seq.).

B. You MUST be a New Jersey resident which means your primary residence is in New Jersey.

C. You must NOT be covered under Medicare Parts A or B.

D. If application is made for the Horizon Advantage EPO Essentials Plan the following additional requirements apply:
1. You must be under 30 years old, or
2. You must have a Certificate of Exemption from the Marketplace. Attach a copy to your application.

The **Annual Open Enrollment Period** is the designated period of time each year during which you may apply for or change coverage for yourself and family members who are currently uninsured or who are covered under another individual plan, or who are covered under a group health plan, group health benefits plan, a governmental plan, or a church plan. Your application must be received during the designated Annual Open Enrollment Period. The effective date of coverage applied for by December 31 will be January 1 of the immediately following year. *If* the designated Annual Open Enrollment Period extends beyond December, the effective date of coverage will be the 1st or 15th of the month following receipt of the application.

A **Special Enrollment Period** that lasts for 60 days follows the Triggering Events listed above. The effective date of a new policy will be no later than the 1st or 15th of the month following receipt of the application. In addition, if the Triggering Event is the loss of eligibility for minimum essential coverage, the Special Enrollment Period includes the 60 days prior to the Triggering Event.

NOTE: If you currently have coverage the plan for which you are applying must REPLACE the current coverage but you SHOULD NOT terminate it until the new coverage is effective.

Pediatric Dental Eligibility:

A. There are no age restrictions to enroll in the pediatric dental or family pediatric dental plans. However, when an applicant age 19 or older enrolls in a Horizon Young Grins SAPD plan, he or she will not be charged premium and will not have pediatric dental benefits. The Horizon Young Grins SAPD plan only provides coverage until the end of the month a person turns age 19.

B. You MUST be a New Jersey resident which means your primary residence is in New Jersey.

C. If you enroll in a pediatric dental or family pediatric dental plan at the same time you enroll in a medical plan your pediatric dental or family pediatric dental coverage will become effective on the same date as your medical coverage. If you enroll in a pediatric dental or family pediatric dental plan at any other time and you enroll on the 1st through the 14th of the month, the effective date is the 15th of the month. If you enroll on the 15th through the end of the month, the effective date is the 1st of the following month,

CONDITIONS OF ENROLLMENT - APPLICANT ACKNOWLEDGMENT AND AGREEMENTS

On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer reporting agency, and any employer to give Horizon BCBSNJ[1], or any consumer reporting agency acting on behalf of Horizon BCBSNJ, information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request Form, unless revoked at an earlier date.

2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that Horizon BCBSNJ has taken in reliance on the authorization.

3. I understand I may receive a copy of this authorization if I request one.

4. I agree Horizon BCBSNJ will provide coverage in accordance with the terms of the contract for the individual plan.

5. I understand that my enrollment and the enrollment of my listed dependents in Horizon BCBSNJ's individual plan is conditioned upon acceptance by Horizon BCBSNJ.

6. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the individual policy if premiums are not paid timely.

Misrepresentations

Any person who includes any false or misleading information on this form is subject to criminal and civil penalties.

[1]Horizon BCBSNJ refers to Horizon Healthcare Services, Inc., doing business as Horizon Blue Cross Blue Shield of New Jersey or any of its wholly owned subsidiaries including Horizon Insurance Company, Horizon Healthcare Dental, Inc., and Horizon Healthcare of New Jersey doing business as Horizon NJ Health.

Horizon Blue Cross Blue Shield of New Jersey

Three Penn Plaza East
Newark, NJ 07105-2200
HorizonBlue.com

Notice of Nondiscrimination

Horizon Blue Cross Blue Shield of New Jersey complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Horizon BCBSNJ does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Horizon BCBSNJ provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Information written in other languages

If you need these services, contact Horizon BCBSNJ's Director of Regulatory Compliance at the phone number, fax or email listed below.

If you believe that Horizon BCBSNJ 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:

Horizon BCBSNJ – Director, Regulatory Compliance
Three Penn Plaza East, PP-16C
Newark, NJ 07105
Phone: 1-800-658-6781
Fax: 1-973-466-7759
Email: ComplianceAndEthicsOffice@HorizonBlue.com

You can file a grievance in person, or by mail, fax or email. If you need help filing a grievance, Horizon BCBSNJ's Director of Regulatory Compliance 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:

Office for Civil Rights Headquarters
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019 or **1-800-537-7697** (TDD)

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

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Horizon Blue Cross Blue Shield of New Jersey

If you need help understanding this Horizon Blue Cross Blue Shield of New Jersey information, you have the right to get help in your language at no cost to you. To talk to an interpreter, please call **1-800-355-BLUE (2583)** during normal business hours.

Spanish (Español): Si necesita ayuda para comprender esta información de Horizon Blue Cross Blue Shield of New Jersey, usted tiene el derecho de obtener ayuda en su idioma sin costo alguno. Para hablar con un intérprete, sírvase llamar al **1-855-477-AZUL (2985)** durante el horario normal de trabajo.

Chinese (中文)：如果您需要幫助來理解這份新澤西州地平線藍十字藍盾 (Horizon Blue Cross Blue Shield of New Jersey)資料，您有權免費獲得以您的語言提供的協助。欲聯絡翻譯人員，請於上班時間致電 **1-800-355-BLUE (2583)**。

Korean (한국어): 가입자는 Horizon Blue Cross Blue Shield of New Jersey에 관한 정보를 이해하기 위해 주로 사용하는 언어로 무료로 도움을 받을 권리가 있습니다. 통역사의 도움을 받으려면 정상 업무 시간 동안에 **1-800-355-BLUE (2583)**로 전화해 주십시오.

Portuguese (Português): Se precisar de ajuda para entender estas informações da Horizon Blue Cross Blue Shield of New Jersey, você tem o direito de receber gratuitamente assistência no seu idioma. Para falar com um intérprete, ligue para: **1-800-355-BLUE (2583)** no horário normal de trabalho.

Gujarati (ગુજરાતી): જો તમને આ ન્યુ જર્સી માહિતીનાં હોરાઈઝન્સ બ્લૂ ક્રોસ બ્લૂ શીલ્ડને સમજવા મદદની જરૂર હોય તો, તમને તમારી ભાષામાં કોઇ પણ ખર્ચ વગર મદદ મેળવવાનો અધિકાર છે. કોઈ દુભાષિયા સાથે વાત કરવા, કૃપા કરીને સામાન્ય બિઝનેસ કલાકો દરમિયાન **1-800-355-BLUE (2583)** પર ફોન કરો .

Polish (Polski): Jeżeli potrzebujesz pomocy, aby zrozumieć informacje planu Horizon Blue Cross Blue Shield of New Jersey, masz prawo poprosić o bezpłatną pomoc w języku ojczystym. Aby skorzystać z pomocy tłumacza, zadzwoń pod numer **1-800-355-BLUE (2583)** podczas normalnych godzin pracy.

Italian (Italiano): Se vi serve aiuto per capire queste informazioni della Horizon Blue Cross Blue Shield of New Jersey, avete diritto ad assistenza gratis nella vostra lingua. Per parlare con un interprete, siete pregati di telefonare al numero **1-800-355-BLUE (2583)** durante le normali ore d'ufficio.

Tagalog (Tagalog): Kung kailangan mo ng tulong sa pag-unawa nitong impormasyon ng Horizon Blue Cross Blue Shield of New Jersey, may karapatan kang humingi ng tulong sa iyong wika nang walang gastos sa iyo. Upang makipag-usap sa isang taga-interpret, mangyaring tumawag sa **1-800-355-BLUE (2583)** sa loob ng karaniwang mga oras ng negosyo.

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Blue Cross and Blue Shield Association.

Russian (Русский язык): Если вам необходима помощь в разъяснении этой информации, предоставленной компанией Horizon Blue Cross Blue Shield of New Jersey, у вас есть право на получение помощи на вашем родном языке бесплатно. Для связи с переводчиком звоните по номеру телефона **1-800-355-BLUE (2583)** в обычные рабочие часы.

Haitian Creole (Kreyòl ayisyen): Si ou bezwen èd pou konprann enfòmasyon sou Horizon Blue Cross Blue Shield of New Jersey, ou gen dwa pou jwenn èd nan lang natifnatal ou gratis. Pou pale avèk yon entèprèt, tanpri rele nimewo **1-800-355-BLUE (2583)** pandan lè nòmal biznis.

Hindi (हिंदी): यदि आपको न्यू जर्सी की इस होराइज़न ब्लू क्रॉस ब्लू शील्ड सूचना को समझने में सहायता की ज़रूरत है, तो आपके पास मुफ्त में अपनी भाषा में सहायता पाने का अधिकार है। किसी दुभाषिए से बात करने के लिए, कृपया सामान्य कार्य समय के दौरान **1-800-355-BLUE (2583)** पर कॉल करें।

Vietnamese (Tiếng Việt): Nếu cần được giúp đỡ để hiểu rõ thông tin này của Horizon Blue Cross Blue Shield of New Jersey, quý vị có quyền được giúp đỡ bằng ngôn ngữ của mình miễn phí. Xin gọi số **1-800-355-BLUE (2583)** trong giờ làm việc để nói chuyện với người thông dịch.

French (Français): Si vous avez besoin d'assistance pour comprendre ces informations au sujet de Horizon Blue Cross Blue Shield of New Jersey, vous avez le droit d'obtenir de l'aide dans votre langue, sans aucun frais. Pour parler avec un interprète, veuillez appeler le **1-800-355-BLUE (2583)** pendant les heures normales de bureau.

Navajo (Diné): Díí New Jersey bił hahoodzo Horizon Blue Cross Blue Shield, t'áá ninizaad k'ehjí baa hane'íí bik'i diitįįh bee shiká' a'doowoł nínízingo éí bee ná'ahoot'i' dóó doo bą́ą́h ílíní da. Ata' halne'é ła' bich'į' hadeesdzih nínízingo t'áá shǫǫdí **1-800-355-BLUE (2583)**jį' nida'anishgo oolkiłíí bik'ehgo hodíílnih.

Arabic (عربي): إذا كنت بحاجة إلى المساعدة في فهم معلومات Horizon Blue Cross Blue Shield of New Jersey، لديك الحق في الحصول على المساعدة بلغتك دون تحملك أية تكلفة. للتكلم مع مترجم، يرجى الاتصال خلال ساعات العمل العادية بالرقم **1-800-355-BLUE (2583)**.

Urdu (**اردو**): اگر آپ کو نیوجرسی انفارمیشن کے اس آسمانی نیلے رنگ والے تیز نیلے رنگ والے شیلڈ کو سمجھنے میں مدد کی ضرورت ہے تو، آپ کو اپنی زبان میں بغیر کسی خرچ کے مدد حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، براہ کرم، معمول کے کاروباری اوقات میں **1-800-355-BLUE (2583)** پر کال کریں۔