Application for Group Coverage

Thank you for applying for coverage from Independence Blue Cross.
Follow the instructions below to complete your application.

1. Carefully review and complete each section by printing clearly in black ink.
2. Your Group Administrator must complete section 2 before your application can be processed. If this is an application for a new member or a member changing plans, the Group Administrator must indicate the type of coverage elected.

PPO	HMO	POS	DPOS
RX	Vision	Dental	MedigapSecurity

3. Provide information about your spouse, domestic partner and dependents only if they are also applying for coverage (Section 4). If you need additional space, attach an additional application with your signature and date. Important: You must include a Relationship Code (listed at the bottom of pages 3 through 6) to indicate your relationship to each person covered under the plan.
4. Your Group Administrator must complete Section 7 and sign the application before it can be processed.
5. Before signing your application, please carefully read the Declarations and Conditions of Enrollment on page 8. Once you have completed and signed your application, be sure to make a copy for your records.

Independence Blue Cross
P.O. Box 8240
Philadelphia, PA 19101

The collection of Race, Ethnicity, and Language data is confidential and voluntary. We are collecting this information as part of our efforts to support equitable, whole-person coverage. This data may be analyzed by our data analysts to support equitable, whole-person health initiatives. For information regarding the Plan's policies and procedures for managing access to and use of race/ethnicity, and language data, including: controls for physical and electronic access to the data, permissible use of the data, as well as impermissible use of the data, please refer to the Notice of Privacy Practices at https://www.ibx.com/privacy-policy.

If you have any questions or need help completing this application, contact Independence Blue Cross at 1-800-ASK-BLUE (1-800-275-2583) (TTY:711), Monday through Friday, between 8 a.m. and 6 p.m. Brokers and small group employers should call 1-866-272-9684 (TTY:711), Monday through Friday, 8:30 a.m. to 5 p.m., with any questions. Thank you for taking the time to complete your application. We look forward to having you as a member of the Independence Blue Cross family!

530351

Universal Enrollment Form

SECTION 1 — Subscriber or member enrollment or change

Employee MUST complete in full

Type of coverage	Change	Reason for application	Other change
☐ Employee only ☐ Employee and child ☐ Employee and children ☐ Employee and spouse or domestic partner ☐ Family	☐ Address ☐ Last name ☐ Primary care office ☐ Rehire ☐ Primary dental office	☐ Add spouse/domestic partner ☐ Add a dependent ☐ Delete a dependent ☐ Other Life event date: (mm/dd/yy) ____/____/____	☐ COBRA Effective date: (mm/dd/yy) ____/____/____ Effective date of coverage: ____/____/____ mm dd yy

SECTION 2 — To be completed by Group Administrator

Plan (please specify copay or benefit option):				Employment Status:	Terminate contract
PPO	HMO	POS	DPOS	☐ Active ☐ Retiree	☐ Terminated employment ☐ Full-time to part-time ☐ Deceased. Indicate date. ____/____/____
RX	Vision	Dental		☐ Medigap /Security	☐ Other. Please Explain

SECTION 3 — Subscriber information

please complete this entire section, whether you are a new applicant or are making a change to an existing contract

Social Security Number or ID number	Last name	Middle initial	First name

Sex assigned at birth:	Date of birth	Street address	Apt or suite
☐ M ☐ F ☐ Intersex	____/____/____		

City	State	Zip code	Date of hire
			/ /

Telephone number (including area code)	Primary Care Office ID number (HMO ID#, HMO/POS/DPOS only)†	Primary Care Office name (HMO ID#, HMO/POS/DPOS only)†
Home ( )		☐ Check if current patient
Work ( )	Primary Care Office ID number	Primary Care Office name ☐ Check if current patient
Mobile ( )	By providing my phone number and/ or email address, I authorize Independence Blue Cross, its subsidiaries and affiliates (collectively "Independence"), and my employer to contact me via email, automated text and/or phone call. I understand that my consent is not a condition of any benefit or purchase. Message and data rates may apply.	
Email address		

†A primary care physician (PCP) code and primary dental office are required for all HMO/POS/DPOS medical and dental plans. Use our website www.ibx.com/findadoctor to find a primary care physician (PCP) or a primary dental office. You can also call 215-241-CARE (2273) to request a PCP directory (HMO/POS/DPOS plans only)

SECTION 3 — Subscriber information (continued)

Racial Identity (select all that apply)*

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown

☐ Other ☐ Prefer not to answer

Ethnic Identity

☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Other

☐ Unknown ☐ Prefer not to answer

Preferred Language

☐ English ☐ Spanish ☐ Chinese

☐ Italian ☐ Portuguese ☐ Other

☐ Prefer not to answer

Cultural Identity (Select up to 5)

☐ Cherokee	☐ Asian Indian	☐ African	☐ Guamanian or Chamorro	☐ English	☐ Cuban
☐ Nanticoke Lenni-Lenape	☐ Chinese	☐ Haitian	☐ Micronesian	☐ German	☐ Dominican (Dominican Republic)
☐ Navajo	☐ Filipino	☐ Jamaican	☐ Native Hawaiian	☐ Irish	☐ Guatemalan
☐ Powhatan Renape Nation	☐ Korean	☐ Nigerian	☐ Polynesian	☐ Italian	☐ Mexican
☐ Ramapough Lenape Indian Nation	☐ Vietnamese	☐ West Indian	☐ Samoan	☐ Polish	☐ Puerto Rican
☐ Other	☐ Prefer not to answer				

SECTION 4 — Family information (if applying)**

Spouse/Domestic Partner name: Last, first, middle initial				Social Security Number
Employer name	Birth date (mm/dd/yy)	Age	Sex assigned at birth:	Relationship Code:‡
_____	___/___/___	____	☐ M ☐ F ☐ Intersex	_____

Racial Identity (select all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown

☐ Other ☐ Prefer not to answer

*The information regarding demographic factors: (1) will be maintained as private; (2) may not be used by the insurer for eligibility determinations, underwriting, or rating purposes; and (3) the insurer will not deny an application based on the applicant's refusal to answer the questions related to demographic data.

**If you need to apply for additional dependents, please complete another application and mail it along with your primary application.

‡Relationship codes: (for dependents, value identifies relationship to the subscriber)

01 = Spouse
02 = Child
09 = Adopted child
10 = Foster child
17 = Stepchild
20 = Subscriber / Self
29 = Domestic Partner
31 = Court appointed guardian

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SECTION 4 — Family information (continued)*

Ethnic Identity

☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Other

☐ Unknown ☐ Prefer not to answer

Preferred Language

☐ English ☐ Spanish ☐ Chinese

☐ Italian ☐ Portuguese ☐ Other

☐ Prefer not to answer

Cultural Identity (Select up to 5)

☐ Cherokee	☐ Asian Indian	☐ African	☐ Guamanian or Chamorro	☐ English	☐ Cuban
☐ Nanticoke Lenni-Lenape	☐ Chinese	☐ Haitian	☐ Micronesian	☐ German	☐ Dominican (Dominican Republic)
☐ Navajo	☐ Filipino	☐ Jamaican	☐ Native Hawaiian	☐ Irish	☐ Guatemalan
☐ Powhatan Renape Nation	☐ Korean	☐ Nigerian	☐ Polynesian	☐ Italian	☐ Mexican
☐ Ramapough Lenape Indian Nation	☐ Vietnamese	☐ West Indian	☐ Samoan	☐ Polish	☐ Puerto Rican
☐ Other	☐ Prefer not to answer				

Primary care office/PCP name (HMO/POS/DPOS only)†	Primary care physician office ID# (HMO ID#, HMO/POS/DPOS only)†
Current patent of PCP? (HMO/POS/DPOS only)† ☐ Yes ☐ No	Primary dental office ID#

Dependent†† name: Last, first, middle initial				Social Security Number
Relationship (e.g., son, stepdaughter)	Birth date (mm/dd/yy) / /	Age	Sex assigned at birth: ☐ M ☐ F ☐ Intersex	Relationship Code:‡

Racial Identity (select all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown

☐ Other ☐ Prefer not to answer

*If you need to apply for additional dependents, please complete another application and mail it along with your primary application.

†A primary care physician (PCP) office/provider ID number is required for all HMO/DPOS medical plans. A primary dental office (PDO)/provider ID selection is not required with your application but must be selected prior to receiving treatment. Use our website www.ibx.com/providerfinder to find a PCP or PDO provider. This plan requires the selection of a Primary Dental Office (PDO) from the Plan's dental HMO network. The Member's PDO provides routine care and arranges or provides most other Dentally Necessary services. Except for emergency services, benefits are covered only when provided or properly referred by the Member's PDO. The manner of accessing benefits through the PDO is made clear in the terms of the Group Contract and Certificate of Coverage. You can also called 1-800-ASK-BLUE (1-800-275-2583)(TTY:711) to request a PCP or PDO directory (for HMO/DPOS Plans only).

††Children under the age of 26 who meet eligibility requirements. Coverage can be applicable past age 26 if they are not self-supportive because of a mental or physical disability.

‡Relationship codes: (for dependents, value identifies relationship to the subscriber)

01 = Spouse
02 = Child
09 = Adopted child
10 = Foster child
17 = Stepchild
20 = Subscriber / Self
29 = Domestic Partner
31 = Court appointed guardian

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SECTION 4 — Family information (continued)*

Ethnic Identity

☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Other

☐ Unknown ☐ Prefer not to answer

Preferred Language

☐ English ☐ Spanish ☐ Chinese

☐ Italian ☐ Portuguese ☐ Other

☐ Prefer not to answer

Cultural Identity (Select up to 5)

☐ Cherokee	☐ Asian Indian	☐ African	☐ Guamanian or Chamorro	☐ English	☐ Cuban
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☐ Navajo	☐ Filipino	☐ Jamaican	☐ Native Hawaiian	☐ Irish	☐ Guatemalan
☐ Powhatan Renape Nation	☐ Korean	☐ Nigerian	☐ Polynesian	☐ Italian	☐ Mexican
☐ Ramapough Lenape Indian Nation	☐ Vietnamese	☐ West Indian	☐ Samoan	☐ Polish	☐ Puerto Rican
☐ Other	☐ Prefer not to answer				

Primary care office/PCP name (HMO/POS/DPOS only)†	Primary care physician office ID# (HMO ID#, HMO/POS/DPOS only)†
Current patent of PCP? (HMO/POS/DPOS only)† ☐ Yes ☐ No	Primary dental office ID#

Dependent†† name: Last, first, middle initial				Social Security Number
Relationship (e.g., son, stepdaughter)	Birth date (mm/dd/yy) / /	Age	Sex assigned at birth: ☐ M ☐ F ☐ Intersex	Relationship Code:‡

Racial Identity (select all that apply)

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10 = Foster child
17 = Stepchild
20 = Subscriber / Self
29 = Domestic Partner
31 = Court appointed guardian

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SECTION 4 — Family information (continued)*

Ethnic Identity

☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Other

☐ Unknown ☐ Prefer not to answer

Preferred Language

☐ English ☐ Spanish ☐ Chinese

☐ Italian ☐ Portuguese ☐ Other

☐ Prefer not to answer

Cultural Identity (Select up to 5)

☐ Cherokee	☐ Asian Indian	☐ African	☐ Guamanian or Chamorro	☐ English	☐ Cuban
☐ Nanticoke Lenni-Lenape	☐ Chinese	☐ Haitian	☐ Micronesian	☐ German	☐ Dominican (Dominican Republic)
☐ Navajo	☐ Filipino	☐ Jamaican	☐ Native Hawaiian	☐ Irish	☐ Guatemalan
☐ Powhatan Renape Nation	☐ Korean	☐ Nigerian	☐ Polynesian	☐ Italian	☐ Mexican
☐ Ramapough Lenape Indian Nation	☐ Vietnamese	☐ West Indian	☐ Samoan	☐ Polish	☐ Puerto Rican
☐ Other	☐ Prefer not to answer				

Primary care office/PCP name (HMO/POS/DPOS only)†	Primary care physician office ID# (HMO ID#, HMO/POS/DPOS only)†
Current patent of PCP? (HMO/POS/DPOS only)† ☐ Yes ☐ No	Primary dental office ID#

Dependent†† name: Last, first, middle initial				Social Security Number
Relationship (e.g., son, stepdaughter)	Birth date (mm/dd/yy) / /	Age	Sex assigned at birth: ☐ M ☐ F ☐ Intersex	Relationship Code:‡

Racial Identity (select all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown

☐ Other ☐ Prefer not to answer

*If you need to apply for additional dependents, please complete another application and mail it along with your primary application.

†A primary care physician (PCP) office/provider ID number is required for all HMO/DPOS medical plans. A primary dental office (PDO)/provider ID selection is not required with your application but must be selected prior to receiving treatment. Use our website www.ibx.com/providerfinder to find a PCP or PDO provider. This plan requires the selection of a Primary Dental Office (PDO) from the Plan's dental HMO network. The Member's PDO provides routine care and arranges or provides most other Dentally Necessary services. Except for emergency services, benefits are covered only when provided or properly referred by the Member's PDO. The manner of accessing benefits through the PDO is made clear in the terms of the Group Contract and Certificate of Coverage.

You can also called 1-800-ASK-BLUE (1-800-275-2583)(TTY:711) to request a PCP or PDO directory (for HMO/DPOS Plans only).

††Children under the age of 26 who meet eligibility requirements. Coverage can be applicable past age 26 if they are not self-supportive because of a mental or physical disability.

‡Relationship codes: (for dependents, value identifies relationship to the subscriber)

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SECTION 4 — Family information (continued)*

Ethnic Identity

☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Other

☐ Unknown ☐ Prefer not to answer

Preferred Language

☐ English ☐ Spanish ☐ Chinese

☐ Italian ☐ Portuguese ☐ Other

☐ Prefer not to answer

Cultural Identity (Select up to 5)

☐ Cherokee	☐ Asian Indian	☐ African	☐ Guamanian or Chamorro	☐ English	☐ Cuban
☐ Nanticoke Lenni-Lenape	☐ Chinese	☐ Haitian	☐ Micronesian	☐ German	☐ Dominican (Dominican Republic)
☐ Navajo	☐ Filipino	☐ Jamaican	☐ Native Hawaiian	☐ Irish	☐ Guatemalan
☐ Powhatan Renape Nation	☐ Korean	☐ Nigerian	☐ Polynesian	☐ Italian	☐ Mexican
☐ Ramapough Lenape Indian Nation	☐ Vietnamese	☐ West Indian	☐ Samoan	☐ Polish	☐ Puerto Rican
☐ Other	☐ Prefer not to answer				

Primary care office/PCP name (HMO/POS/DPOS only)†	Primary care physician office ID# (HMO ID#, HMO/POS/DPOS only)†
Current patent of PCP? (HMO/POS/DPOS only)† ☐ Yes ☐ No	Primary dental office ID#

SECTION 5 — Dependent information

If you listed dependents, you MUST answer these questions.

Do any dependents listed live at another address? ☐ Yes ☐ No Is any dependent's last name different from yours? ☐ Yes ☐ No	If you answered yes to either question, please explain.

SECTION 6 — Other insurance

Please list health insurance information if you or any dependents listed in Section 4 have other coverage.

Insurance Company Name	Policy Number	
Policy Holder	Type of benefits	Effective date
		/ /

*If you need to apply for additional dependents, please complete another application and mail it along with your primary application.

†A primary care physician (PCP) office/provider ID number is required for all HMO/DPOS medical plans. A primary dental office (PDO)/provider ID selection is not required with your application but must be selected prior to receiving treatment. Use our website www.ibx.com/providerfinder to find a PCP or PDO provider. This plan requires the selection of a Primary Dental Office (PDO) from the Plan's dental HMO network. The Member's PDO provides routine care and arranges or provides most other Dentally Necessary services. Except for emergency services, benefits are covered only when provided or properly referred by the Member's PDO. The manner of accessing benefits through the PDO is made clear in the terms of the Group Contract and Certificate of Coverage.

You can also called 1-800-ASK-BLUE (1-800-275-2583)(TTY:711) to request a PCP or PDO directory (for HMO/DPOS Plans only).

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SECTION 6 — Other insurance (continued)

Are you or any of your dependents receiving Medicare Benefits? ☐ Yes ☐ No

	Name	Medicare Number	Part A Effective Date	Part B Effective Date	Reason
Self			/ /	/ /	
Spouse/ Domestic Partner			/ /	/ /	Check all that apply
Child			/ /	/ /	☐ Age ☐ Disability ☐ ESRD
Child			/ /	/ /	

SECTION 7 — Group and employer information

Your Group Administrator MUST complete this section. Your application CANNOT be processed unless this section is complete.

Group name _____ Group number _____ Payroll/ Work Location _____

Employer or Group Administrator signature _____ Date / / Account number _____

Declarations and Conditions of Enrollment

Your application cannot be processed without your signature.

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

For PPO members:

By signing this application, I elect coverage under the plan specified on this form and for the persons listed here and agree to abide by the conditions of the agreement and to pay required premiums for the selected plan. I authorize my licensed physician, medical or medically-related facility, insurance company, or other organization or institute that has any records concerning my health or the health of any covered family member to forward such information to Independence Blue Cross and its affiliate, QCC Insurance Company, Highmark Blue Shield, and ancillary service providers who are responsible for administrating certain covered services. This application is subject to acceptance and to the waiting periods, exclusions, and all other provisions contained in the agreement between my employer, association, or welfare board and Independence Blue Cross and Highmark Blue Shield.

For HMO/POS and DPOS members:

I understand that the provision of services to me and my dependents as members of Keystone Health Plan East (''Keystone'') is governed by the applicable master group contract, which provides that: 1)Except for emergencies and select DPOS services, all medical or dental care must be initiated at the primary care office or primary dental office we have selected; and, 2) I and my dependents authorize any person or organization provider services to furnish Keystone, its affiliates, and ancillary service providers who are responsible for administrating certain covered services with medical or dental records or other information concerning such services for purposes including, but not limited to, Keystone quality and utilization review.

I further understand that I can change health plans only at the time my employer and Keystone specify.

Keystone DPOS program self-referred benefits may be underwritten by QCC Insurance company. Referred benefits underwritten or administered by Keystone Health Plan East.

X _____ / / _____

Employee signature — Date (mm/dd/yy)

_____

Subscriber's County of Residence

I acknowledge that I have read, understand all statements in this application, and have supplied the requested information. The information supplied on the application and any signed addendum is accurate and complete to the best of my knowledge. No material information has been withheld or omitted on any person applying. I understand that if my signature and date do not appear and/or my answers are incomplete, the application will either be rejected or returned for completion.

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Independence

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意：如果您讲中文，您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કૉલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic:
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Telugu: శ్రద్ధ పెట్టం డి: ఒకవేళ మీరు తెలుగు భాష మాట్లా డుతున్న ట్యితే, మీ కొరకు తెలుగు భాషాసహాయక సేవలు ఉచితంగాలభిన్న యి. 1-800-275-2583 (TTY: 711) కు కాల చేయండి.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考：母国語が日本語の方は、言語アシスタンスサービス（無料）をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):
توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh. Hódíílnih kojį' 1-800-275-2583.

Urdu:
توجہ درکارہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583.

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

Taglines as of 12/31/2022

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free 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, contact our Civil Rights Coordinator. If you believe that This 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 our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscoordinator@1901market.com. 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, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Taglines as of 12/31/2022