Employee Enrollment Application
For 1–50 Employee Small Groups[1]
Georgia

BlueCross BlueShield of Georgia

BlueCross BlueShield Healthcare Plan of Georgia

Greater Georgia Life Insurance Company

You, the employee, must complete this application. You are solely responsible for its accuracy and completeness.
To avoid the possibility of delay, answer all questions and be sure to sign and date your application.

Please complete in black ink only.

Section A: Employee Information

Last name	First name	M.I.	Social Security no.[2] (required)

Home address – Street and PO Box if applicable

City	County	State	ZIP code

Marital status	Primary phone no.	Secondary phone no.
☐ Single ☐ Married ☐ Domestic Partner		

Employee email address

Employer name	Group no. (if known)

Employer street address

City	County	State	ZIP code

Employment status:	Income reported by:
☐ Full time ☐ Part time ☐ Disabled ☐ Retired	☐ W-2 ☐ 1099 ☐ Other: _____

Date of hire (MM/DD/YYYY)	Date of full-time employment (MM/DD/YYYY)	Date waiting period begins (MM/DD/YYYY)	No. of hours worked per week

Section B: Application Type

Select one

☐ New enrollment
☐ Open enrollment (not applicable for Life and Disability)
☐ Rehire – Rehire date:

☐ COBRA –
Select qualifying event
☐ Left employment
☐ Loss of dependent child status
☐ Medicare
☐ Reduction in hours
☐ Divorce or legal separation
☐ Covered employee's Medicare entitlement
☐ Death

Qualifying event date

1 A small group must have at least one eligible employee, in addition to the business owner. A spouse cannot be the only eligible employee.
2 Blue Cross and Blue Shield of Georgia (BCBSGA) is required by the Internal Revenue Service to collect this information.

Reset Form Save and Print

Social Security no.

Section C: Type of Coverage

1. Medical Coverage

Enter network selected: _____

Enter product selected: _____

Enter contract code selected: _____

Member medical coverage — select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family

2. Dental Coverage — Please ask your employer which dental options are available before making your selection.

BCBSGA Family Dental and BCBSGA Family Dental Enhanced plans include certified pediatric dental essential health benefits. All other plans including BCBSGA Dental Prime and Complete with product families including Value, Classic, Enhanced, and Voluntary do not include certified pediatric dental essential health benefits. Your employer will advise you of your plan options. Please list below the contract code for the dental plan you select.

Member dental coverage — select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family ☐ No coverage

If waiving coverage for employee and/or any eligible family members, you must complete Section F.

Contract code — Please indicate the contract code for the dental plan chosen. Your employer will advise you of your plan options and contract codes.

Contract code: _____

3. Vision Coverage — Select one plan option.

Member vision coverage — select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family ☐ No coverage

If waiving coverage for employee and/or any eligible family members, you must complete Section F.

Contract code — Please indicate the contract code for the vision plan chosen. Your employer will advise you of your plan options and contract codes.

Contract code: _____

Social Security no.

4. Life and Disability Coverage – A minimum of two employees must enroll.

- ☐ Basic Life and AD&D
- ☐ Basic Dependent Life
- ☐ Optional Supplemental/Voluntary Life and AD&D $ _____ (employee amount)
- ☐ Optional Supplemental/Voluntary Dependent Life Spouse $ _____ (spouse amount)
- ☐ Optional Supplemental/Voluntary Dependent Life Child $ _____ (child amount)
- ☐ Short Term Disability
- ☐ Long Term Disability
- ☐ Voluntary Short Term Disability
- ☐ Voluntary Long Term Disability

Current annual income	Life and Disability class no.

Primary Beneficiary – Attach a separate sheet if necessary.

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
Address					Percentage to be paid to beneficiary

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
Address					Percentage to be paid to beneficiary

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
Address					Percentage to be paid to beneficiary

Contingent Beneficiary

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
Address					Percentage to be paid to beneficiary

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
Address					Percentage to be paid to beneficiary

Total percentages should add up to 100%. If no percentages are indicated, the proceeds will be divided equally. If no Primary beneficiary survives, the proceeds will be paid to the contingent beneficiary(ies) listed above.

NOTICE OF EXCHANGE OF INFORMATION: To proposed Insured and other persons proposed to be Insured, if any – information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report on this information to MIB, Inc., a non-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB may, upon request, supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of this information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734; and telephone number is 1-866-692-6901.

Spousal Consent for Community Property States Only (Note: The insurance company is not responsible for the validity of a spouse's consent for designation.) If you live in a community property state (AZ, CA, ID, LA, NM, NV, TX, WA and WI), your state may require you to obtain the signature of your spouse if your spouse will not be named as a primary beneficiary for 50% or more of your benefit amount. Please have your spouse read and sign the following. I am aware that my spouse, the Employee/Retiree named above, has designated someone other than me to be the beneficiary of group life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.

Spouse signature	Spouse name	Date
X		

Social Security no.

Section D: Coverage Information — All fields required. Attach a separate sheet if necessary.

Dependent information must be completed for all additional dependents (if any) to be covered under this coverage. An eligible dependent may be your spouse or domestic partner, your children, or your spouse or domestic partner's children (to the end of the calendar month in which they turn age 26 unless they qualify as a disabled person). List all dependents beginning with the eldest.

Court ordered health care coverage? ☐ Yes ☐ No If yes, attach legal documentation.

Employee last name	First name	M.I.	
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant Self
Primary Care Physician (PCP) name	PCP ID no.	Existing patient? ☐ Yes ☐ No	

Spouse/Domestic Partner last name	First name	M.I.	Social Security no.[1] (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Spouse ☐ Domestic Partner
PCP name	PCP ID no.	Existing patient? ☐ Yes ☐ No	

Dependent last name	First name	M.I.	Social Security no.[1] (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Child ☐ Other If other, what is relationship? ________
PCP name	PCP ID no.	Existing patient? ☐ Yes ☐ No	
Does this dependent have a different address? ☐ **Yes** ☐ **No** **If yes, please enter:** ________			

Dependent last name	First name	M.I.	Social Security no.[1] (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Child ☐ Other If other, what is relationship? ________
PCP name	PCP ID no.	Existing patient? ☐ Yes ☐ No	
Does this dependent have a different address? ☐ **Yes** ☐ **No** **If yes, please enter:** ________			

Dependent last name	First name	M.I.	Social Security no.[1] (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Child ☐ Other If other, what is relationship? ________
PCP name	PCP ID no.	Existing patient? ☐ Yes ☐ No	
Does this dependent have a different address? ☐ **Yes** ☐ **No** **If yes, please enter:** ________			

1 BCBSGA is required by the Internal Revenue Service to collect this information.

Social Security no.

Section E: Other Group Coverage

Are you or anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No

If yes, give name: _____

Medicare ID no.	Part A effective date	Part B effective date	Medicare eligibility reason (check all that apply) ☐ Age ☐ Disability ☐ ESRD: Onset date:

Medicare Part D ID no.	Medicare Part D Carrier	Part D effective date

On the day your coverage begins, will you or a family member be covered by Medicare? ☐ Yes ☐ No

On the day your coverage begins, will you or a family member be covered by other health coverage? ☐ Yes ☐ No

On the day your coverage begins, will you or a family member be covered by other dental coverage? ☐ Yes ☐ No

If yes to any of these questions, please provide the following:

Name of person covered (Last name, first, M.I.)	Type (check one)	Coverage (check all that apply)	Carrier name	Carrier phone no.	Policy ID no.	Dates (if applicable)
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental				Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental				Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental				Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental				Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental				Start: End:

Social Security no.

Section F: Waiver/Declining Coverage

Medical Coverage

Medical coverage declined for – check all that apply: ☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)

Reason for declining coverage – check all that apply:

☐ Covered by spouse's/domestic partner's group coverage
☐ Enrolled in other Insurance –Please provide company name and plan: _____
☐ Enrolled in Individual coverage
☐ Spouse covered by employer's group medical Coverage
☐ Medicare/Medicaid/VA
☐ Other – please explain: _____
☐ No coverage

Dental Coverage

Dental coverage declined for – check all that apply: ☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)

Reason for declining coverage – check all that apply:

☐ Covered by spouse's/domestic partner's group coverage
☐ Enrolled in other Insurance –Please provide company name and plan: _____
☐ Enrolled in Individual coverage
☐ Spouse covered by employer's group medical Coverage
☐ Medicare/Medicaid/VA
☐ Other – please explain: _____
☐ No coverage

Vision Coverage

Vision coverage declined for – check all that apply: ☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)

Reason for declining coverage – check all that apply:

☐ Covered by spouse's/domestic partner's group coverage
☐ Enrolled in other Insurance –Please provide company name and plan: _____
☐ Enrolled in Individual coverage
☐ Spouse covered by employer's group medical Coverage
☐ Medicare/Medicaid/VA
☐ Other – please explain: _____
☐ No coverage

Life Coverage

***Life/AD&D** coverage declined for: ☐ Myself
Spouse, Domestic Partner and Dependent coverage not available if life coverage is waived/declined.

Dependent Life coverage declined for: ☐ Spouse/Domestic Partner and Dependents

Short Term Disability coverage declined for: ☐ Myself

Long Term Disability coverage declined for: ☐ Myself

Optional Supplemental/Voluntary coverage declined for: ☐ Myself

Optional Supplemental/Voluntary Dependent Life coverage declined for: ☐ Spouse/Domestic Partner and Dependents

Voluntary Short Term Disability coverage declined for: ☐ Myself

Voluntary Long Term Disability coverage declined for: ☐ Myself

Reason for declining coverage – check all that apply:

☐ Covered by spouse's/domestic partner's group coverage
☐ Enrolled in other Insurance –Please provide company name and plan: _____
☐ Enrolled in Individual coverage
☐ Spouse covered by employer's group medical Coverage
☐ Medicare/Medicaid/VA
☐ Other – please explain: _____
☐ No coverage

*I hereby certify that I have been given the opportunity to apply for the available group life benefits offered by my employer, the benefits have been explained to me, and I and/or my dependent(s) decline to participate. Neither I nor my dependent(s) were induced or pressured by my employer, agent, or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for such coverage in the future, I may be required to provide evidence of insurability at my expense.

Sign here only if you are declining coverage.

Signature of applicant	Printed name	Social Security no.	Date (MM/DD/YYYY)
X			

Social Security no.

Section G: Terms, Conditions and Authorizations

Please read this section carefully before signing the application.

Eligible employee:

- An active employee of the Employer who works the number of hours per week to be eligible for benefits as defined by the Employer and approved by Blue Cross and Blue Shield of Georgia (BCBSGA) as of the effective date. Employment must be verifiable from state or federal wage tax reports.
- An employee, as defined above, who enters into employment after the coverage effective date and who completes the group imposed waiting period for eligibility (if any) and applies for coverage within 30 days.
- Any other class of persons identified by the Employer, provided that written approval of their eligibility is obtained from the Company(ies); or
- Employees eligible for continuous coverage under state or federal laws.

Eligible employee does not include independent contractors (whose compensation is reported on IRS Form 1099) and directors and officers of the Group Policyholder if they do not work the required number of hours per week described above.

Eligible dependent:

- Employee's spouse, or children age 26 or younger, which includes a newborn, natural child, or a child placed with the employee for adoption, a stepchild or any other child for whom the employee has legal guardianship or court ordered custody. The age limit for enrolling a child is age 26. Coverage for children will end on the last day of the month in which the children reach age 26.
- The age limit of 26 does not apply for the initial enrollment or maintaining enrollment of an unmarried child who cannot support himself or herself because of mental retardation, mental illness, or physical incapacity that began prior to the child reaching the age limit. Coverage may be obtained for the child who is beyond the age limit at the initial enrollment if the employee provides proof of handicap and dependence at the time of enrollment. (The employee may be asked to provide a physician's certification of the dependent's condition.)
- Dependents eligible for continuous coverage under state or federal laws.

As an eligible employee, I am requesting coverage for myself and all eligible dependents listed and authorize my employer to deduct any required contributions for this insurance from my earnings. All statements and answers I have given are true and complete. I understand it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. I understand all benefits are subject to conditions stated in the Group Contract and coverage document.

In signing this application I represent that: I have read or have had read to me the completed application, and I realize any false statement or misrepresentation in the application may result in loss of coverage.

I certify each Social Security number listed on this application is correct.

I understand that I may not assign any payment under my BCBSGA program. I agree to have money taken from my wages/pension, if necessary, to cover the premium cost for the coverage applied for.

I am asking for the coverage I chose on this form. If I made choices that are not available to me, I agree that my choices may be changed to those on the employer's application.

I understand that, to the extent allowed by law, BCBSGA reserves the right to accept or decline this application for coverage (and that Greater Georgia Life Insurance Company (GGL) may accept only certain people or terms for coverage), and that no right is created by my application for coverage.

I also understand that I may not be covered for pre-existing conditions for Long Term Disability and Short Term Disability, if applicable. (See the policy/certificate for important information).

I agree that I will let my employer know right away of any changes that would make me or any dependent(s) ineligible for this coverage.

By signing this application, I agree to the taping or monitoring of any phone calls between BCBSGA and myself.

By signing below, I (primary applicant) agree to receive my plan-related communications either by email or electronically. This may include my certificate, evidence of coverage, explanation of benefits statements, required notices or helpful information to get the most out of my plan. I agree to provide and update BCBSGA with my current email address. I know that at any time I can change my mind and request a copy of these materials (or any specific materials) by mail, by contacting BCBSGA.

For Health Savings Account enrollees: Except as otherwise provided in any agreement between me and the financial custodian, the custodian of my Health Savings Account (HSA), I understand that my authorization is required before the financial custodian may provide BCBSGA with information regarding my HSA. I hereby authorize the financial custodian to provide BCBSGA with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide BCBSGA with a written request to revoke my authorization at any time.

Coverage Option: If your employer/group offers HMO coverage which does not permit you to receive the full range of covered services from the provider of your choice, you will also have the option at the time of your initial enrollment and at each renewal to choose a health care plan allowing you to access care from the provider of your choice ("point-of-service" plan). This point-of-service plan may be offered by the HMO, BCBSGA or by another carrier.

Abbreviated Notice of Insurance Information Practices Privacy Act. Georgia state law establishes standards for the collection, use and disclosure of information gathered in connection with insurance transactions. The application attached to this notice contains specific personal questions about you and your dependents. We are required to advise you that personal information may be collected from persons other than you or other individuals proposed for coverage. An investigative consumer report may be made to help us obtain additional medical data from physicians or hospitals.

All Data Confidential. O.C.G.A. section 33-39-5, subsection (c) (1 through 4) requires that: 1. Personal information may be collected from persons other than the individual or individuals proposed for coverage; 2. Such information as well as other personal or privileged information subsequently collected by the insurance institution or agent may in certain circumstances be disclosed to third parties without authorization; 3. A right of access and correction exists with respect to all personal information collected; 4. The notice prescribed in subsection (b) of the above referenced Code section will be furnished to the applicant or policyholder upon request.

Access to Your Data. You have the right to see or obtain a photocopy of your personal information which we have. You also have the right to send us a written request if you want any of your personal information to be amended, corrected or deleted. If you wish to have a more detailed explanation of our information practices, please contact Blue Cross and Blue Shield of Georgia, Inc. or Blue Cross Blue Shield Healthcare Plan of Georgia, Inc., Customer Service Department, Post Office Box 7368, Columbus, Georgia 31908-7368.

Sign here	Applicant signature X	Date (MM/DD/YYYY)

Special Enrollment Rights

If you declined enrollment for yourself or your dependent(s) (including a spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependent(s) in this plan if you or your dependent(s) lose eligibility for the other health insurance or group health plan coverage (or if the employer stops contribution towards your coverage or your dependent's other coverage). However, you must request enrollment within 31 days after coverage ends (or after the employer stops contribution toward the other coverage). In addition, if you have a dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependent(s) provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. I also understand that my dependents and I may enroll under two additional circumstances:

- Either your or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- You or your dependent becomes eligible for a subsidy (state premium assistance program).

In these cases, you may be able to enroll yourself and your dependents provided that you request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

Get help in your language

Language Assistance Services

BlueCross BlueShield of Georgia

BlueCross BlueShield Healthcare Plan of Georgia

Greater Georgia Life Insurance Company

Curious to know what all this says? We would be too. Here's the English version:
If you need assistance to understand this document in an alternate language, you may request it at no additional cost by calling the Member Services number (855-738-6652). (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number on the back of your ID card.

Spanish
Si necesita ayuda para entender este documento en otro idioma, puede solicitarla sin costo adicional llamando al número de Servicios para Miembros (855-738-6652). (TTY/TDD: 711)

Amharic
ይህንን ሰነድ ለመረዳት በአማራጭ ቋንቋ እርዳታ ማግኘት ከፈለጉ፣ የአባል አገልግለቶች ቁጥርን (855-738-6652) በመደወል ያለምንም ክፍያ ማግኘት ይችላሉ። (TTY/TDD: 711)

Arabic
إذا احتجت إلى المساعدة لفهم هذا المستند بلغة أخرى، فيمكنك طلب المساعدة دون تكلفة إضافية من خلال الاتصال برقم خدمات الأعضاء (855-738-6652). (TDD/TTY: 711)

Chinese
如果您需要協助以便以另一種語言理解本文件，您可以撥打成員服務號碼(855-738-6652)請求免費協助。(TTY/TDD: 711)

Farsi
در صورتی که برای درک این سند به زبانی دیگر نیازمند کمک هستید، می‌توانید بدون هیچ هزینه اضافی این را درخواست کنید. برای این کار با مرکز خدمات اعضاء به شماره (855-738-6652) تماس بگیرید. (TTY/TDD: 711)

French
Si vous avez besoin d'aide pour comprendre ce document dans une autre langue, vous pouvez en faire la demande gratuitement en appelant les Services destinés aux membres au numéro suivant : 855-738-6652. (TTY/TDD: 711)

German
Falls Sie Hilfe in einer anderen Sprache benötigen, um dieses Dokument zu verstehen, können Sie diese kostenlos anfordern, indem Sie die Servicenummer für Mitglieder anrufen (855-738-6652). (TTY/TDD: 711)

Gujarati
વૈકલ્પિક ભાષામાં આ દસ્તાવેજો સમજવામાં તમને કોઈ મદદની જરૂર હોય તો તમે મેમ્બર સર્વિસ નંબર (855-738-6652). પર કોલ કરીને કોઈપણ વધારાના ખર્ચ વિના વિનંતી કરી શકો છો. (TTY/TDD: 711)

Haitian
Si ou bezwen èd pou konprann dokiman sa a nan yon lòt lang, ou kapab rele nimewo Manm Sèvis la pou mande asistans gratis nan nimewo (855-738-6652). (TTY/TDD: 711)

Hindi
अगर आपको यह दस्तावेज़ वैकल्पिक भाषा में समझने के लिए सहायता की ज़रूरत है, तो आप सदस्य सेवाएँ नंबर (855-738-6652) पर कॉल करके अतिरिक्त लागत के बिना इसके लिए अनुरोध कर सकते हैं। (TTY/TDD: 711)

Japanese
この書面を他の言語で理解するための支援が必要な場合には、メンバーサービス番号（855-738-6652）に電話して支援を求めることができます。追加費用はかかりません。(TTY/TDD: 711)

Korean
다른 언어로 본 문서를 이해하기 위해 도움이 필요하실 경우, 추가 비용 없이 회원 서비스 번호(855-738-6652)로 전화를 걸어 도움을 요청할 수 있습니다. (TTY/TDD: 711)

Portuguese-Europe
Se necessitar de ajuda para compreender este documento noutro idioma, poderá solicitá-la gratuitamente ligando para o número dos Serviços para Membros (855-738-6652). (TTY/TDD: 711)

Russian
Если вам нужна помощь, чтобы понять содержание настоящего документа на другом языке, вы можете бесплатно запросить ее, позвонив в отдел обслуживания участников (855-738-6652). (TTY/TDD: 711)

Vietnamese
Nếu quý vị cần hỗ trợ để hiểu được tài liệu này bằng một ngôn ngữ thay thế, quý vị có thể yêu cầu mà không tốn thêm chi phí bằng cách gọi số của Dịch Vụ Thành Viên (855-738-6652). (TTY/TDD: 711)

It's important we treat you fairly
That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.