Employer Enrollment Application For 1-50 Employee Small Groups[1] Connecticut

Consult the Certificate of Coverage for complete coverage terms and conditions. For more information about Anthem Blue Cross and Blue Shield (Anthem) and Anthem Life Insurance Company (Anthem Life), its products and services, visit anthem.com. Please complete electronically or in black ink only and use extra paper if necessary.

Section A: Application Type

☐ New enrollment ☐ Change(s)	Requested effective date (MM/DD/YYYY): / /

Section B: Company Information

Legal company name				Employer tax ID no. (required) – –
Doing Business As (DBA) (if applicable)				
Street address	City	County	State	ZIP code
Billing address — If different from above	City		State	ZIP code

Organization Company Type (Corporation (C or S), Partnership, Proprietorship, etc.): _____

SIC code — required	Type of business (be specific)	Date business established (MM/DD/YYYY) / /
Company contact name	Email address	Primary phone no.
Additional company contact name	Email address	

Does group have a cafeteria plan under IRS Section 125? ☐ Yes ☐ No

Do you have any affiliates that qualify as a single employer under subsection (b), (c), (m) or (o) of Internal Revenue Code Section 414?
☐ Yes ☐ No If yes, please complete below.

Legal name	Federal tax ID no.	No. of employees employed

Will any insurance carrier(s), in addition to Anthem, provide health coverage as part of the group's employee benefit plan? ☐ Yes ☐ No
If yes, list carrier(s) and product(s) offered: _____

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.

Section C: Type of Coverage

1. Medical Coverage

Choose your medical contribution for each month — The minimum employer contribution is 25% of the lowest eligible employee rate. We will contribute (25% to 100%) _____% per employee _____% per dependent (optional).

Participation Requirements — If Employees contribute to the premium, then at least 75% of net eligible employees must enroll. If Employer pays 100% of premium, then 100% of net eligible employees must enroll. Participation requirements do not apply to Small Group Employer applications from November 15 — December 15.

For employers providing a Health Savings Account (HSA) option (only **one** choice is allowed)
Do you want Anthem to disclose your group's data to its banking services provider to establish Health Savings Accounts?
☐ Yes (Requires completion of the CDHP questionnaire) ☐ No

HSA administrator name	Phone no.	Email address

Medical plans – Indicate the contract codes for the medical plan(s) selected. The codes can be found on the proposal/quote.

	Medical plan name	Medical contract code
Plan option 1		
Plan option 2		
Plan option 3		
Plan option 4		
Plan option 5		

Riders/Optional Benefits — select additional optional benefits

☐ Calendar Year ☐ Plan Year

2. Dental Coverage — Indicate the contract code(s) for the dental plan(s) selected. The codes can be found on the proposal/quote.

Anthem Dental Prime, Anthem Dental Complete, and Anthem Essential Choice with product families including Value, Classic, Enhanced, and Voluntary do not include certified pediatric dental essential health benefits.

Dental contract code 1:_____ Dental contract code 2:_____

Choose your dental contribution for each month (optional)**:** _____% per employee _____% per dependent

Select premium level: (Subject to underwriting approval)
☐ Base premium ☐ Bundled premium

Is this plan intended to replace any existing group dental coverage? ☐ Yes ☐ No

If yes, please complete the information below for each group dental insurance plan you now have.

Insurer	Type of plan (DHMO, EPO, PPO)	Effective date (MM/DD/YYYY)	Proposed termination date (MM/DD/YYYY)
		/ /	/ /
		/ /	/ /

3. Vision Coverage — Indicate the contract code for the vision plan selected. The codes can be found on the proposal/quote.

Vision contract code: _____ ☐ Employer-Sponsored Plans ☐ Voluntary Plans

Choose your vision contribution for each month (optional)**:** _____% per employee _____% per dependent

Select premium level: (Subject to underwriting approval)
☐ Base premium ☐ Bundled premium

4. Life, Accidental Death & Dismemberment (AD&D), and Disability Coverage (Anthem Life) — Select all that apply. A minimum of two employees must enroll.

Life products		Disability products	
Select Life products and group contribution percentage:		**Select products and group contribution percentage:**	
Product choice	**Percentage**	**Product choice**	**Percentage**
☐ None		☐ None	
☐ Basic Life and AD&D	_____%	☐ Short Term Disability	_____%
☐ Basic Dependent Life	_____%	☐ Long Term Disability	_____%
☐ Optional Supplemental/Voluntary Life and AD&D*	_____%	☐ Voluntary Short Term Disability*	_____%
☐ Optional Supplemental/Voluntary Dependent Life*	_____%	☐ Voluntary Long Term Disability*	_____%
*Available for Groups of 10+		*Available for Groups of 10+	

If disability benefits are selected, indicate whether the employee pays disability premiums on a pre or post tax basis. If it varies by class, attach a separate sheet with details by class.

Short Term Disability	**Voluntary Short Term Disability**	**Long Term Disability**	**Voluntary Long Term Disability**
☐ Pre Tax	☐ Pre Tax	☐ Pre Tax	☐ Pre Tax
☐ Post Tax	☐ Post Tax	☐ Post Tax	☐ Post Tax

Short Term Disability

1. Do you have any employees who work in New York? ☐ No ☐ Yes – If yes and you want us to be your state-mandated NY Disability Benefit Leave/Paid Family Leave carrier, an additional application and proposal are required.
2. Do you have any employees who work in New Jersey? ☐ No ☐ Yes – If yes and you want us to be your state-mandated NJ Temporary Disability Benefit carrier, an additional application and proposal are required.

Life/AD&D and/or Disability Eligibility Probationary Period/Waiting Period

Would you like to waive the eligibility probationary period/waiting period for ALL existing employees at initial group enrollment? ☐ Yes ☐ No

Is the eligibility probationary period/waiting period for new eligible employees enrolling in Life/AD&D and/or Disability plans after the group's coverage effective date the same as the Anthem medical policy eligibility period? ☐ Yes ☐ No
If no, enter the Life/AD&D and Disability eligibility probationary period/waiting period below.

Class number	Coverage description (Ex. Life, Short Term Disability, Long Term Disability, etc.)	Description of eligibility probationary period (Ex. Date of hire, First of month following 60 days of continuous employment, etc.)

Will rehired employees be eligible to reinstate their Life/AD&D and/or Disability coverage at the level of coverage they had on their last day worked?
☐ Yes ☐ No
If yes, length of time the group has to rehire an employee under this provision: ☐ 3 months ☐ 6 months ☐ 9 months ☐ 12 months

Prior Coverage

Has this group had life/AD&D, optional life, voluntary life, and/or disability coverage within 12 months of this application's signature date?
☐ Yes ☐ No

Will this plan replace current	Insurance Company Name – Policy/Contract Number	Termination date (MM/DD/YYYY)
Life/AD&D coverage ☐ Yes ☐ No		/ /
Disability coverage ☐ Yes ☐ No		/ /

Participation Requirements — Refer to the Proposal for life and disability participation requirements.

Section D: Eligibility

An employee not actively at work on the life, AD&D, or disability policy effective date or the employee's eligibility date will not be covered until such employee returns to active work.

1. Average number of Full Time Equivalent (FTE) employees during the prior calendar year (including employed owners/officers):_____
2. Number of eligible full-time employees (minimum 30 hours per week):_____
3. Are part time employees to be covered (working 20 or more hours per week)? ☐ Yes ☐ No
4. Number of employees enrolling in:

   Medical:_____ Dental:_____

   Vision:_____ Life/Disability:_____
5. Number of eligible DECLINING employees:_____
6. Number of employees working outside of CT:_____
7. Total number of part-time employees based on the above small employer definition: Total calendar year hours worked by all part-time employees divided by 12 (the months in a calendar year) divided by 120 (the number of full-time hours in a typical month):_____
8. Probationary period/waiting period for **new employees**:
   ☐ None ☐ 1 month ☐ 30 days
   ☐ 2 months ☐ 60 days ☐ 90 days

   New eligible enrollees[1] will become effective on:
   ☐ First of month following completion of waiting period/probationary period (excluding 90 day choice)
   ☐ Day following completion of waiting period/probationary periods (excluding None choice)
9. Probationary period/waiting period for **rehire employees**: Coverage is reinstated back to the date of the loss of coverage if rehired within 31 days of the loss of employment. If re-hire date is within 92 days of lay-off or termination of employment, the probationary period will be waived and the employee's coverage will be effective the date of rehire. If the employee is hired back after 92 days, then the employee must serve the group's probationary period for new employees.
10. Do you wish to offer coverage for Domestic Partners?
    ☐ Yes ☐ No
11. Under the Medicare Secondary Payer rules, which one applies for your group for Medicare due to age?
    ☐ Medicare is primary (less than 20 employees)
    ☐ Anthem is primary (20 or more employees)

    Anthem is primary coverage for groups with 20 or more total employees on each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.
12. Is your company currently subject to COBRA (employed 20 or more total employees on at least 50% of the working days in the previous calendar year)? ☐ Yes ☐ No
13. Do you have a COBRA administrator? ☐ Yes ☐ No
14. Do you want an Anthem affiliate to administer COBRA for your group? ☐ Yes ☐ No
    If yes, please complete and sign the COBRA agreement.

Section E: Ownership

Please account for 100% of the ownership, regardless of eligibility. Insert an additional sheet if necessary.

Last name	First name	M.I.	Percentage of ownership	Eligible
			_____%	☐ Yes ☐ No
			_____%	☐ Yes ☐ No
			_____%	☐ Yes ☐ No
			_____%	☐ Yes ☐ No

1 New eligible employees include new employees and rehired employees. Newly eligible employees have 31 days from time of eligibility to enroll in coverage.

Section F: Electronic Access of Group Information by Agent/Producer/Broker/General Agent

We, the employer, hereby authorize the agent/producer/broker/general agent whose name is attached to this application to use the EmployerAccess system of Anthem or Anthem Life Insurance Company to access the group's information, such as but not limited to enrollees, plan selections, and bills/invoices. Such agent/producer/broker/general agent is also hereby authorized to use the EmployerAccess system of Anthem and/or Anthem Life Insurance Company to make changes to the group's information on behalf of the group, such as but not limited to adding/deleting plans, adding/deleting employees, and/or changing employee demographic information. These authorizations shall terminate if the group's designated agent/producer/broker/general agent changes. The agent/producer/broker/general agent must maintain original employee/member enrollment documentation, and shall make them available upon Anthem's request.

Select this box ☐ ONLY if the employer DOES NOT want to authorize the agent/producer/broker/general agent to access and change the group's information on behalf of the group. **Do not select this box if you consent.**

Section G: General Terms and Agreements — Please read this section carefully before signing the application. In this section, "Anthem" and "Company" refers to Anthem Blue Cross and Blue Shield and Anthem Life Insurance Company.

Standard Open Enrollment for Employees: The standard open enrollment period is at least 31 days before the group's renewal date and 31 days after, no more often than once in any 12 consecutive months. The open enrollment period does not apply to life and disability products.

Please select the box that applies:

☐ We, the employer, as administrator of an Employee Welfare Benefit Plan under ERISA (Employee Retirement Income Security Act of 1974), apply to obtain the coverage indicated on this application. We understand that any dispute involving an adverse benefit decision may be subject to voluntary binding arbitration only after the ERISA appeals procedure has been completed.

☐ We, the employer, as administrator of an Employee Welfare Benefit Plan which is a church plan or governmental plan as defined under ERISA (Employee Retirement Income Security Act of 1974) and therefore not subject to ERISA, apply to obtain the coverage indicated on this application.

We understand that this small group off-exchange product is not eligible for a premium tax credit.

If we decide to cancel our group coverage after coverage has been issued, we understand that the cancellation will become effective on the last day of the month in which Anthem received the written notification of cancellation, and that no premiums will be refunded for any period between Anthem's receipt of the notification and the last day of the month when the cancellation takes effect. If there are any premiums after the cancellation date, we understand that Anthem will refund these premiums after 45 days from the premium deposit date.

For employers offering a Health Savings Account (HSA) compatible EPO plan: We, the employer, understand that the High Deductible EPO plan is designed for Exclusive Provider Organization (EPO) usage, and that using non-participating providers could result in significantly higher out-of-pocket costs. We understand that having this coverage does not establish an HSA.

The HSA, which must be established for tax-advantaged treatment, is a separate arrangement between the individual and a bank or other qualified institution. Applicant must be an "eligible individual" under IRS regulations to receive the HSA tax benefits. The IRS has not yet issued HSA or high deductible health plan regulations or determined that Anthem high deductible plans are qualifying high deductible health plans. Consultation with a tax advisor is recommended.

By signing below, I, the employer, agree that Anthem can deliver plan materials and related items, including but not limited to benefit booklets, summaries, billing statements, notices of non-payment and cancellation and other notices, via email or other electronic means. I agree that I will provide and update Anthem with a current email address. I understand that at any time I can request a free copy of these materials by mail, by contacting Anthem at 1-800-922-4770. I also agree that by providing Anthem with an employee or participant's e-mail address, the employer thereby represents that: (1) the employer has the employee's consent to receive plan documents (including explanation of benefits, claim denials and life and disability Evidence of Insurance underwriting documents) electronically; (2) the employee has reasonable access to the electronic communication at work; and (3) the employer obtained the employee consent using Anthem's application form or in a manner that clearly and conspicuously described the types of communications which can be made electronically, any hardware or software required to access those communications, the ability and process to change email addresses or withdraw consent and request a paper copy or otherwise in a manner that complies with applicable state and federal law regarding electronic delivery of plan materials and adverse benefit determinations.

To the best of our knowledge and belief, all information on this application is true and complete, and Anthem may rely on this application in deciding whether to provide coverage. If the application is not complete, Anthem reserve(s) the right to reject it and notify us in writing. We understand and agree that no coverage will be effective before the date determined by Anthem, and that such coverage will be effective only if we have paid our first month's premium and this application is accepted. We understand that the premium rates calculated for the employer are contingent on the accuracy of eligibility data submitted on employees and covered dependents to Anthem. Any misstatements on the employees' applications may result in a material change to the group's coverage or premium rates as of the effective date of the group coverage. We further understand and agree that we should keep prior coverage in force until notified of acceptance in writing by Anthem and that no agent has the right to accept this application or bind coverage. If this application is accepted, it becomes a part of our contract with Anthem. We shall comply with all provisions of the contract(s) issued.

The undersigned employer and/or authorized representative(s) agree:

1. To comply with all terms and provisions of the Group Contract(s) issued, and trust agreements, if applicable, and also accepts enrollment under the (Anthem Life) trust policy(ies), if applicable;
2. To make the insurance coverage available to all eligible employees and their eligible dependents and to distribute information and documents to enrolled employees as needed;

3. To maintain records and furnish to the insurer or their designated agent(s), any information required in connection with administration of the insurance coverage;
4. To provide notice of applicable conversion and/or portability rights to eligible employees and eligible dependents;
5. That statements of medical history will be required of employees and dependents when applying for coverage within or outside the time frames or amount of coverage limits established by the insurer;
6. That approval for this insurance may cancel any prior contracts and/or coverage with the insurer effective immediately preceding the effective date of the employer's coverage;
7. To pay the insurer by the premium due date, the premiums on behalf of each member covered under the contract, unless otherwise stated in any financial agreement between the parties, to submit applications of employees prior to their date of eligibility, to keep all necessary records regarding membership;
8. That claims filed by or on behalf of members may, at Anthem Life option, be suspended if premiums are not received timely;
9. Employer will receive, on behalf of members, all notices delivered by Company, and immediately forward such notices to persons involved, at their last known address;
10. The advance premium check does not create temporary or interim insurance coverage and that receipt and deposit of that payment does not guarantee issuance of insurance coverage. Rather, issuance of insurance coverage is expressly conditioned on Company's determination that the group is an acceptable risk based on their current underwriting practices and procedures. Unless these Conditions are met, there shall be no liability on the part of Company except to refund the payment. The employer will be responsible for returning to individual employees any part of the payment contributed by those employees;
11. That in order for Company to accept or decline this application, all the information requested on this application must be completed. In the event the application is not complete, Company, or its designated agent(s), is authorized to obtain the necessary information and to complete that information on this application. The employer understands that the coverage issued by Company may be different than the coverage applied for herein. In that event, Company shall notify the employer of such differences, and by payment of the appropriate premiums, the employer will accept the coverage as issued;
12. The premium rates calculated for the employer are contingent, based upon the accuracy of the eligibility data submitted on employees and covered dependents to Company by the employer. Company reserves the right to review such rates upon receipt of all individual applications and modify the rates, if the enrollment information so warrants. Any misstatements on employees' applications or failure to report new medical information prior to the employees' effective dates may result in a material change to the group's coverage or premium rate as of the effective date of coverage;
13. All employees applying for coverage are employees of the employer, receive salary or wages documented on state and/or federal payroll reports, work full-time (unless otherwise approved by Company in writing) and meet any other eligibility requirements for coverage;
14. The requested coverage is not in effect unless and until this application is approved by Company, that approval of coverage shall be evidenced by issuing insurance contracts and/or policies to the employer, and an employee's coverage is not in effect unless and until the employee applies and is approved for coverage by Company.
15. I understand that 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.

Sign here	Company officer signature **X**	Title	
	Printed name		Today's date (MM/DD/YYYY) / /
Accepted by Anthem authorized representative		Printed name	Today's date (MM/DD/YYYY) / /

Section H: Agent Certification — In this section, "Anthem" refers to Anthem Blue Cross and Blue Shield and Anthem Life.

1. I am not aware of any information not disclosed by the employer in this application that may have bearing on this risk.
2. I have not completed any of the information contained in the application except with the permission of the applicant and as noted by my initials and date on the application.
3. I have not signed any of the applications for an employer representative or individual applicant. If after submission of this application, I request any additions or changes to any of the above information, I will do so only with the written consent of the applicant, and I authorize Anthem to attribute such additions or changes to me.
4. I have advised the employer that a failure to provide complete and accurate information may result in a loss of coverage retroactive to the effective date of coverage or re-rating of the employer's premium retroactive to the coverage effective date and that coverage shall not be effective until Anthem reviews and approves the application and the employer receives a written notice from Anthem.
5. I have fully explained to the employer that an employee not actively at work on the policy effective date or their eligibility date will not be covered for life, AD&D or disability insurance until such employee returns to active work full-time.
6. I am the appointed agent/broker and am receiving commissions for the submission of this employer. No portion of my commission payments from Anthem shall be paid to an agent/broker/producer who is not appointed/approved by Anthem. I am licensed in the state of Connecticut for the types of insurance solicited.
7. I have advised the employer not to terminate any existing coverage until receiving written notification from Anthem that the coverage being applied for by this application is accepted.

Writing payable/sub-agent/producer/broker			%	**Second writing payable/sub-agent/producer/broker**			%
Agency name	Agency ID or TIN			Agency name	Agency ID or TIN		
Agent/producer/broker name				Agent/producer/broker name			
Agent/producer/broker Tax ID/SSN				Agent/producer/broker Tax ID/SSN			
Payable/sub-agent/producer/broker Tax ID/SSN if different				Payable/sub-agent/producer/broker Tax ID/SSN if different			
Street address				Street address			
City	State	ZIP code		City	State	ZIP code	
Phone no.	Fax no.			Phone no.	Fax no.		
Email address				Email address			
Signature	Today's date (MM/DD/YYYY) / /			Signature	Today's date (MM/DD/YYYY) / /		
For General Agent/Producer/Broker use only							
General agent/producer/broker name				Agent/producer/broker Tax ID/SSN			
Street address				City	State	ZIP code	
Sales Representative and Account Manager							
Sales representative name				Sales representative ID no.			
Street address				City	State	ZIP code	
Account manager name				Account manager ID no.			

ANTHEM USE ONLY	Group no.	Tracking no.	Effective date (MM/DD/YYYY) / /

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

Spanish
Usted tiene derecho a recibir ayuda en su idioma en forma gratuita. Simplemente llame al número de Servicios para Miembros que figura en su tarjeta de identificación.

Chinese
您有權免費獲得透過您使用的語言提供的幫助。請撥打您的 ID 卡片上的會員服務電話號碼。若您是視障人士，還可索取本文件的其他格式版本。

Vietnamese
Quý vị có quyền nhận miễn phí trợ giúp bằng ngôn ngữ của mình. Chỉ cần gọi số Dịch vụ dành cho thành viên trên thẻ ID của quý vị. Bị khiếm thị? Quý vị cũng có thể hỏi xin định dạng khác của tài liệu này."

Korean
귀하는 자국어로 무료지원을 받을 권리가 있습니다. ID 카드에 있는 멤버 서비스번호로 연락하십시오.

Tagalog
May karapatan ka na makakuha ng tulong sa iyong wika nang libre. Tawagan lamang ang numero ng Member Services sa iyong ID card. May kapansanan ka ba sa paningin? Maaari ka ring humiling ng iba pang format ng dokumentong ito.

Russian
Вы имеете право на получение бесплатной помощи на вашем языке. Просто позвоните по номеру обслуживания клиентов, указанному на вашей идентификационной карте. Пациенты с нарушением зрения могут заказать документ в другом формате.

Armenian
Դուք իրավունք ունեք ստանալ անվճար օգնություն ձեր լեզվով: Պարզապես զանգահարեք Անդամների սպասարկման կենտրոն, որի հեռախոսահամարը նշված է ձեր ID քարտի վրա:

Farsi
"شما این حق را دارید تا به صورت رایگان به زبان مادری تان کمک دریافت کنید. کافی است با شماره خدمات اعضا (Member Services) درج شده روی کارت شناسایی خود تماس بگیرید." دچار اختلال بینایی هستید؟ می توانید این سند را به فرمت های دیگری نیز درخواست دهید.

French
Vous pouvez obtenir gratuitement de l'aide dans votre langue. Il vous suffit d'appeler le numéro réservé aux membres qui figure sur votre carte d'identification. Si vous êtes malvoyant, vous pouvez également demander à obtenir ce document sous d'autres formats.

Arabic
لك الحق في الحصول على مساعدة بلغتك مجانًا. ما عليك سوى الاتصال برقم خدمة الأعضاء الموجود على بطاقة الهوية. هل أنت ضعيف البصر؟ يمكنك طلب أشكال أخرى من هذا المستند.

Japanese
お客様の言語で無償サポートを受けることができます。IDカードに記載されているメンバーサービス番号までご連絡ください。

Haitian
Se dwa ou pou w jwenn èd nan lang ou gratis. Annik rele nimewo Sèvis Manm ki sou kat ID ou a. Èske ou gen pwoblèm pou wè? Ou ka mande dokiman sa a nan lòt fòma tou.

Italian
Ricevere assistenza nella tua lingua è un tuo diritto. Chiama il numero dei Servizi per i membri riportato sul tuo tesserino. Sei ipovedente? È possibile richiedere questo documento anche in formati diversi

Polish
Masz prawo do uzyskania darmowej pomocy udzielonej w Twoim języku. Wystarczy zadzwonić na numer działu pomocy znajdujący się na Twojej karcie identyfikacyjnej.

Punjabi
ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮੁਫ਼ਤ ਵਿੱਚ ਮਦਦ ਹਾਸਲ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਬਸ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਸਿਰਵਸ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। ਨਜ਼ਰ ਕਮਜ਼ੋਰ ਹੈ? ਤੁਸ ਇਸ ਦਸਤਾਵੇਜ਼ ਦੇ ਹੋਰ ਰੂਪਾਂਤਰ ਮੰਗ ਸਕਦੇ ਹੋ।

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. By calling Member Services, our members can get free in-language support, and free aids and services if you have a disability. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. 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 in any of these areas, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279, or directly to 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. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf