Employee Enrollment Application/ Change Form

For 51+ employee groups
Connecticut

Anthem

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 electronically or in blue or black ink only.

Employer name		
Group no.	Suffix	Requested effective date (MMDDYYYY)

Section 1: Employee information

Last name	First name	M.I.	Social Security no.* (required)
Birthdate (MMDDYYYY)	Home address		
City	County	State	ZIP code
Sex ☐ Male ☐ Female	Marital status ☐ Single ☐ Married ☐ Domestic Partner	Primary phone no.	
Employee email address			
Employment status ☐ Full time ☐ Part time ☐ Disabled ☐ Retired	Hire date (MMDDYYYY)	No. of hours worked per week	
Primary Care Physician (PCP) name	PCP ID no.	Existing patient? ☐ Yes ☐ No	

Section 2: Reason for application — Select one

☐ New enrollment ☐ New group (initial enrollment) ☐ Annual open enrollment
☐ New hire ☐ Rehire — Rehire date: _____ (MMDDYYYY)
☐ Add dependent (Fill in section 4)
☐ Marriage — Date of marriage: _____ (MMDDYYYY)
☐ Birth of child ☐ Adoption ☐ Domestic partner
☐ Court order
☐ Entrance to the military ☐ Discharge from the military
☐ Covered by Medicaid
☐ Voluntary cancellation
☐ Loss of eligibility for other coverage — Date previous coverage ended: _____ (MMDDYYYY)
☐ Death
☐ COBRA — Select qualifying event
☐ Left employment ☐ Reduction in hours ☐ Death ☐ Medicare
☐ Loss of dependent child status ☐ Divorce or legal separation ☐ Covered employee's Medicare entitlement
Qualifying event date: _____ (MMDDYYYY)
☐ Other: _____
☐ Waiver (To decline ALL coverage skip to section 8.)
Qualifying event date: _____ (MMDDYYYY)

*Anthem Blue Cross and Blue Shield (Anthem) is required by the Internal Revenue Service to collect this information.

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans, Inc. Independent licensees of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Social Security no.* (required)

Section 3: Type of coverage

Medical coverage

Large Group 51–100 options

- ☐ BlueCare HMO Choice Basic
- ☐ BlueCare Prime HMO HSA (Renewal Only)
- ☐ Century Preferred PPO
- ☐ Century Preferred PPO Basic
- ☐ Century Preferred PPO HRA
- ☐ Century Preferred PPO HRA Deductible First
- ☐ Century Preferred PPO HSA
- ☐ Century Preferred PPO Value
- ☐ Clear Choice Century Preferred EPO
- ☐ Clear Choice Century Preferred PPO
- ☐ Guided Advantage Century Preferred EPO
- ☐ Guided Advantage Century Preferred PPO

Large Group 101+ options

- ☐ BlueCare HMO
- ☐ BlueCare HMO Basic
- ☐ BlueCare HMO Choice
- ☐ BlueCare HMO Choice Basic
- ☐ BlueCare HMO HSA
- ☐ BlueCare Deductible HMO (Renewal Only)
- ☐ BlueCare Prime HMO (Renewal Only)
- ☐ BlueCare POS
- ☐ BlueCare POS Basic
- ☐ Add HRA Wrap (Administered by Anthem)
- ☐ Century Preferred PPO
- ☐ Century Preferred PPO Basic
- ☐ Century Preferred PPO Choice
- ☐ Century Preferred PPO Choice Basic
- ☐ Century Preferred PPO HRA
- ☐ Century Preferred PPO HRA Deductible First
- ☐ Century Preferred PPO HSA
- ☐ Century Preferred PPO Choice HSA
- ☐ Century Preferred EPO
- ☐ Century Preferred EPO HRA
- ☐ Century Preferred EPO HSA
- ☐ Century Preferred PPO Value
- ☐ Clear Choice Century Preferred EPO
- ☐ Clear Choice Century Preferred PPO
- ☐ Guided Advantage Century Preferred EPO
- ☐ Guided Advantage Century Preferred PPO
- ☐ Other: _____

Member medical coverage — select one:

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

Flexible Spending Account (FSA) coverage — More than one plan may be selected, depending on employer offerings.

- ☐ Healthcare FSA (excluded if you have an HSA plan)
- ☐ Limited-Purpose FSA (for dental and vision services)
- ☐ Dependent Care FSA
- ☐ Commuter Parking
- ☐ Commuter Transit
- ☐ No FSA coverage at this time

Dental coverage

☐ Prime Essential Choice ☐ Prime Consumer Choice ☐ Complete Essential Choice ☐ Complete Consumer Choice

☐ Other: _____

Member dental coverage — select one:

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

Vision coverage

☐ Vision

Member vision coverage — select one:

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

Group Accident, Critical Illness, and Hospital Indemnity Insurance

☐ **Group Accident Insurance** — Coverage option: ☐ Employee only ☐ Employee + Spouse ☐ Employee + Children ☐ Family
If more than one Accident plan offered please select: ☐ Low Plan ☐ High Plan

☐ **Group Critical Illness Insurance** — Coverage option: ☐ Employee only ☐ Employee + Spouse ☐ Employee + Children ☐ Family
If more than one Critical Illness plan offered please select: ☐ Low Plan ☐ High Plan
Have you smoked or used tobacco products in the last 12 months? ☐ No ☐ Yes, explain product used: _____

☐ **Group Hospital Indemnity Insurance** — Coverage option: ☐ Employee only ☐ Employee + Spouse ☐ Employee + Children ☐ Family
If more than one Hospital Indemnity plan offered please select: ☐ Low Plan ☐ High Plan

If any person to be covered by a Critical Illness or Hospital Indemnity plan is a resident of CA, GA, NY, or CO, please answer the following question:

Will all applicants who reside in CA, GA, NY, or CO, when such coverage is to become effective, be enrolled in comprehensive health benefits from an individual or group health insurance policy, an employer sponsored health plan, or an HMO that provides essential health benefits? ☐ Yes ☐ No (Please note that if the response is No, such applicants are not eligible for coverage)

*Anthem is required by the Internal Revenue Service to collect this information.

Social Security no.* (required)

Group Accident, Critical Illness, and Hospital Indemnity Insurance beneficiary designation

Beneficiary type ☐ Primary ☐ Contingent	Name of beneficiary	Percentage %	Social Security no.*	Relationship to applicant		Date of birth
	Street address	City		State	ZIP code	Phone no.
Beneficiary type ☐ Primary ☐ Contingent	Name of beneficiary	Percentage %	Social Security no.*	Relationship to applicant		Date of birth
	Street address	City		State	ZIP code	Phone no.
Beneficiary type ☐ Primary ☐ Contingent	Name of beneficiary	Percentage %	Social Security no.*	Relationship to applicant		Date of birth
	Street address	City		State	ZIP code	Phone no.
Beneficiary type ☐ Primary ☐ Contingent	Name of beneficiary	Percentage %	Social Security no.*	Relationship to applicant		Date of birth
	Street address	City		State	ZIP code	Phone no.

Total percentages must add up to 100%. If the total percentages add up to less than 100%, the remaining percentage will be paid in equal shares to all named beneficiaries to total 100%. If the total percentages add up to more than 100%, each named beneficiary's share will be reduced equally to total 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. Beneficiaries may be changed by the insured's written notice to his or her employer.

Section 4: 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 renewal date of the group in which they turn age 26 unless they qualify as a disabled person). List all dependents beginning with the eldest.
Please read the Genetic Information Non-discrimination Act (GINA) information on page 6 of the application, under Section 6, Terms, Conditions, and Authorizations, prior to answering the questions in Section 4.

Spouse/Domestic Partner last name	First name	M.I.	Social Security no.* (required)

Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MMDDYYYY)	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.* (required)

Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MMDDYYYY)	Relationship to applicant ☐ Biological child of applicant/spouse/domestic partner ☐ 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.* (required)

Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MMDDYYYY)	Relationship to applicant ☐ Biological child of applicant/spouse/domestic partner ☐ 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: _____

*Anthem is required by the Internal Revenue Service to collect this information.

Social Security no.* (required)

Section 4: Coverage information — Continued.

Dependent last name	First name	M.I.	Social Security no.* (required)

Sex	Disabled	Birthdate (MMDDYYYY)	Relationship to applicant
☐ Male ☐ Female	☐ Yes ☐ No		☐ Biological child of applicant/spouse/domestic partner ☐ 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: _____

Section 5: Prior and 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 (MMDDYYYY)	Part B effective date (MMDDYYYY)	Medicare eligibility reason (check all that apply)
			☐ Age ☐ Disability ☐ ESRD: Onset date: _____ (MMDDYY)

Medicare Part D ID no.	Medicare Part D carrier	Part D effective date (MMDDYYYY)

Are you or a family member previously or currently covered by a Medicare, medical and/or dental plan? ☐ Yes ☐ No

If yes, 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.	Policyholder name	Dates (if applicable) (MMDDYY)
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:

*Anthem is required by the Internal Revenue Service to collect this information.

Social Security no.* (required)

Section 6: Terms, Conditions, and Authorizations (TERMS)

Please read this section carefully before signing the application.

Genetic Information Non-discrimination Act (GINA): When answering questions about a person on this form, only give answers about that person, and do not include any genetic information. Genetic information includes family health history, genetic testing, genetic services, genetic counseling, or genetic diseases for which the person may be at risk. All responses about a person will only be considered and used for that person.

Medical Loss Ratio (MLR): For insurance entities, the "medical loss ratio" (MLR) is defined as the ratio of incurred claims to earned premium for the prior calendar year. The MLR is calculated once in accordance with state and again in accordance with federal laws for managed care HMO plans and PPO/Indemnity plans issued in Connecticut. For [**2022**], Anthem's Medical Loss Ratio for state law purposes was [**84.44%**] for HMO plans and [**86.70%**] for Non HMO plans. For [**2022**], Anthem's MLR for federal law purposes was [**93.2%**] for large group plans. Please refer to anthem.com for the most current MLR information.

Health Savings Account Notice: I authorize the financial custodian of my Health Savings Account (HSA) to give Anthem Blue Cross and Blue Shield (Anthem) facts about my HSA, including account number, account balance and account activity. I understand that I may take back my authorization by written request to Anthem at any time.

1. **Except as specifically required or permitted by applicable law, I understand that I may not assign any payment under my Anthem program.**
2. I agree to have money taken from my wages/pension, if necessary, to cover the premium cost for the coverage applied for.
3. 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.
4. 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.
5. By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself.

I have read and accept the Terms, Conditions and Authorizations as a condition of coverage. My answers to all questions are true to the best of my knowledge, and I understand that Anthem relies on these answers in accepting this application. I understand that any untrue answers or failure to report new medical information before my effective date may cause a material change in coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits, rescission or cancellation of coverage. I agree to these terms for myself and on behalf of any dependents covered by the Plan. I am acting as their agent and representative.

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

FRAUD NOTICE: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I am signing here because I, and my enrolled dependents, want to receive information about our benefits electronically. These communications may include Identification (ID) Cards, Certificates of Coverage or Evidence of Coverage, grievance, appeals, and medical necessity determination notifications, Explanation of Benefits, other required notices, and personalized information to help get the most out of the benefits. I understand I need to register on [**anthem.com**] or the Sydney Health mobile app to get the most out of my plan's digital tools, and I will make sure [Anthem] has my most up-to-date email address. I, and my enrolled dependents, understand that we can update our email addresses, change our communication preferences, and request free copies of any materials at any time by going to [**anthem.com**] or calling the Member Services number on my ID Card.

Thank you for choosing Anthem Blue Cross and Blue Shield.

Section 7: Signature — Required if you are applying for coverage. Please review your application for errors or omissions.

Read section 6 carefully before signing. By signing, I understand that any person, including myself, that is already covered by Medicaid is not eligible for Critical Illness coverage and cannot be included in the group.

I have read and understand the language in the TERMS section of this application and agree to all of its terms.

Employee signature	Date (MMDDYYYY)
X	

*Anthem is required by the Internal Revenue Service to collect this information.

Social Security no.* (required)

Important Accident Insurance eligibility information:

The following notice applies to all Accident and Voluntary Accident coverage presented on this form:

ACCIDENT INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT A QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Important Critical Illness Insurance eligibility information:

The following notice(s) apply to all Critical Illness and Voluntary Critical Illness coverage presented on this form:

CRITICAL ILLNESS INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Important Hospital Indemnity Insurance eligibility information:

The following notice applies to all Hospital Indemnity and Voluntary Hospital Indemnity coverage presented on this form:

HOSPITAL INDEMNITY INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT A QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Section 8: Waiver/Declining coverage

Medical coverage

Medical coverage declined for — check all that apply:
Reason for declining coverage — check all that apply:

- ☐ Myself ☐ Spouse/domestic partner ☐ Dependent(s)
- ☐ 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:
Reason for declining coverage — check all that apply:

- ☐ Myself ☐ Spouse/domestic partner ☐ Dependent(s)
- ☐ 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:
Reason for declining coverage — check all that apply:

- ☐ Myself ☐ Spouse/domestic partner ☐ Dependent(s)
- ☐ 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

Sign here only if you are declining coverage.

Signature of applicant	Printed name	Social Security no.	Date (MMDDYYYY)
X			

*Anthem is required by the Internal Revenue Service to collect this information.

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 obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

Chinese
您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID 卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

Vietnamese
Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của tài liệu này.

Korean
귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인이신가요? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

Tagalog
May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

Russian
У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

French Creole
Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòma nan dokiman sa a.

Arabic
لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجانًا. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضًا طلب تنسيقات أخرى لهذه الوثيقة.

French
Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

Persian
شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

Armenian
Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Պարզապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցո՞ղ եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

Japanese
あなたにはあなたの言語で無料で支援を受ける権利があります。ID カードに記載されている会員サービス番号にお電話ください」視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

Italian
Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

German
Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen Formaten anfordern.

Polish
Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

Pennsylvania Dutch
Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kannscht des do Schreiwes in en differnter Weg griege so as du's besser sehne kannscht.

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, 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