Employee Enrollment Application
For Small Groups
Nevada

Consult the Evidence 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. The employee who completes this application is solely responsible for its accuracy and completeness. Be sure to answer all questions and to sign and date your application.

Section A: Application Type — Select one

☐ New enrollment ☐ Open enrollment (not applicable for Life and Disability) ☐ COBRA ☐ Rehire date: (MM/DD/YYYY) ____/____ /_____

Select qualifying event

☐ Birth, adoption or placement for adoption (for dependent life, only birth, legal adoption)
☐ Covered employee's Medicare entitlement*
☐ Death*
☐ Left employment*
☐ Loss of CHIP
☐ Loss of coverage*
☐ Loss of dependent child status*
☐ Marriage/Domestic Partnership
☐ Medical subsidy*
☐ Medicare*
☐ Reduction in hours*
☐ Other* _____
*Not applicable for Life or Disability

Qualifying event date: (MM/DD/YYYY) ____/____ /_____

Section B: Employee Information

Last name	First name	M.I.	Social Security no.[1] (required) / /
Home address - street and PO Box if applicable	City	State	ZIP code
County	Primary phone no.	Marital status ☐ Single ☐ Married ☐ Domestic Partner	
Employer name		Group no. (if known)	
Employer street address	City	State	ZIP code
Employment status: ☐ Full-time ☐ Disabled	Occupation		

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

Employee email address: _____

For myself and any dependents, I'm providing my email address because I agree to get information about my benefits by email or electronically. This may include my certificate or Evidence of Coverage, explanation of benefits, Evidence of Insurability underwriting documents, required notices, and helpful or personalized information to get the most out of my benefits. I will make sure Anthem and/or Anthem Life has my most up to date email. These electronic communications may include specific details about me and my plan. I also understand that by providing my email address, information about my dependents may also be sent by email or electronically. I know I can change my mind at any time and request a free copy of specific materials by mail. To do either, I (or my enrolled dependents) will update our communication preferences by going to anthem.com or calling Member Services.

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

Section C: Type of Coverage

1. Medical Coverage — Indicate the product and contract code for the plan selected. Your employer will advise you of your plan options and contract codes.

Medical product plan name:	Contract code, if known:

Member medical coverage — select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Family

2. Dental Coverage — Indicate the contract code for the dental plan selected. Your employer will advise you of your plan options and contract codes.

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.

Member dental coverage — select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Family

Dental product plan name:	Contract code, if known:

3. Vision Coverage — Indicate the contract code for the vision plan selected. Your employer will advise you of your plan options and contract codes.

Member vision coverage — select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Family

Vision product plan name:	Contract code, if known:

4. Life, Accidental Death & Dismemberment (AD&D), and Disability Coverage

☐ 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.:

If selecting Short Term Disability coverage: Do you work in New York? ☐ Yes ☐ No Do you work in New Jersey? ☐ Yes ☐ No

Primary Beneficiary — Attach a separate sheet if necessary.

Last name	First name	M.I.	Relationship	Social Security no. / /	Percentage
Last name	First name	M.I.	Relationship	Social Security no. / /	Percentage
Last name	First name	M.I.	Relationship	Social Security no. / /	Percentage

Contingent Beneficiary — Attach a separate sheet if necessary.

Last name	First name	M.I.	Relationship	Social Security no. / /	Percentage
Last name	First name	M.I.	Relationship	Social Security no. / /	Percentage
Last name	First name	M.I.	Relationship	Social Security no. / /	Percentage

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.

If an applicant's age at the time of application is 15, the applicant must submit a written statement, signed by the parent, consenting to the minor's application for coverage.

Spousal or Domestic Partner Consent for Community Property States Only (Note: The insurance company is not responsible for the validity of a Spouse's/Domestic Partner'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/Domestic Partner if your Spouse/Domestic Partner will not be named as a primary beneficiary for 50% or more of your benefit amount. Please have your Spouse/ Domestic Partner read and sign the following. I am aware that my Spouse/Domestic Partner, 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/Domestic Partner signature	Spouse/Domestic Partner name	Date (MM/DD/YYYY)
X		/ /

Section D: Coverage Information — All fields required. Attach a separate sheet if necessary. Complete this section for yourself and all dependents.

Dependent information must be completed for all additional dependents (if any) to be covered under this coverage. An eligible dependent may be your Spouse/Domestic Partner, or your children, or your Spouse's/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.

Employee Last name	First name	M.I.

Sex	Disabled	Birthdate(MM/DD/YYYY)
☐ Male ☐ Female	☐ Yes ☐ No	/ /

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	Disabled	Birthdate(MM/DD/YYYY)	Relationship to applicant
☐ Male ☐ Female	☐ Yes ☐ No	/ /	☐ 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	Disabled	Birthdate(MM/DD/YYYY)	Relationship to applicant
☐ Male ☐ Female	☐ Yes ☐ No	/ /	☐ Child ☐ Other[2] 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	Disabled	Birthdate(MM/DD/YYYY)	Relationship to applicant
☐ Male ☐ Female	☐ Yes ☐ No	/ /	☐ Child ☐ Other[2] 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 Anthem is required by the Internal Revenue Service to collect this information.

2 Eligibility subject to Evidence of Coverage.

Employee name: ________________________ Social Security no.: ______/_____/________

Section E: Prior and Other Group Coverage

Is anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No If yes, give name:____________________________________

Medicare ID no.	Part A effective date (MM/DD/YYYY) / /	Part B effective date (MM/DD/YYYY) / /	Medicare eligibility reason(select all that apply) ☐ Age ☐ Disability ☐ ESRD: Onset date (MM/DD/YYYY) ___/___/_____

Medicare Part D ID no.	Medicare Part D Carrier	Part D effective date (MM/DD/YYYY) / /

Is anyone applying for coverage covered by other health coverage? ☐ Yes ☐ No If yes, please provide the following:

Name of person covered (Last, First, M.I.)	Type (select one)	Coverage (select all that apply)	Insurer name	Insurer phone no.	Policy ID no.	Dates (if applicable) (MM/DD/YYYY)
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				Start: ____/_____/______ End: ____/_____/______
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				Start: ____/_____/______ End: ____/_____/______
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				Start: ____/_____/______ End: ____/_____/______
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				Start: ____/_____/______ End: ____/_____/______
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				Start: ____/_____/______ End: ____/_____/______

Section F: Waiver/Declining Coverage

Type of coverage/Declined for – Select all that apply.		**Reason for declining/refusing coverage** – Select all that apply.
☐ Employee	☐ Medical ☐ Dental ☐ Vision ☐ *Life/AD&D (Spouse/Domestic Partner and Dependent coverage not available if life coverage is waived/declined) ☐ Short Term Disability ☐ Long Term Disability ☐ Optional Supplemental/Voluntary Life ☐ Voluntary Short Term Disability ☐ Voluntary Long Term Disability	☐ No coverage ☐ Covered by Spouse's/Domestic Partner's group coverage ☐ Spouse/Domestic Partner covered by employer's group medical coverage ☐ Enrolled in individual coverage
☐ Spouse/ Domestic Partner	☐ Medical ☐ Dental ☐ Vision ☐ Dependent Life ☐ Optional Supplemental/Voluntary Dependent Life	☐ Medicare/Medicaid/VA ☐ Enrolled in other Insurance — Please provide company name and plan:
☐ Dependent(s)	☐ Medical ☐ Dental ☐ Vision ☐ Dependent Life ☐ Optional Supplemental/Voluntary Dependent Life List name of dependents to be waived: ______________________________________	______________________________________ ☐ Other — please explain: ______________________________________

*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, to decline this coverage. I elect of my (our) own accord to decline coverage. I understand that if I wish to apply for such coverage in the future, where permitted by law I may be required to provide Evidence of Insurability at my expense.

Sign here only if you are declining coverage.

Signature of applicant X	Printed name	Today's date (MM/DD/YYYY) / /

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 Anthem and/or Anthem Life 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 (see Evidence of Coverage for complete dependent eligibility terms)**:**

- Employee's Spouse/Domestic Partner, 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 a child will end on the last day of the month in which the child reaches age 26. For life coverage, only employee's Spouse, or children age 26 or younger, legally adopted children, and stepchildren are eligible.
- 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 intellectual disability, 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.

Special Enrollment Rights for Medical Coverage Only (see Evidence of Coverage for complete enrollment rights)**:**
If you are declining enrollment for yourself or your dependent(s) (including a Spouse/Domestic Partner) 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 30 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 or foster care, you may be able to enroll yourself and your dependent(s) provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption or foster care.

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 subsidy eligibility determination.

In signing this application I represent that:

- I have read, or have had read to me, the completed application, I represent that the information and statements about me and my dependents is complete and accurate, 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 Anthem and/or Anthem Life 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, Anthem and/or Anthem Life reserves the right to accept or decline this application for coverage (and that Anthem Life Insurance Company 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, Short Term Disability, Voluntary Long Term Disability, and Voluntary 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 Anthem and/or Anthem Life and myself.

Employee name: _____ Social Security no.: _____/_____/_____

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 Anthem with information regarding my HSA. I hereby authorize the financial custodian to provide Anthem with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide Anthem with a written request to revoke my authorization at any time.

Sign here	Applicant signature X	Today's date (MM/DD/YYYY) / /

Life and/or Disability Authorization Section — Read carefully before signing.

1. I authorize any licensed physician, any other medical practitioner or provider, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, including any health or other insurance company affiliated with Anthem Life Insurance Company, consumer reporting agency or employer having information available as to claims, diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me, to give any and all such information to authorized representatives of Anthem Life Insurance Company (Anthem Life), its affiliates, and any administrators, reinsurers, agents, or other entity providing services on behalf of Anthem Life, and including, but not limited to any other mental or psychiatric records, medical, dental and hospital records (including psychiatric, alcohol, and drug abuse, and HIV/AIDS information) which may have been acquired in the course of examination or treatment. I understand that the information obtained by use of this authorization will be used by Anthem representatives to evaluate and adjudicate my current application for life or disability coverage or any claims under such coverage, and may be re-disclosed to (a) any medical, investigative, financial or vocational specialist or entity, or (b) any other organization or person, employed by or representing Anthem solely to assist with the evaluation and adjudication of my current life or disability application or claim. Each such person or entity to whom this re-disclosure is made shall comply with the HIPAA Privacy Rule as regards any re-disclosed protected health information as applicable. I understand that Anthem may collect personal information about me from outside sources, and that both personal and privileged information may be collected and disclosed to third parties without my further authorization, and may no longer be protected by Federal privacy laws. I also understand that I have a right to see and correct personal information that Anthem collects about me, and that I may receive a more detailed description of my rights under this law by writing to Anthem.
2. Payment of proceeds shall be made in accordance with the terms of the group contract. Unless otherwise provided herein, if one or more life insurance beneficiaries are named, the proceeds due shall be paid in equal shares to the named beneficiaries surviving the insured. Beneficiaries may be changed by the insured employee's written notice to his or her employer.
3. These coverages will become effective on the date established by the provisions of the group contract and certificates issued thereunder.
4. 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 denial of insurance benefits.

This authorization, for purposes of processing this application form, is valid from the date signed for a period of 30 months unless revoked by me in writing, which I may do at any time by contacting Anthem Life. For the purpose of collecting information in connection with a claim for benefits under an insurance policy, this authorization shall remain valid for the term of coverage of the policy for an accident and sickness insurance benefit and for the duration of the claim if the claim is not for an accident and sickness insurance benefit. A photocopy and/or electronic copy is as valid as the original. The Applicant or the Applicant's authorized representative is entitled to receive a copy of this Authorization.

I give this authorization for myself and on behalf of my eligible dependents if covered by the Plan, including my Spouse/Domestic Partner unless he/she signs below. I am acting as their agent and representative.

Employee signature X	Today's date (MM/DD/YYYY) / /
Spouse/Domestic Partner signature X	Today's date (MM/DD/YYYY) / /

Get help in your language

Language Assistance Services

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 (855-711-8949). (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 (855-711-8949). (TTY/TDD: 711)

Amharic
ይህንን ሰነድ ለመረዳት በአማራጭ ቋንቋ እርዳታ ማግኘት ከፈለጉ፣ የአባል አገልግለቶች ቁጥርን (855-711-8949) 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 (855-711-8949). (TTY/TDD: 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(855-711-8949)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 (855-711-8949) 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 : 855-711-8949. (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 (855-711-8949). (TTY/TDD: 711)

Ilokano
Nu kasapulam ti tulong tapno maawatan daytoy a dokumento iti alternatibo a lengguahe, mabalinmo a kiddawen daytoy nga awanan ti kanayunan a gastos babaen ti panagawag ti numero ti Serbisyo para ti Kameng (855-711-8949). (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（855-711-8949）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(855-711-8949)로 전화를 걸어 도움을 요청할 수 있습니다. (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 (855-711-8949). (TTY/TDD: 711)

Samoan
Afai e te manaomia se feesoasoani e malamalama lenei tusi i seisi gagana, e mafai ona e talosagaina e aunoa ma se totogi e ala i le vili le numera mo Sauniuniga mo lou Vaega (855-711-8949). (TTY/TDD: 711)

Tagalog
Kung kailangan ninyo ng tulong upang maunawaan ang dokumentong ito sa ibang wika, maaari ninyo itong hilingin nang walang karagdagang bayad sa pamamagitan ng pagtawag sa Member Services sa numerong (855-711-8949). (TTY/TDD: 711)

Thai
หากท่านต้องการความช่วยเหลือเพื่อทำความเข้าใจเกี่ยวกับเอกสารนี้ในภาษาอื่น ท่านอาจขอรับบริการได้โดยไม่เสียค่าใช้จ่ายเพิ่มเติมใดๆ โดยโทรไปที่หมายเลขฝ่ายบริการสมาชิก (855-711-8949) (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 (855-711-8949). (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.