Wellmark

Group Employee Application for ACA Small Business Plans (1-50) Health, Dental & Vision Insurance

A. Employer Information

Employer: _____ Phone: (_____) _____

Group Number: _____

Address Line 1 (Street address or Apt/Suite#): _____

Address Line 2 (PO Box, Street address): _____

City: _____ State: IA ZIP: _____

Employee Classification (if applicable): _____

B. Employee Information

First Name: _____ MI: _____ Last Name: _____

Address Line 1 (Street address or Apt/Suite#): _____

Address Line 2 (PO Box, Street address): _____

City: _____ State: _____ ZIP: _____

County: _____

Home Phone Number: (_____) _____ Work Phone Number: (_____) _____ Ext.: _____

Email Address (optional): _____

Date of Birth: _____/_____/_____ (mm/dd/yyyy)

Social Security Number/Tax Identification Number[1]

a. ☐ SSN/TIN: _____
b. ☐ I do not have a SSN/TIN
c. ☐ I refuse to provide the SSN/TIN

[1]The IRS requires Wellmark to collect SSNs/TINs for federal reporting purposes. Wellmark will follow up with you to collect this information if you do not check/complete a, b, or c. Failure to provide the SSN/TIN information may result in a $50 penalty, per violation, assessed to you by the IRS.

Gender: ☐ Male ☐ Female

Status: ☐ Married ☐ Single ☐ Divorced ☐ Legally separated ☐ Common law
☐ Domestic partner (Domestic Partnership Certification form required. NOTE: Some plan options may not provide coverage for domestic partners. For more information, contact your Wellmark representative.)

Date of hire: _____/_____/_____ (mm/dd/yyyy) Requested effective date: _____/_____/_____ (mm/dd/yyyy)

Employment Status: ☐ Active ☐ COBRA ☐ Retired ☐ Seasonal

Job Title (optional): _____ Hours Worked/Week: _____

C. Waiver of Coverage - Complete only if you do not want coverage.

I decline coverage for:
☐ Medical ☐ Dental ☐ Vision
(Note: If you decline medical coverage, you must also decline vision coverage.)

I am declining medical coverage due to existence of another coverage:
☐ Spouse's or domestic partner's employer's plan ☐ Medicare ☐ COBRA from prior employer ☐ VA eligibility
☐ Individual plan ☐ TRICARE ☐ Medicaid ☐ I (we) do not have other coverage at this time.

☐ Other _____

I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a special enrollment event or at the next open enrollment period. I have read Section I within this application.

Employee First Name:_____ Employee Last Name:_____

Social Security Number:_____ Employee Signature:_____

D. Enrollment Reason or Event

Enrollment Reason: ☐ Open Enrollment ☐ Newly Eligible ☐ Special Enrollment (If you check this option, complete the following)

Special Enrollment Event Reason:

☐ Birth/adoption or placement for adoption
☐ Marriage
☐ Divorce
☐ Foster child placement
☐ Other: ______________________________
☐ Involuntary loss of creditable coverage
☐ Court-ordered coverage
☐ Legal guardianship
☐ Returning from military service

List date of special enrollment event ____/____/____ (mm/dd/yyyy)

E. Dependent Information

If you need to list more than four dependents, please write all necessary information on a separate sheet of paper and attach to this application. Your employer determines eligibility for coverage. Please confirm with your employer that the dependent types listed below are eligible.

Name (First, MI, Last)		Date of Birth (mm/dd/yyyy)	Social Security Number/Tax Identification Number[2] REQUIRED	Gender	FT Student?[3]	Disabled?[3]
☐ Spouse ☐ Domestic partner		____/____/____	☐ a. SSN/TIN: ________ ☐ b. I do not have a SSN/TIN ☐ c. I refuse to provide the SSN/TIN	☐ Male ☐ Female	N/A	N/A
☐ Child		____/____/____	☐ a. SSN/TIN: ________ ☐ b. I do not have a SSN/TIN ☐ c. I refuse to provide the SSN/TIN	☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No
☐ Child		____/____/____	☐ a. SSN/TIN: ________ ☐ b. I do not have a SSN/TIN ☐ c. I refuse to provide the SSN/TIN	☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No
☐ Child		____/____/____	☐ a. SSN/TIN: ________ ☐ b. I do not have a SSN/TIN ☐ c. I refuse to provide the SSN/TIN	☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No
☐ Child		____/____/____	☐ a. SSN/TIN: ________ ☐ b. I do not have a SSN/TIN ☐ c. I refuse to provide the SSN/TIN	☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No

[2]The IRS requires Wellmark to collect SSNs/TINs for federal reporting purposes. Wellmark will follow up with you to collect this information if you do not check/complete a, b, or c for each person listed. Failure to provide the SSN/TIN information may result in a $50 penalty, per violation, assessed to you by the IRS.

[3]Some plans do not provide coverage for disabled dependents age 26 or older. For more information, contact your Wellmark representative.

1. If you listed a dependent above who is an unmarried student age 26 or older, please provide name of school that this student is attending: ______________________________
2. Are you a court appointed legal guardian and/or have power of attorney for anyone listed above? ☐ Yes ☐ No

   If yes, list first and last name of that person: ______________________________

   What is your relationship to that person?: ______________________________

   If your address is different than the name of that person, please provide that person's address:

   Address Line 1 (Street Address or Apt/Suite#): ______________________________

   Address Line 2 (PO Box, Street Address): ______________________________

   City: ____________________ State: ________ ZIP: __________

   Note: If applicable, please provide the legal documentation for the dependent child(ren) to meet the eligibility requirements for enrollment.
3. Does your spouse or domestic partner or any of the dependent(s) listed above have an address different than the address listed in Section B? ☐ Yes ☐ No If yes and not already provided above, please complete following:

   Spouse/Domestic Partner/Dependent Name: ______________________________

   Address Line 1 (Street Address or Apt/Suite#): ______________________________

   Address Line 2 (PO Box, Street Address): ______________________________

   City: ____________________ State: ________ ZIP: __________

F. Coverage Selected

Mark each box for products you are selecting and indicate the plan name.

1. Health ☐ List health plan name: _____
   - ☐ Employee
   - ☐ Employee + spouse/domestic partner[6]
   - ☐ Employee + child(ren)
   - ☐ Employee + spouse/domestic partner + child(ren)

2. Vision may only be selected if you have selected a health plan:
   Vision[4] ☐
   - ☐ Employee
   - ☐ Employee + spouse/domestic partner[6]
   - ☐ Employee + child(ren)
   - ☐ Employee + spouse/domestic partner + child(ren)

   Pediatric vision coverage for children age 18 and under is included in your Wellmark health plan. Pediatric vision coverage will discontinue at the end of the month the child turns age 19.

3. Blue Dental[5] ☐ List dental plan name: _____
   - ☐ Employee
   - ☐ Employee + spouse/domestic partner[6]
   - ☐ Employee + child(ren)
   - ☐ Employee + spouse/domestic partner + child(ren)

[4]The vision plan is provided by Avesis Vision, an independent company that does not provide Wellmark Blue Cross and Blue Shield of Iowa products or services. Avesis Vision is underwritten by Fidelity Security Life Insurance Company, Kansas City, Missouri. Vision coverage includes a Hearing Discount Savings Plan provided by Amplifon. Amplifon is an independent company that does not provide Wellmark Blue Cross and Blue Shield of Iowa products or services.

[5]This policy does not include pediatric dental coverage. Pediatric dental coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your agent or visit Iowa's Marketplace if you wish to purchase stand-alone pediatric dental coverage or a stand-alone dental product.

[6]Some plans do not provide coverage for domestic partners. For more information, contact your Wellmark representative.

The Summary of Benefits and Coverage you have received or will be receiving includes important information about the Wellmark coverage available to you. In addition, there is important information available to you at Wellmark.com/Inform that addresses a number of topics such as a Wellmark's guidelines on investigational and experimental procedures, the methodologies Wellmark uses to compensate providers and information on how to access Wellmark's internal claims appeal and external review process. You can also obtain this information by calling Wellmark Customer Service at 1-800-990-1106.

G. Other Coverage

Medicare Coverage (answer both questions.)

1. (Required) Are you and/or anyone listed in the Dependent Information section enrolled in Medicare? ☐ Yes ☐ No
2. (Required) Are you and/or anyone listed in the Dependent Information section Social Security disabled? ☐ Yes ☐ No

If yes, list names: _____

If yes to either question 1 or 2, complete the following as appropriate:

Employee Name (as it appears on Medicare card): Medicare ID (HIC) No.:

_____ _____

Effective Date (Part A): _____/_____/_____ Effective Date (Part B): _____/_____/_____ Effective Date (Part C): _____/_____/_____

Spouse or Domestic Partner Name (as it appears on Medicare card): Medicare ID (HIC) No.:

_____ _____

Effective Date (Part A): _____/_____/_____ Effective Date (Part B): _____/_____/_____ Effective Date (Part C): _____/_____/_____

Dependent Name (as it appears on Medicare card): Medicare ID (HIC) No.:

_____ _____

Effective Date (Part A): _____/_____/_____ Effective Date (Part B): _____/_____/_____ Effective Date (Part C): _____/_____/_____

Other Coverage:

Will you, your spouse or domestic partner, or your dependent(s) keep other coverage in addition to this coverage? ☐ Yes ☐ No

If yes, list name(s) of applicants keeping other coverage: _____

Provide complete information below:

Other Insurance Carrier Name: _____

Address Line 1 (Street Address or Apt/Suite#): _____

Address Line 2 (PO Box, Street Address): _____

City: _____ State: _____ ZIP: _____

Other Coverage Effective Date: _____/_____/_____ Other Coverage End Date: _____/_____/_____

G. Other Coverage, cont'd

If the other coverage is another BCBS carrier in another state, indicate carrier name and state: _____

Policyholder Name: _____ Policyholder Date of Birth: _____/_____/_____

List dependent(s) covered under policy: _____

List name of person that has primary responsibility for the dependent(s): _____

Is there a court-ordered document? ☐ Yes ☐ No

H. Personal Doctor: Please choose a personal doctor for each member of your family. This information is required for applicants choosing Wellmark Synergy Health, Inc. or Wellmark Value Health Plan, Inc., including family members who live outside the network area (for example, those who are under age 26 and remain on a parent's plan). The personal doctor designation is not for applicants who permanently live outside of Iowa. You can choose from among five different provider types: General/Family Practice Physicians, Internists, Nurse Practitioners, Physician Assistants, or Pediatricians. The personal doctor you choose must participate in the network associated with your plan. In addition, female members may choose an OB/GYN. You can access the Wellmark provider directory at wellmark.com/HealthAndWellness/FindaDoctor/FindaDoctor.aspx or by calling 1-800-524-9242. You may also see a personal doctor referred to as a Primary Care Provider (PCP) in other Wellmark documentation.

For each person named in Sections B and E, complete the following information.

Employee

Doctor Name: _____

Doctor Address Line 1 (Street Address or Apt/Suite#): _____

Doctor Address Line 2 (PO Box, Street Address): _____

City: _____ State: _____ ZIP: _____

Are you an established patient? ☐ Yes ☐ No

OB/GYN Name (optional): _____

OB/GYN Address Line 1 (Street Address or Apt/Suite#): _____

OB/GYN Address Line 2 (PO Box, Street Address): _____

City: _____ State: _____ ZIP: _____

Are you an established patient? ☐ Yes ☐ No

Spouse or Domestic Partner

Doctor Name: _____

Doctor Address Line 1 (Street Address or Apt/Suite#): _____

Doctor Address Line 2 (PO Box, Street Address): _____

City: _____ State: _____ ZIP: _____

Are you an established patient? ☐ Yes ☐ No

OB/GYN Name (optional): _____

OB/GYN Address Line 1 (Street Address or Apt/Suite#): _____

OB/GYN Address Line 2 (PO Box, Street Address): _____

City: _____ State: _____ ZIP: _____

Are you an established patient? ☐ Yes ☐ No

Dependent 1

Doctor Name: _____

Doctor Address Line 1 (Street Address or Apt/Suite#): _____

Doctor Address Line 2 (PO Box, Street Address): _____

City: _____ State: _____ ZIP: _____

Are you an established patient? ☐ Yes ☐ No

OB/GYN Name (optional): _____

OB/GYN Address Line 1 (Street Address or Apt/Suite#): _____

OB/GYN Address Line 2 (PO Box, Street Address): _____

City: _____ State: _____ ZIP: _____

Are you an established patient? ☐ Yes ☐ No

H. Personal Doctor, cont'd: Please choose a personal doctor for each member of your family. This information is required for applicants choosing Wellmark Synergy Health, Inc. or Wellmark Value Health Plan, Inc., including family members who live outside the network area (for example, those who are under age 26 and remain on a parent's plan). The personal doctor designation is not for applicants who permanently live outside of Iowa. You can choose from among five different provider types: General/Family Practice Physicians, Internists, Nurse Practitioners, Physician Assistants, or Pediatricians. The personal doctor you choose must participate in the network associated with your plan. In addition, female members may choose an OB/GYN. You can access the Wellmark provider directory at wellmark.com/HealthAndWellness/FindaDoctor/FindaDoctor.aspx or by calling 1-800-524-9242. You may also see a personal doctor referred to as a Primary Care Provider (PCP) in other Wellmark documentation.

Dependent 2

Doctor Name: _____

Doctor Address Line 1 (Street Address or Apt/Suite#): _____

Doctor Address Line 2 (PO Box, Street Address): _____

City: _____ State: _____ ZIP: _____

Are you an established patient? ☐ Yes ☐ No

OB/GYN Name (optional): _____

OB/GYN Address Line 1 (Street Address or Apt/Suite#): _____

OB/GYN Address Line 2 (PO Box, Street Address): _____

City: _____ State: _____ ZIP: _____

Are you an established patient? ☐ Yes ☐ No

Dependent 3

Doctor Name: _____

Doctor Address Line 1 (Street Address or Apt/Suite#): _____

Doctor Address Line 2 (PO Box, Street Address): _____

City: _____ State: _____ ZIP: _____

Are you an established patient? ☐ Yes ☐ No

OB/GYN Name (optional): _____

OB/GYN Address Line 1 (Street Address or Apt/Suite#): _____

OB/GYN Address Line 2 (PO Box, Street Address): _____

City: _____ State: _____ ZIP: _____

Are you an established patient? ☐ Yes ☐ No

Dependent 4

Doctor Name: _____

Doctor Address Line 1 (Street Address or Apt/Suite#): _____

Doctor Address Line 2 (PO Box, Street Address): _____

City: _____ State: ZIP: _____

Are you an established patient? ☐ Yes ☐ No

OB/GYN Name (optional): _____

OB/GYN Address Line 1 (Street Address or Apt/Suite#): _____

OB/GYN Address Line 2 (PO Box, Street Address): _____

City: _____ State: _____ ZIP: _____

Are you an established patient? ☐ Yes ☐ No

I. Important Information Regarding Waiver of Enrollment

If you are declining enrollment for yourself or your dependent(s) (including your spouse or domestic partner), you may be able to enroll yourself or your dependent(s) in this plan if you notify us within 60 days of one of the following events:

- Birth, adoption, placement for adoption or foster child placement
- Court-ordered coverage
- Involuntary loss of creditable coverage
- Legal guardianship

Additionally, you may be able to enroll yourself or one of your dependent(s) following return from military service if you notify us within 120 days. To request special enrollment or obtain more information, contact Customer Service, Wellmark, Inc., PO Box 9232, Mail Station 3E499, Des Moines, IA 50306-9232, or call 1-800-524-9242.

J. Authorization and Certification

I certify that I am legally authorized to apply for coverage for myself and all other persons named in this application. I understand that I am making application for the coverage sponsored by my employer or group sponsor offered by Wellmark, Inc., doing business as Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Health Plan of Iowa, Inc., Wellmark Synergy Health, Inc., Wellmark Value Health Plan, Inc. (each referenced herein as "Wellmark") and, when applicable, vision insurance provided by the vision insurance carrier (collectively the "Insurers"). I authorize my employer, as my agent, to deduct from my pay or collect from me in advance the monthly rates therefore and remit such sums to the Insurers on my behalf. This authorization is to remain in effect until the Insurers are notified by me or my employer to the contrary. I understand that written notice of rate changes will be furnished to my employer as my agent. I further understand that the coverage applied for will not start until after this application and the appropriate coverage rates are received and accepted by each Insurer and an effective date of coverage is established by the Insurers.

I certify that, after this application was completed, I carefully and fully read it, that the statements and answers set forth are full, true, and correct to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that the Insurers will rely on the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentations, or have failed to disclose or concealed any material fact, the Insurers will be entitled to declare the contracts applied for void and to refuse allowance on benefits to any person thereunder.

I acknowledge I have received or have been advised and understand I will receive from my employer the Summary of Benefits and Coverage (SBC).

The coverage effective date will be assigned according to my employer's eligibility rules and Wellmark guidelines. For special enrollment events, Wellmark must be notified within 60 days of event (or 120 days of returning from military service). The coverage effective dates for special enrollment events will be the 1st of the month following the event. Exceptions are birth, adoption, placement for adoption, legal guardianship, court ordered coverage and foster child placement or otherwise required or permitted under federal or state law. For these events, coverage effective date is the date of the event.

My employer is responsible for compliance with all applicable laws related to employee eligibility waiting periods.

Health Savings Account (HSA)
In the event I have selected a High Deductible Health Plan, I understand that enrolling in such coverage does not guarantee that I am or will be eligible to make contributions to an HSA or that contributions can be made to an HSA on my behalf.

Providing Social Security Numbers or Tax Identification Numbers
In order for Wellmark to report my coverage status to the federal government, I must provide to Wellmark my Social Security number or tax identification number and the Social Security numbers or tax identification numbers of all members covered under my coverage. The IRS requires that Wellmark report this information using the Social Security number or tax identification number of the plan member and each dependent. If Wellmark does not have Social Security or tax identification numbers, I understand Wellmark will be unable to report and send the information needed to complete federal tax returns. If I have not previously provided Social Security numbers or tax identification numbers to Wellmark for all members covered under my coverage, I will contact Wellmark by calling the Customer Service number on my ID card. If I do not provide the Social Security numbers or tax identification numbers to Wellmark for this purpose, I may be subject to a $50 penalty per violation imposed by the Internal Revenue Service.

Release of Medical Information
I authorize any health care provider, including but not limited to: surgeon, physician, psychologist, nurse, social worker, or health care facility to release to the Insurers all health and mental health records, including those records protected by Federal or State law relating to AIDS or AIDS related complex, mental health and substance abuse, the past, present, or future treatments or conditions for myself or for my dependent(s) eligible for health care coverage. I understand that I have the right to revoke this authorization in writing at any time by delivering such written notification to the requestor. I understand that a revocation is not effective until received by the requestor. I further understand that any revocation is not effective to the extent that the Insurers or provider have relied on it in the use or disclosure of protected health information.

This form does not authorize the redisclosure of medical information. Federal and State regulations do not allow further disclosure of mental health, substance abuse and AIDS/HIV related information. Wellmark maintains the confidentiality of **all** information received and it will not be released to any person or facility.

J. Authorization and Certification, cont'd.

The protected health information described above may be disclosed to and/or received by persons or organizations that are not health plans, covered health care providers or healthcare clearinghouses subject to federal health information privacy laws. They may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

I understand that I have the right to refuse to sign this authorization, but that the Insurers then have the right to condition eligibility determination and enrollment on the receipt of this signed authorization.

I have read and understand the Authorization and Certification language on this application and acknowledge receipt of a fully completed copy of this application.

The information in this application is correct to the best of my knowledge. I understand that if I intentionally provide false information in this application, I will be disenrolled from the plan. My signature is considered valid whether I supplied it online, electronically, by telephone or on paper and has the same full force and effect as my handwritten signature.

☐ I authorize the Wellmark Agent or Agency who is identified with this application or my employer's group application to enter my application information through Wellmark's electronic enrollment process. In the event of any discrepancy between this paper application form and the information entered electronically, the information entered electronically may be considered the source of record, and I may contact Wellmark to make any changes to my enrollment information. Wellmark authorized agents are required to retain this original paper application for 10 + 1 years.

Print Name: _____

Your Signature X: _____ **Date Signed:** _____/_____/_____

If applicant is a minor, please sign below. (If legal guardian, please provide proof of guardianship)

Power of Attorney or Legal Guardian Printed Name: _____

Power of Attorney or Legal Guardian Signature X: _____ **Date Signed:** _____/_____/_____

Required Federal Accessibility and Nondiscrimination Notice

Discrimination is against the law

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

Wellmark provides:

- Free aids and services to people with disabilities so they may communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call 800-524-9242.

If you believe that Wellmark has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Wellmark Civil Rights Coordinator, 1331 Grand Avenue, Station 5W189, Des Moines, IA 50309-2901, 515-376-4500, TTY 888-781-4262, Fax 515-376-9073, Email CRC@Wellmark.com. You can file a grievance in person, by mail, fax or email. If you need help filing a grievance, the Wellmark Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail, phone or fax at: U.S. Department of Health and Human Services, 200 Independence Avenue S.W., Room 509F, HHH Building, Washington DC 20201, 800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意：如果您说普通话，我们可免费为您提供语言协助服务。请拨打 800-524-9242 或（听障专线：888-781-4262）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobe oštećena sluha: 888-781-4262).

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 800-524-9242 أو (خدمة الهاتف النصي: 888-781-4262).

ສ່ຽງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາ ໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ຫາ. (TTY: 888-781-4262.)

주의: 한국어 를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

ध्यान रखें : अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, नि:शुल्क उपलब्ध हैं। 800-524-9242 पर संपर्क करें या (TTY: 888-781-4262)।

ATTENTION : si vous parlez français, des services d'assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

Geb Acht: Wann du Deitsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิดค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

တၢ်နုးသ့ဉ်ညါ–နမ့ၢ်ကတိၤကညီကျိာ်.ကျိာ်တၢ်မၤစၢၤတၢ်ဖံးတၢ်မၤတဖဉ်.လၢတဘဉ်လာ်ဘူးလဲ.ဆိဉ်လၢနဂီၢ်လီၤ.ဆဲးကျိုးဆူ ၈၀၀–၅၂၄–၉၂၄၂မ့တမ့ၢ်(TTY:၈၈၈–၇၈၁–၄၂၆၂)တက့ၢ်.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

सावधान: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंका लागि नि:शुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ। 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस्।

ማሳሰቢያ: አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ እገዛ አገልግሎቶች፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም (በTTY: 888-781-4262) ይሙሉ ያነጋግሩን።

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maaɗa. Heɓir 800-524-9242 malla (TTY: 888-781-4262).

FUULEFFANNAA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajiloonni gargaarsa afaanii, kaffaltii malee, isiniif ni jiru. 800-524-9242 yookin (TTY: 888-781-4262) quunnamaa.

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Ge': Diné k'ehjí yáníłti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóló. Kojį' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)

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