UTAH INDIVIDUAL HEALTH INSURANCE APPLICATION

Only for use outside the Federally Facilitated Marketplace

A. APPLICANT INFORMATION

Please check one of the following boxes: ☐ New Application ☐ Dependent Addition

Name (Last) _____ (First) _____ (MI) _____

Marital Status ☐ Legally Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partner*

Mailing Address _____ Apt. _____ City _____ State State Zip xxxxx-xxxx

Street Address _____ Apt. _____ City _____ State State Zip xxxxx-xxxx

Applicant's county of residence: _____

Home/Cell Phone (xxx) xxx-xxxx _____ Business Phone (xxx) xxx-xxxx _____

Driver's License Number: _____ Email Address: Email address

Are all persons applying for coverage a U.S. citizen or U.S. national? ☐ Yes ☐ No If no, provide name(s):_____

If a person applying for coverage is not a U.S. citizen or U.S. national, do they have eligible immigration status? ☐ Yes ☐ No

If yes, provide your document type and ID number below.

Immigration document type: _____ Document ID number: _____

Lived in the U.S. since 1996? ☐ Yes ☐ No Veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

Is any person applying for coverage incarcerated or jailed? ☐ Yes ☐ No If yes, provide name(s):_____

B. APPLICANT AND DEPENDENT INFORMATION

In the section below, list yourself and all eligible family members to be included under the policy. Eligible family members include spouse, natural child, stepchild, adopted child, child placed for adoption, and child for whom you are appointed as legal guardian by the court. To be eligible for coverage, children must be under the age of 26 unless the child meets the requirements of children with a disability. Any dependent not listed will not be considered for coverage. Attach a separate sheet if necessary.

	Name(Last, First, MI)	Social Security # (for insurer use only)	Date of Birth MM/DD/YYYY	Gender	Tobacco Use
Self			(mm/dd/yyyy)	☐ Male ☐ Female	☐ Yes ☐ No
Spouse/ Domestic Partner*			(mm/dd/yyyy)	☐ Male ☐ Female	☐ Yes ☐ No
Dependent			(mm/dd/yyyy)	☐ Male ☐ Female	☐ Yes ☐ No
Dependent			(mm/dd/yyyy)	☐ Male ☐ Female	☐ Yes ☐ No
Dependent			(mm/dd/yyyy)	☐ Male ☐ Female	☐ Yes ☐ No

*Check with your employer to determine if domestic partner coverage is available.

Does any listed proposed insured live, reside, work or attend school outside the state of Utah at any time during the year? ☐ Yes ☐ No

If yes, name of proposed insured and % of time outside the state: _____

C. CURRENT COVERAGE INFORMATION

Please indicate for EACH person listed on this application any health care coverage, including Medicare or Medicaid, currently in effect. This information will be used to determine if benefits will be coordinated. If no health care coverage was in effect, please indicate NONE. If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation that shows who is responsible for the dependents' health care coverage so that the insurer can determine whose coverage is primary. Attach a separate sheet if necessary.

Name of Individual	Insurer (List policyholder name, insurer name and phone number)	Date of Coverage MM/YY Start Date	End Date	Will coverage continue?	Type of Coverage (Check all that apply)
Applicant:		(mm/dd/yyyy)	(mm/dd/yyyy)	☐ Yes ☐ No	☐ Employer group ☐ Individual ☐ Medicare ☐ Governmental ☐ Other_____
Spouse/ Domestic Partner:		(mm/dd/yyyy)	(mm/dd/yyyy)	☐ Yes ☐ No	☐ Employer group ☐ Individual ☐ Medicare ☐ Governmental ☐ Other_____
Dependent:		(mm/dd/yyyy)	(mm/dd/yyyy)	☐ Yes ☐ No	☐ Employer group ☐ Individual ☐ Medicare ☐ Governmental ☐ Other_____
Dependent:		(mm/dd/yyyy)	(mm/dd/yyyy)	☐ Yes ☐ No	☐ Employer group ☐ Individual ☐ Medicare ☐ Governmental ☐ Other_____
Dependent:		(mm/dd/yyyy)	(mm/dd/yyyy)	☐ Yes ☐ No	☐ Employer group ☐ Individual ☐ Medicare ☐ Governmental ☐ Other_____

D. EMPLOYMENT INFORMATION

Employer _____ Group Insurer _____ Job Title _____ Hrs/Week _____
Spouse's Employer _____ Spouse's Group Insurer _____ Spouse's Job Title _____ Hrs/Week _____

1. Is any employer reimbursing or paying for any portion of this policy? ☐ Yes ☐ No
2. Does your employer offer health insurance? ☐ Yes ☐ No
3. Are you self-employed? ☐ Yes ☐ No If self-employed, do you have any full or part-time employees? ☐ Yes ☐ No

E. ACKNOWLEDGMENT & SIGNATURE

I hereby apply to be enrolled with my listed dependents, if applicable, for coverage. When incorporated with the policy, this application will become part of the policy. Once fully signed and executed, insurer and I agree to terms set forth in the policy. In connection with both this application and any coverage that may be obtained, I am acting as agent and/or as natural guardian for my spouse and other dependents. I agree to act on behalf of myself and my dependents. I understand that coverage is dependent upon my satisfaction of applicable eligibility criteria. I also understand that no benefits will be provided for any services which begin before the policy is effective; and that except as expressly provided in the policy, benefits will not extend beyond the termination of either my coverage or the policy.

CONSENT AT ENROLLMENT.
I understand that it is my continuing responsibility to report to the insurer changes in the eligibility of any applicants who become enrolled.

I understand that the data obtained by the use of this authorization will only be used to determine eligibility for coverage and for future benefit administration.

I understand that my choice of health care providers whose services will be covered may be restricted by the policy.

I understand there may not be participating providers in all specialty fields.

I agree that coverage for any services that are obtained without or contrary to required preauthorization/precertification requirements in the policy may be denied

NOTICE TO APPLICANT REGARDING REPLACEMENT OF HEALTH BENEFIT PLAN.
According to information furnished, you may intend to lapse or otherwise terminate an existing health benefit plan and replace it with a new policy. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

You may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

I hereby declare that to the best of my knowledge and belief, the information given on this application is correctly recorded, true, and complete. I understand that material omissions or intentional misrepresentations regarding information provided on this application could cause an otherwise covered service to be denied and/or could void any coverage issued. **If I subsequently become aware of information different from that provided in this application, I agree to provide that additional information promptly to the insurer. A change of information prior to the effective date of the policy may void an offer to provide coverage.** If any information provided is false or incomplete, the insurer may without advance notice pursue any remedies available under state or federal law, including but not limited to: declaring the policy null and void and canceling the policy retroactive to its original effective date.

If the policy contains a voluntary arbitration provision: ANY MATTER IN DISPUTE BETWEEN YOU AND THE INSURER MAY BE SUBJECT TO ARBITRATION AS AN ALTERNATIVE TO COURT ACTION PURSUANT TO THE RULES OF THE AMERICAN ARBITRATION ASSOCIATION OR OTHER RECOGNIZED ARBITRATOR, A COPY OF WHICH IS AVAILABLE ON REQUEST FROM THE INSURER. THE INSURER SHALL BEAR THE COSTS OF ARBITRATION, FILING FEES, ADMINISTRATIVE FEES AND ARBITRATOR FEES. OTHER EXPENSES OF ARBITRATION, INCLUDING, BUT NOT LIMITED TO: ATTORNEY FEES, EXPENSES OF DISCOVERY, WITNESSES, STENOGRAPHER, TRANSLATORS, AND SIMILAR EXPENSES, WILL BE BORNE BY THE PARTY INCURRING THOSE EXPENSES. ANY DECISION REACHED BY ARBITRATION SHALL BE BINDING UPON BOTH YOU AND THE COMPANY. THE ARBITRATION AWARD MAY INCLUDE ATTORNEY'S FEES, IF ALLOWED BY STATE LAW, AND MAY BE ENTERED AS A JUDGMENT IN ANY COURT OF PROPER JURISDICTION.

I attest that all information on this form is accurate. I have read the Acknowledgment of this document and agree to its terms.

Applicant Signature _____ Date (mm/dd/yyyy) _____
(A faxed signature shall be valid as an original signature.)

Spouse/Domestic Partner Signature _____ Date (mm/dd/yyyy) _____
(Required if applying for coverage. A faxed signature shall be valid as an original signature.)

Requested Effective Date (mm/dd/yyyy) _____
(Coverage is not in force until the insurer approves your application and determines the effective date.)

Regence

Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association

2018 Utah Individual Enrollment Application Cover Sheet

Thank you for considering Regence BlueCross BlueShield of Utah for your Individual health insurance coverage. Please complete all sections of this form in black ink. Anything left incomplete may delay your coverage effective date. We may call you if we have questions about information you provide.

You can apply with this cover sheet and the Utah Individual Health Insurance Application or save time by shopping for a plan at regence.com.

If you want to buy coverage through the Exchange, go to HealthCare.gov.

If you need help completing your application or have questions, contact your insurance producer (agent) or call us at 1-888-REGENCE.

Applicant's name:	Spoken language preference if other than English (optional):
Preferred communication method for application processing: ☐ Secure email ☐ US Postal Service	

Section 1: Application type

Check the boxes that apply to you. If you're applying outside of open enrollment, you must have a qualifying event (see Cover Sheet Section 3: Qualifying events).

☐ I'm applying to become a new Regence member

☐ I'm a current Regence member (Member ID #:

_____) and want to:

- ☐ Change my plan (give us a call or complete this form)
- ☐ Add a child (complete this form)
- ☐ Add a spouse/domestic partner (complete this form)
- ☐ Cancel my existing medical policy and apply for a new Individual medical plan (give us a call or complete this form)

  I wish to cancel my current medical policy with Regence on the effective date of my new Individual policy.

  _____ (mm/dd/yyyy)

  Signature and date

You must be up to date on paying your premiums in order to change plans. If your policy cancels because you didn't pay the premium, you will need to submit a new application and cover sheet.

Section 2: Eligibility

You can apply for Individual health insurance coverage if you are both:

- A resident of Utah, with a primary residence in Utah for at least 6 months each year.
- Not entitled to Medicare. If you're 65 or older but not eligible for Medicare, please submit a "Not Eligible for Medicare" document from the Social Security Administration.

What about dependents?

You can include these dependents on your Regence plan:

- Your spouse or domestic partner
- Your children (including children placed with you for adoption, or adopted by you) under age 26
- Your disabled children over age 26 (We will need a copy of the medical certification of disability for disabled children.)

Section 2: Eligibility, continued

When can you apply?

1. Open enrollment: Every fall, Utah holds open enrollment for Individuals applying for coverage that may start on Jan. 1. You can find this year's dates on regence.com. We need to receive your application and cover sheet during open enrollment.
2. Special enrollment: You can apply outside open enrollment if you have a qualifying life event (like a birth or a marriage) that changes your coverage needs. See Cover Sheet Section 3 to learn more.

Section 3: Qualifying events

Complete this section if you've had a life event that changes your coverage needs outside the open enrollment period. Check the box next to the situation that applies to you and include the requested documents. You must apply no more than 60 days after the date of the qualifying event. If you're applying during open enrollment and not due to one of these situations, skip to Cover Sheet Section 4.

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

(Your qualifying event date may not be the same as your effective date.)

Which of these applies to you?	Include the following:
☐ You have a new dependent(s) through birth, adoption or placement for adoption, or marriage. If marriage, you or your spouse also must have either had minimum essential coverage for at least 1 of the 60 days immediately before marriage, been living in a foreign country or U.S. territory for at least 1 of the 60 days immediately before marriage, or be an Indian as defined in federal law.	• Copy of birth certificate; adoption or placement papers; or marriage or domestic partnership certification. For marriage, provide a copy of the marriage certificate plus one of the following, according to your situation: • Proof of coverage or other creditable coverage • A copy of a utility bill in your name from your prior address dated within the last 60 days (if you got married and moved from a foreign country) • Tribal ID card (if you are Indian as defined in federal law)
☐ You lost group coverage due to: death of employee; termination of job; reduction in hours; divorce or legal separation; Medicare entitlement; loss of dependent child status; or bankruptcy of employer due to Chapter 11 filing.	• Employer letter on company letterhead, Certificate of Coverage or other evidence of qualifying event and date of event.
☐ You lost minimum essential coverage as defined in federal law, including but not limited to most government-sponsored programs (e.g., Medicare, Medicaid, CHIP), employer-sponsored plans, and Individual plans in the state (except due to nonpayment of premium or fraud/intentional material misrepresentation).	• Employer letter on company letterhead, Certificate of Coverage or other evidence of coverage termination reason. If this reason is due to dissolution of marriage, please provide a copy of the divorce decree.
☐ You enrolled or did not receive coverage on a Qualified Health Plan due to an error by the Exchange, the Qualified Health Plan, or Health and Human Services.	• Documentation from the Exchange finding error.
☐ Your Qualified Health Plan violated your contract.	• A copy of the contract showing the provision that was violated. • Proof of the violation.
☐ You're newly eligible or ineligible for advance payment of premium tax credit, or your eligibility for cost-sharing reductions changed.	• Letter from Health and Human Services, the IRS or the Exchange reflecting the change.

Section 3: Qualifying events, continued

Which of these applies to you?	Include the following:
☐ You gained access to a new Qualified Health Plan due to a permanent move and either had minimum essential coverage for at least 1 day of the 60 days immediately before your move or you were living in a foreign country or U.S. territory immediately before your move.	• Proof of coverage or other credible coverage. • A copy of a utility bill in your name from your **prior address** dated within the last 60 days. • A valid picture ID showing your home address: — Utah driver's license — Utah state-issued ID card — Tribal ID card — Military ID card • Any one additional document that shows your home address: — Utility bill for services received for your current residence (examples: gas, water or electric bill) • Bill date cannot be older than 60 days • Must include dates of service • Must include service address • Must include mailing address — Signed rental agreement for current residence (signed by the tenant and landlord) • If you are submitting a month-to-month lease, it must be signed within 60 days of application — Current student enrollment or letter from college/ university registrar noting residence address

Section 4: Plan options

Below are the plan choices available to you. Check one box to indicate your health plan selection.

Counties available: Box Elder, Cache, Carbon, Daggett, Davis, Duchesne, Emery, Juab, Morgan, Rich, Salt Lake, Sanpete, Summit, Tooele, Uintah, Utah, Weber

- ☐ Silver HSA 2500 EPO
- ☐ Silver 3000 EPO
- ☐ Bronze HSA 5000 EPO
- ☐ Bronze Essential 7150 EPO

EPO plans cover only in-network care. This means you will be responsible for 100% of the costs for any out-of-network care (excluding emergency services). Visit regence.com to learn which doctors and hospitals are in each network.

Optional benefits (only available when you also buy a medical plan)

- ☐ Dental, vision and Individual Assistance Program (IAP)

If you selected an HSA plan:

An HSA plan offers its most value when you set up its savings account with a financial institution. You can use our preferred partner, HealthEquity®, or use any other institution. HealthEquity works with Regence to integrate your funds and claims information for greater convenience for you.

- ☐ Yes, I authorize Regence to share my eligibility and claims information with HealthEquity for the purposes of establishing and administering my HealthEquity Health Savings Account (your Social Security number must be provided on the Utah Individual Health Insurance Application).

  Terms and conditions of the health savings account will be mailed with your HealthEquity HSA Visa Card.

- ☐ No, do not share my information with HealthEquity. I have/will open my own HSA bank account.

To take advantage of the pre-tax savings offered by your HSA from day one, you must have your account open by your effective date.

Section 5: Parent or guardian consent

(Complete only if applicant is under age 18 and will be the only insured)

I am giving notice that _____ , who is under the age of 18, is making application for individual health care coverage with my full consent. I request that you consider the child for health care coverage. I accept full responsibility for the payment of monthly premium and the contents of this cover letter and the application.

Signature	Date (mm/dd/yyyy)
Print name	Relationship to child
Address	Phone number (xxx) xxx-xxxx

Section 6: Residency

Does anyone included on your application reside, work or attend school outside Utah at any time during the year?

☐ Yes ☐ No

If yes, please provide the name and percentage of time spent outside Utah: _____

Please indicate the reason:

☐ Reside ☐ Work ☐ School (provide current registrar information) _____

Section 7: Child custody information

If parents are separated or divorced, please indicate who has legal custody. Please use additional paper if needed. If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation that shows who is responsible for dependent health coverage so that we can determine whose coverage is primary.

Name of child(ren)	Father	Mother	Joint	Other	Date awarded	Who is required to provide coverage for the child(ren)
	☐	☐	☐	☐	(mm/dd/yyyy)	
	☐	☐	☐	☐	(mm/dd/yyyy)	
	☐	☐	☐	☐	(mm/dd/yyyy)	

Section 8: Tobacco usage

You will state on the Utah Individual Health Insurance Application whether you or a dependent over age 18 whom you are enrolling uses tobacco and has used tobacco (in any form, but excluding any religious or ceremonial use) on average four or more times per week within the last six months. A surcharge is applied to the regular periodic rate for each enrolled tobacco user.

If an enrollee becomes a tobacco user after you apply, you must notify Regence immediately and a surcharge will be added for that enrollee. If we receive false information about tobacco usage or if you fail to notify Regence of a change in tobacco usage, Regence can collect unpaid surcharges and take any other available action.

Section 9: Acknowledgement

By signing the attached Individual application, you understand and agree to the terms and conditions set forth on this cover sheet as well as the terms and conditions set forth on the application.

I certify that all statements contained herein are true to the best of my knowledge. I understand that any misrepresentation, omission, or inaccurate information required herein shall prevent recovery under the policy if such answer is fraudulent or materially affects the risk assumed by Regence. I understand this request will be underwritten to determine the extent of my eligibility, and that Regence will consider all medical information currently on file. I hereby expressly authorize any physician or hospital, or any other health care provider, to disclose to Regence any information obtained by having attended me or hereafter attending or examining me, and I understand that Regence will not disclose any information so obtained, except as permitted by law.

I acknowledge that I received an Outline of Coverage (OOC) in conjunction with this application.

Section 10: Your privacy

For information about the use and disclosure of health information, including uses and disclosures required by law, please refer to the Regence Consumer Privacy Notice. A copy is available at regence.com or by calling 1-888-REGENCE.

Section 11: Payment options

Billing address (complete only if billing should be sent to an address other than the mailing address listed on the application.)		
Last name	First name	
Address		
City	State	ZIP
County (required)		
Relationship to applicant		

We offer two ways to pay your premium:

- ☐ Pay with electronic funds transfer (EFT). Please fill out the EFT authorization agreement to the right. EFT occurs around the fifth of the month and typically takes one or two days to post to your account.
- ☐ Monthly bill. If you select this option, we'll send you a bill every month.

Note: We do not accept third-party payments from employers, providers and not-for-profit agencies unless required by law.

Is any third-party payer paying for any portion of this policy?

☐ Yes ☐ No

If you answered yes, is that person your family member or guardian?

☐ Yes ☐ No

Are you self-employed?

☐ Yes ☐ No

If yes, what is the name of your business?

_____

Authorization to my bank

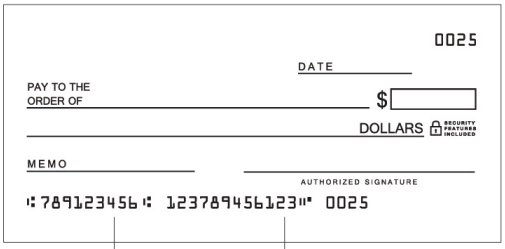
Depending on the timing of your effective date, your first premium payment may have to cover multiple months. If more than one month's premium is due for the first draft, do you authorize Regence to pull the full amount from your account?

☐ Yes ☐ No

If you check "No," you are not eligible for EFT right away. You can enroll in EFT and provide your bank information at a later time.

I (or we, if this is a joint account) authorize Regence to charge my/our checking account for monthly premiums for the below named individual. I also authorize my bank to honor these monthly charges. This authority remains in effect until I revoke it in writing and provide notice to Regence.

Financial institution or bank	
Transit/routing number	
Account number	
Check one: ☐ Checking account ☐ Savings account	
Account holder's name (please print)	
Account holder's signature	**Date** (mm/dd/yyyy)



Section 12: Replacement of coverage

Will this policy replace any other accident and sickness insurance currently in force? ☐ Yes ☐ No

If yes, please review the "Notice of Applicant Regarding Replacement of Accident and Health Insurance" contained in the Acknowledgment & Signature Section of the Utah Individual Health Insurance Application.

Section 13: Comments

Please note, in clear handwriting, any unique circumstances or feel free to add your thoughts on how we can serve you better.

Section 14: For producer use only

I (the producer) certify I have explained the eligibility provisions to the applicant. I have not made any statements about benefits, conditions or limitations of the contract except through written material furnished by Regence. I have informed the applicant that the effective date of coverage is assigned only by Regence. **I certify that the information supplied to me by the applicant has been truly and accurately recorded here.**	
Name (please print or type)	Regence producer number
Mailing address	
Email Email address	Phone number (xxx) xxx-xxxx
Signature (required)	Date (required) (mm/dd/yyyy)

Next steps

Fill out the application and mail, fax or email **both forms** to Regence BlueCross BlueShield of Utah.

Mail:

P.O. Box 1106, MS-LC1NW
Lewiston, ID 83501-1106

Fax:

1-866-797-1786

Email:

IndElig@regence.com

Questions?

Talk to your producer or agent. Call us at 1-888-REGENCE (1-888-734-3623).

New to Regence?

You'll receive a letter with your member ID number to get started on regence.com.

Regence BlueCross
BlueShield of Utah
2890 E. Cottonwood Parkway
Salt Lake City, UT 84130-0270

Regence may provide producers with bonuses, commissions, administrative fees or other compensation (including non-cash compensation). Incentives may be based on such factors as the product you buy, the producer's volume of business with Regence, and other services. These incentives may have an indirect impact on your rates. Please talk to your producer to learn more.

NONDISCRIMINATION NOTICE

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

Regence:
Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, and accessible electronic formats, other formats)

Provides 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 listed above, please contact:

Medicare Customer Service
1-800-541-8981 (TTY: 711)

Customer Service for all other plans
1-888-344-6347 (TTY: 711)

If you believe that Regence 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 our civil rights coordinator below:

Medicare Customer Service
Civil Rights Coordinator
MS: B32AG, PO Box 1827
Medford, OR 97501
1-866-749-0355, (TTY: 711)
Fax: 1-888-309-8784
medicareappeals@regence.com

Customer Service for all other plans
Civil Rights Coordinator
MS CS B32B, P.O. Box 1271
Portland, OR 97207-1271
1-888-344-6347, (TTY: 711)
CS@regence.com

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 at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW,
Room 509F HHH Building
Washington, DC 20201

1-800-368-1019, 800-537-7697 (TDD).

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

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-344-6347 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-344-6347 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-344-6347 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-344-6347 (телетайп: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-344-6347 (ATS : 711)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-344-6347（TTY:711）まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-888-344-6347 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-344-6347 (TTY: 711)

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ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-344-6347 (TTY: 711)

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-344-6347 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-344-6347 (TTY: 711)

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توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم TTY: 711)