Regence

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

Regence BlueShield of Idaho, Inc.
Medicare Supplement (Medigap) Application

Thank you for considering Regence BlueShield of Idaho, Inc. for your health insurance coverage.

Section 1: Plan selection

If you are enrolled in Medicare Part A and Part B, you may choose one of the following plans:

- ☐ Plan A
- ☐ Plan G
- ☐ Plan K
- ☐ Plan N

If you became Medicare eligible before January 1, 2020, based on disability or ESRD status, or turned 65 before January 1, 2020, and are currently enrolled in Medicare Part A and Part B, you may be eligible for the following additional plan options:

- ☐ Plan C
- ☐ Senior Selection (Modified Plan F)

Section 2: Enrollment information

First name, MI	Last name (including suffix if applicable)	Birthdate	Gender ☐ Male ☐ Female
Language preference if other than English (optional) ☐ Spanish ☐ Other (please define)		In the last 12 months have you smoked or used tobacco? ☐ Yes ☐ No	
Medicare number		Requested effective date for this policy	
Medicare effective date - Part A (hospital)		Medicare effective date - Part B (physician)	

Section 2: Enrollment information (continued)

IDAHO RESIDENCE ADDRESS To be eligible to apply for our Medicare Supplement plans, you must reside in our service area. A photocopy of a valid Idaho state driver's license or identification card and a current utility bill with name and address may be requested as proof of residency.		
Residence street address	Apartment/unit number (if applicable)	City, state, ZIP code
Mailing address (if different from residence street address)	Apartment/unit number (if applicable)	City, state, ZIP code
Home phone number	Alternate phone number	Email address

Race and Ethnicity (optional)

We use this data exclusively to improve services to our members. You do not have to answer these questions and giving us this information will not affect your eligibility, plan choices, or access to programs.

Ethnicity:

☐ Cuban ☐ Guatemalan ☐ Hispanic or Latino/a ☐ Mexican ☐ Mexican American ☐ Chicano/a
☐ Puerto Rican ☐ Salvadoran
☐ Not Hispanic or Latino/a ☐ Other (please define) _____ ☐ Prefer not to answer

Race:

☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African American ☐ Chinese ☐ Filipino
☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian
☐ Other Pacific Islander ☐ Samoan ☐ Vietnamese ☐ White ☐ Other (please define) _____
☐ Prefer not to answer

Section 3: Other coverage information

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application.

NOTE: To cancel a current policy, please contact your group administrator or insurance carrier.

Please answer all questions to the best of your knowledge. (Please mark Yes or No with an "X.")
General Medicare coverage information

A. Did you turn 65 in the last six months? ☐ Yes ☐ No

B. Will you be turning 65 in the next six months? ☐ Yes ☐ No

C. Regardless of age, did you enroll in Medicare Part B in the last six months? ☐ Yes ☐ No

If Yes, what is your effective date for Medicare Part B? _____

If you answered Yes to A, B, or C, please skip the Health Statement (Section 4).

Please note: Congress has established a six-month open enrollment period for buying Medicare Supplement health insurance. The law guarantees that for six months immediately following enrollment in Medicare medical coverage Part B, individuals cannot be denied insurance due to health conditions.

Section 3: Other coverage information (continued)

Medicaid coverage information

D. Are you covered for medical assistance through the state Medicaid program? ☐ Yes ☐ No

(Note to applicant: If you are participating in a "Spend Down Program" and have not met your "share of cost," please answer No to this question.)

If Yes to D, please answer the following two sub-questions:

1. Will Medicaid pay your premiums for this Medicare Supplement contract? ☐ Yes ☐ No
2. Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium? ☐ Yes ☐ No

E. Have you recently lost coverage for medical assistance through the state Medicaid program? ☐ Yes ☐ No

If Yes, what date did coverage end? _____

Medicare insurance plans

F. Have you had coverage from any Medicare plan other than Original Medicare within the past 63 days (for example, a Medicare Advantage HMO or PPO)? If yes, fill in your start and end dates below. If you are still covered under this plan, leave "End" blank. ☐ Yes ☐ No

If No, skip to question G.

If Yes: Start* _____ End _____

If Yes, with which company? _____ and what plan? _____

If Yes, answer questions a, b and c.

a. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ☐ Yes ☐ No

b. Was this your first time on this type of Medicare plan? ☐ Yes ☐ No

c. Did you voluntarily disenroll from a Medicare Supplement policy to enroll in the Medicare plan? ☐ Yes ☐ No

Please complete Section 7, "Notice to applicant regarding replacement of Medicare Supplement insurance or Medicare Advantage."

G. Do you have another Medicare Supplement policy in force? ☐ Yes ☐ No

If No, skip to question H.

If Yes, with which company? _____ and what plan? _____

If Yes, do you intend to replace your current Medicare Supplement policy with this policy? ☐ Yes ☐ No

If Yes: Start* _____ End _____

Please complete Section 7, "Notice to applicant regarding replacement of Medicare Supplement insurance or Medicare Advantage.

*Start date is the date your policy originally began, not renewed.

Section 3: Other coverage information (continued)

Group or individual insurance coverage

H. Have you had coverage under any other health insurance within the past 63 days? (For example, through an employer, union, or individual plan.) ☐ Yes ☐ No

If No, skip to next section.

If Yes, with which company? _____

If Yes, what kind of policy? _____

If Yes, do you intend to replace your current policy with this policy? ☐ Yes ☐ No

If Yes, what are your dates of coverage under the other policy? If you are still covered under this plan, leave "End" blank. Start* _____ End _____

*Start date is the date your policy originally began, not renewed.

I have a guaranteed issue right which does not require the health statement to be complete. ☐ Yes ☐ No

If Yes, please skip the health statement (Section 4).

Note: A health statement may be required if guaranteed issue eligibility criteria is not met.

Section 4: Health statement

Complete this section if you are not applying during your open enrollment period. Your open enrollment period is the six-month period immediately following your 65th birthday or your enrollment in Medicare Part B. There are other exceptions where you will not need to complete this section. If you have a guaranteed issue right that does not require the health statement, please skip this section.

Applicant's height _____ weight _____

In the last 12 months, have you used tobacco or vaped? ☐ Yes ☐ No

A. Within the last five years, have you had diagnosis, treatment, or advice relating to any of the following:

1. Accident, injury, or deformity..... ☐ Yes ☐ No
2. Acquired immune deficiency syndrome (AIDS) or related disease ☐ Yes ☐ No
3. Alcoholism/drug dependency..... ☐ Yes ☐ No
4. Anemia, blood disease, or leukemia ☐ Yes ☐ No
5. Arthritis or rheumatoid arthritis..... ☐ Yes ☐ No
6. Asthma or chronic bronchitis..... ☐ Yes ☐ No
7. Back trouble (recurrent or chronic)... ☐ Yes ☐ No
8. Cancer or tumor..... ☐ Yes ☐ No
9. Confusion or Alzheimer's..... ☐ Yes ☐ No
10. Diabetes..... ☐ Yes ☐ No
11. Dizziness or headaches (fequent).... ☐ Yes ☐ No
12. Epilepsy or convulsions..... ☐ Yes ☐ No
13. Ear, nose, or throat disorders..... ☐ Yes ☐ No
14. Eye disorder, glaucoma..... ☐ Yes ☐ No
15. Female disorders, fibroids, or excessive or irregular bleeding..... ☐ Yes ☐ No
16. Gallbladder..... ☐ Yes ☐ No
17. Heart or circulatory..... ☐ Yes ☐ No
18. High or low blood pressure, or cholesterol..... ☐ Yes ☐ No
19. Intestines, bowel, or colon..... ☐ Yes ☐ No
20. Joint problems, including knee and other..... ☐ Yes ☐ No
21. Kidney or bladder..... ☐ Yes ☐ No
22. Liver disorder or hepatitis..... ☐ Yes ☐ No
23. Lung problems, chronic obstructive pulmonary disease, emphysema, or oxygen use..... ☐ Yes ☐ No
24. Mental anxiety, emotional condition, or depression..... ☐ Yes ☐ No
25. Muscular disorders/dystrophies..... ☐ Yes ☐ No
26. Neurological disease or Parkinson's ☐ Yes ☐ No
27. Neuritis, chronic or recurrent numbness/tingling..... ☐ Yes ☐ No
28. Obesity (overweight)..... ☐ Yes ☐ No
29. Prostate or male disorder..... ☐ Yes ☐ No
30. Rectal disorder, hemorrhoids, or bleeding..... ☐ Yes ☐ No
31. Sciatica or chronic pain..... ☐ Yes ☐ No
32. Skin condition or disease, melanoma ☐ Yes ☐ No
33. Stroke..... ☐ Yes ☐ No
34. Stomach disorders, frequent or chronic heartburn..... ☐ Yes ☐ No
35. Thyroid or glandular..... ☐ Yes ☐ No
36. Ulcer (stomach or duodenal)..... ☐ Yes ☐ No
37. Varicose veins, phlebitis, or blood clots ..... ☐ Yes ☐ No
38. Any other condition or disease not listed above (list below)..... ☐ Yes ☐ No

Section 4: Health statement (continued)

Please explain below any items that you checked "Yes" on the previous page.

Question number	Year	Duration	Disease, injury, or condition	Was recovery complete?	Name of physician

B. In the past three years, have you been advised to have an operation that was not performed? ☐ Yes ☐ No

If Yes, please give full details, including name of physician.

C. Have you been hospitalized in the last five years or are you currently hospitalized or in an extended care facility? ☐ Yes ☐ No

If Yes, please explain below (use an extra sheet of paper if necessary).

Date of hospitalization	Disease, injury, or condition	Name of operation performed, if any	Name of physician

D. Are you planning to be hospitalized within the next six months? ☐ Yes ☐ No

If Yes, please explain.

E. Have you taken any prescription medications within the past 12 months? ☐ Yes ☐ No

If Yes, please explain below (use an extra sheet of paper if necessary).

Medication	Prescribing physician	Medical condition	Still taking?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Section 5: Premium billing options

Billing address (Complete only if billing should be sent to an address other than the mailing address listed on the front of the application.)		
First name	Last name	Relationship to applicant
Address		Apartment/unit (if applicable)
City, state, ZIP code		County

Please indicate which billing option you want to use. (If billing option is left blank, your policy will automatically default to monthly paper billing).

☐ Monthly paper billing ☐ EFT (premium is automatically deducted from your bank account on the 5th of each month)

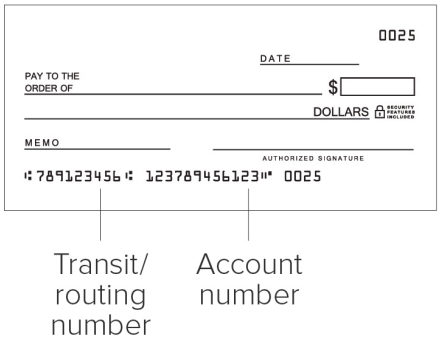
EFT information (complete only if EFT is selected)

Authorization to my bank

I authorize Regence to charge my bank account for monthly premiums. 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.

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



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

Section 6: Household discount (if application is approved)

If you are not applying to receive a household discount, please continue to Section 7.

You may receive a premium discount if you qualify for our household discount. Eligibility for the household discount requires two current Regence Medicare Supplement members to reside at the same physical address. Only members on a community rated Regence Bridge Medicare Supplement plan may be eligible to receive the discount. List the individual who you reside with that meets the household discount criteria.

Please complete the information below regarding your household member.

First name	Last name	
Is the person a current member? ☐ Yes ☐ No	**If Yes**, provide current member ID number	**If No**, please provide date application was submitted

Section 7: Notice to applicant regarding replacement of Medicare Supplement insurance or Medicare Advantage

Please review this section if you indicated in Section 3 of the application that you intend to terminate existing Medicare Supplement coverage or Medicare Advantage insurance, and replace it with a policy to be issued by Regence. Your new policy will provide 30 days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage plan. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement to applicant by issuer, producer (agent)

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement coverage or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

☐ Additional benefits

☐ No change in benefits, but lower rates

☐ Fewer benefits and lower rates

☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D

☐ Disenrollment from a Medicare Advantage plan (please explain reason for disenrollment)

☐ Other (please define)

State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premiums as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. Do not cancel your present policy until you have received your new policy and are sure you want to keep it.

Applicant's name (please print)	Producer signature*
Applicant or personal representative's signature	Producer number*
Date of applicant or personal representative's signature	Date of producer's signature*

*Producer information not required if you do not have a producer

Section 8: Certification, authorization and signature

Be sure to sign and date the following page of the application. Signature applies to both "Certification of completion and correctness" and "Authorization for use and disclosure of protected health information":

Certification of completion and correctness

- I affirm that the answers given in this application are true, complete, and correct.
- I am providing these answers as part of the application procedure required by Regence to enroll in their coverage.
- I understand that Regence will rely on each answer in making coverage and rating determinations.
- I understand that Regence can rescind my policy if additional information changes my eligibility status.
- It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.
- If coverage is rescinded due to ineligibility, fraud or intentionally misleading statements, Regence will reimburse premium less any claims paid and will pursue reimbursement for claims paid exceeding any premium.
- I will promptly inform Regence in writing if anything happens before my coverage takes effect that makes this application incomplete or incorrect.
- I understand and agree that no coverage shall be in force until approved by Regence. Regence may call me to clarify answers on this application.
- As the applicant, I understand I have the right to inspect the information in my file.
- I will promptly inform Regence if my Medicare eligibility status changes.
- If applying with an insurance producer (agent), I have received the ***Choosing a Medigap Policy***: *A Guide to Health Insurance for People with Medicare* booklet and an Outline of Coverage.

Authorization for use and disclosure of protected health information

I acknowledge and understand my health plan may request or disclose health information about me from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits, or as required by law.*

Health information requested or disclosed may be related to treatment or services performed by:

- A physician, dentist, pharmacist or other physical or behavioral health care practitioner
- A clinic, hospital, long-term care or other medical facility
- Any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or
- An insurance carrier or health plan

Health information requested or disclosed may include, but is not limited to, claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). A separate authorization will be required for psychotherapy notes.

I understand that if this application contains any material misstatements or omissions, Regence may deny coverage, modify or cancel coverage and/or take any other legal action available to it by law.

This authorization may not be used for psychotherapy notes (notes recorded and separately maintained by a mental health professional documenting or analyzing the contents of a conversation during a counseling session).

*For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Regence Consumer Privacy Notice. A copy is available on our website at regence.com or by telephone request at 1-800-365-3155.

Section 8: Certification, authorization and signature (continued)

Do you have a personal representative (legal power of attorney/ guardian) that is completing this application on your behalf? ☐ Yes ☐ No **If Yes, complete the following:**	
Personal representative's first name	Personal representative's last name
Relationship to the individual	
Personal representative's signature	Date
Please attach legal power of attorney or guardianship documentation if signing as a personal representative.	

If no personal representative, complete the following:	
Signature of applicant	Date
If additional health information is required to qualify you for coverage, we may send you a separate authorization form for the purpose of obtaining medical information.	

Do not send payment with your application. We will bill you upon acceptance of your application.

Section 9: Insurance producer (agent) certification

If you have a producer, that producer may receive bonuses, commissions, administrative service fees, or other compensation, including non-cash compensation, from Regence. Incentives may be based on any of several factors, including the products you buy, your producer's volume of business with Regence, and the other services your producer provides you. For more information, please contact your producer.

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 policy except through written material furnished by Regence. I have informed the applicant that the effective date of coverage is assigned only by Regence and provided the Idaho Disclosure Information required. **I certify that the information supplied to me by the applicant has been truly and accurately recorded here.**		
List any other medical or health insurance policies sold to the applicant		
List the policies still in force		
List the policies sold in the past five years that are no longer in force		
Producer name (please print or type)		
Producer phone number	Producer number	
Producer signature (required)		Date (required)
Producer: Collect no premium with application.		

Congratulations. You're almost done!
Mail, fax or email this form to Regence BlueShield of Idaho, Inc.

Mail:
ATTN: Individual Underwriting
P.O. Box 1106
Lewiston, ID 83501-1106

Fax:
1-877-369-3418

Email:
MedSupElig@regence.com

Questions?
Talk to your producer/agent or call us at

1-844-REGENCE
(1-844-734-3623).

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

Special Notice

- You do not need more than one Medicare Supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be re-instituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the re-instituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in, a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be re-instituted, if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the re-instituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a qualified Medicare beneficiary (QMB) and specified low-income Medicare beneficiary (SLMB).
- Your rate may change at the Plan's annual renewal date on March 1, so you may initially see an increase before a 12-month period. Rates are guaranteed not to increase for 12 months after the renewal date.
- Except as required by law, we will not accept payments of premium or other cost-sharing obligations on your behalf from a hospital, hospital system, health care provider or other similar individuals or entities that have or will receive financial remuneration related to Your choice of health care. As permitted by the Centers for Medicare and Medicaid Services (CMS), we will accept premium and cost-sharing payments made on your behalf by the Ryan White HIV/AIDS Program, other federal and state government programs that provide premium and cost sharing support for specific individuals, Indian Tribes, Tribal Organizations and Urban Indian Organizations and as directed by the Idaho Department of Insurance pursuant to Bulletin 16-04.
- You understand that you must be enrolled in Medicare Part A and Part B to be eligible for Medicare Supplement coverage. If Medicare Part A and/or Part B terminate for any reason, a Medicare Supplement policy is no longer beneficial because Medicare covered benefits will not be reimbursed.
- If you are eligible for and have enrolled on a Medicare Supplement policy, your contract may contain a Coordination of Benefits (COB) provision. We depend on your help in order for us to process your claims correctly. If you have other coverage that overlaps with your new Medicare Supplement policy, please contact Customer Service.
- Regence will validate householder eligibility and may request additional documentation. If you are deemed ineligible for the household discount after the effective date of your coverage, your premium will be adjusted back to your original effective date.
- **Your application is subject to review and approval by Regence. Complete applications received in our office by midnight Pacific time on the last business day of the month will be eligible for an effective date of the first of the following month, unless otherwise indicated. Incomplete applications may receive a later effective date.**

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 less favorably because of race, color, national origin, age, disability, or sex.

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

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

Provides free language assistance services to people whose primary language is not English, which may include:

- Qualified interpreters
- Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Civil Rights Coordinator.

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. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

Customer Service
Civil Rights Coordinator
PO Box 1106
Lewiston, ID 83501-1106
Phone: 1-888-344-6347, (TTY: 711)
Fax: 1-888-309-8784
Email: CS@regence.com

Medicare Customer Service
Phone: 1-800-541-8981 (TTY: 711)
Email: medicareappeals@regence.com

VSP Customer Service
Phone: 1-844-299-3041
TTY: 1-800-428-4833

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 or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 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' hódíilnih 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)