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Wellmark Blue Cross Blue Shield of Iowa
Wellmark Health Plan of Iowa, Inc.

Independent Licensees of the Blue Cross and Blue Shield Association

Individual Health Plan Contract Change Form
(For Grandfathered Plans and pre-ACA Non-Grandfathered Plans)

Instructions: Use a ballpoint pen to complete the form and follow guidelines listed below:

GUIDELINES

Complete checked section if you are using this form to:	A	B	C	D	E	F	G	I
Remove the Policyholder	✓	✓	✓	✓	✓*	✓		✓
Remove a member	✓	✓			✓*	✓		✓
Remove a member and member moving to new policy	✓	✓	✓	✓	✓*	✓		✓
Add an eligible individual or a newborn to current coverage Reinstate an eligible individual on current coverage	✓	✓		✓	✓*	✓		✓
Change to a different plan option to decrease level of benefits, e.g., increasing deductible	✓				✓	✓		✓
Change billing option	✓					✓		✓
Cancel entire policy	✓						✓	✓

*Complete if changing plan option.
NOTE: Existing benefits will remain in place unless you complete section E. Plan Changes.

A. EXISTING POLICYHOLDER INFORMATION

Existing Policyholder Name *(First, Middle, Last)*	Social Security Number/Tax Identification Number

Social Security Number (SSN) or Tax Identification Number (TIN) must be provided for you and every covered member for timely processing. Further review may be necessary if an SSN or TIN is not provided.

Please check box to left of item(s) you are changing and provide complete information.

B. CONTRACT CHANGES

☐ **Removing Policyholder:** ☐ Annual Open Enrollment Period (End date cannot be retroactive.) ☐ Death ☐ Medicare Eligible ☐ Active Military Duty ☐ Obtain Employer Group Coverage (Please provide copy of military papers, indicating date of entry.)

If obtaining employer group coverage: List group name _____ List carrier name _____

List date of event: _____/_____/_____

Cancellation date will be as applicable:
- During open enrollment, the first of the month following your signature date on this change form
- Day after death of policyholder or through the end of the month if family policy
- Date your Medicare Supplement policy becomes effective
- Date you begin basic training or are called to active military service
- First of the month following start of employer group coverage (or same day if coverage starts on the first of the month)

☐ **Adding Eligible Individual:**
☐ Adoption, placement for adoption or foster care ☐ Birth ☐ Marriage ☐ Gained U.S. Citizenship ☐ Loss of coverage due to move to Iowa ☐ Court-ordered coverage ☐ Involuntary loss of group coverage or employer contribution ☐ Returning from military service ☐ Legal guardianship ☐ Involuntary loss of creditable coverage.
☐ Qualifying event not listed_____

For loss of group or other creditable coverage, please list prior insurance company name and policy ID number:

_____

List date of event: _____/_____/_____ Your effective date will be as described in Section H: Effective Dates.

☐ **Removing Member:**
☐ Active Military Duty Service (Please provide copy of military papers, indicating date of entry.)
☐ Completion of full-time schooling of a dependent child age 26 or older
☐ Death
☐ Dependent Child reaches age 26 and is not a full-time student or permanently disabled
☐ Divorce/Annulment/Legal Separation
☐ Marriage of a dependent child age 26 or older
☐ Spouse Obtains Employer Group Coverage
☐ Other, Specify _____

List date of event: _____/_____/_____ **List name(s) of member(s) removed:** _____
If removing a member without an event, your cancellation date will be the first of the month following your signature date on this change form.

Existing Policyholder Name *(First, Middle, Last)*	Social Security #/Tax Identification Number

C. NEW POLICYHOLDER INFORMATION

New Policyholder Name *(First Middle, Last)*	Social Security Number / Tax Identification Number[1]

Mailing Address Street	Bldg. Name/No., Apt. No.	PO Box	City	State	Zip

Provide name of county in which policyholder resides:

Billing Address (if different from Mailing Address) Street	Bldg. Name/No., Apt. No.	PO Box	City	State	Zip

Telephone Number ( )	E-mail Address

D. MEMBERS ADDED TO EXISTING CONTRACT OR MEMBERS MOVED TO NEW CONTRACT

☐	Name (First, MI, Last)	Relationship	Birthdate	Social Security Number / Tax Identification Number[1]	Gender	Full-time Student?	Disabled?[2]	Tobacco User?*
	Applicant	Self			☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Spouse	Spouse			☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Dependent				☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Dependent				☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Are you, your spouse, or any dependents listed above enrolled in Medicare?
☐ Yes ☐ No If yes, please provide names: _____

*Answer yes if the person listed has used any form of tobacco during the 12 months immediately preceding the date of this application.

[1]Social Security Number (SSN) or Tax Identification Number (TIN) must be provided for you and every covered member for timely processing. Further review may be necessary if an SSN or TIN is not provided.

[2]Disabled dependents and full-time students age 26 or older must be unmarried to be eligible for coverage as a dependent.

E. PLAN CHANGES

☐ 1. Complete this section to decrease your level of benefits.
If you have a post-Pool 4 or Pool 5 plan, you may move to a plan with lesser benefits within the same plan family at any time during the year (i.e., increasing your deductible within the same plan family). You must be a resident of Iowa to change your deductible amount.
a. Select your health plan option by placing a check mark in the box prior to plan deductible level.
b. Select a first of the month effective date:___/_1_/___ (If you do not list an effective date, your effective date will be the first of the month following signature date.)

2. If you are enrolled in any other pool and wish to make a change to your benefits, you will need to apply for an ACA (Affordable Care Act) plan during an annual open enrollment or within a special enrollment period.

Pool 5 Plan Change Options (Not Available for New Sales)

Alliance Select℠ Comprehensive	Alliance Select℠ Enhanced	Alliance Select℠ Value	Blue PriorityHSA℠	Blue Basics℠	Blue Advantage Premier℠	Blue Advantage HSA℠	Blue Advantage Standard℠
☐ 500 ☐ 1000 ☐ 1500 ☐ 3000 ☐ 4500	☐ 750 ☐ 1250 ☐ 1850 ☐ 2500 ☐ 5500 ☐ 9500	☐ 2000 ☐ 5000	☐ 1700A ☐ 1700B ☐ 2750A ☐ 2750B ☐ 5400A ☐ Maternity ($2500 Deductible)	☐ 3000 ☐ 5000	☐ 1500 with Blue Rx Value ☐ 2500 with Blue Rx Value ☐ Maternity ($2500 Deductible) ☐ 1500 with Blue Rx Complete ☐ 2500 with Blue Rx Complete ☐ Maternity ($2500 Deductible)	☐ 1900 with Blue Rx Complete ☐ 3000 with Blue Rx Complete	☐ 2500 with Blue Rx Value ☐ 4000 with Blue Rx Value ☐ 2500 with Blue Rx Complete ☐ 4000 with Blue Rx Complete

If you select a Blue Advantage plan, you must complete form N-5423.

Existing Policyholder Name *(First, Middle, Last)*	Social Security #/Tax Identification Number

E. PLAN CHANGES (CONT'D)

Pool 4 Plan Change Options (Not Available for New Sales)

Alliance Select℠ Comprehensive	Alliance Select℠ Enhanced	Alliance Select℠ Essential	HSA	Classic Blue®
☐ 300 ☐ 750 ☐ 1250 ☐ 1750	☐ 600 ☐ 1200 ☐ 1800 ☐ 2400 ☐ 3000 ☐ 4200	☐ 1500 ☐ 2500	☐ 1550 ☐ 2550	☐ 3000 ☐ 5000

Contact your agent or call the Customer Service number on your ID card if you need to verify which plan you currently have.

Please indicate "Yes" or "No" for each of the following Wellmark optional benefits. If you do not answer "Yes" or "No" for each optional benefit, Wellmark will assign optional benefits as covered in existing policy.

Blue Dental ☐ Yes ☐ No **Supplemental Accident** ☐ Yes ☐ No *(Not available with HSA products)*

Contraceptives ☐ Yes ☐ No *(Available with grandfathered plans only. Contraceptive coverage included with non-grandfathered plans.)*

Important information is available to you at *Wellmark.com/Inform* that addresses a number of topics such as 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 800-978-3221.

F. BILLING INFORMATION - Complete if new policyholder, changing billing option or selecting "Use Billing information on file with Wellmark".

1a. Will your employer be paying any part of the premium or fee for this policy either directly or through wage adjustments or other means of reimbursement? ☐ Yes ☐ No

1b. Will your premium and fee payments for this coverage be deductible on your federal income tax return as a trade or business expense other than the special health insurance deductions available to self-employed persons? ☐ Yes ☐ No

If you answered "yes" to either 1a or 1b, check one item below:

☐ Applicant is owner of a sole proprietor business
☐ Employer is deducting the full premium and fee
☐ Employee is part-time or temporary
☐ Employer has been denied the opportunity to purchase insurance due to low participation/contribution (attach copy of denial)

2. How do you want to pay for health premiums? **Please do not send payment with this form.**

Note: All billing periods are based on a calendar year.

☐ **a. Direct Bill.** On what basis? ☐ Semi-annually ☐ Annually
☐ **b. Use billing information on file with Wellmark.** (Available only for those with current Wellmark individual coverage.)
☐ **c. Automatic Account Withdrawal from Policyholder's account.**
☐ **d. Automatic Account Withdrawal from account other than Policyholder's.**

If you checked c or d, please complete the following:

On what basis? ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually
Date of withdrawal: ☐ 1st of the month ☐ 5th of the Month
From: ☐ Checking ☐ Savings

Attach a voided check OR complete the following information:

Financial Institution Name: _____

Bank Account Name(s) (exactly as it appears on the account): _____

Financial Institution Routing Number (9 digits): _____

Account Number: _____

State Code (found on your check on top right corner above the date - e.g., 78): _____

If Direct Bill is ***not*** selected:

I hereby certify that I have read and understand the section below entitled "Authorization and Certification," and agree to the terms regarding automatic premium withdrawals as described therein. As the Bank Account Holder, I authorize Wellmark to make automatic withdrawals from the account shown in the amount of the premium and fees. I understand and agree that notices of any premium and fee adjustments provided to the Policyholder shall constitute notice to the undersigned of any such adjustment. This authorization supersedes and replaces any previous authorization given by me for automatic premium withdrawal.

Bank Account Holder's Signature (if other than Policyholder)_____ **Date** _____/_____/_____

You may cancel automatic account withdrawal at any time. However, we need to receive your written notification by the 10th of the month before your next scheduled withdrawal.

Existing Policyholder Name *(First, Middle, Last)*	Social Security #/Tax Identification Number

G. CANCELLATION OF ENTIRE POLICY

I am requesting cancellation of my entire policy effective _____/ 1 / _____. I understand Wellmark does not allow cancellation on odd dates, and the earliest available cancellation date is the 1st day of the month after Wellmark's receipt of this request. My coverage will continue through the last day of the month in which I notify Wellmark to cancel. If I have vision and/or dental benefits for any member under age 19 included in my health coverage, these vision and/or dental benefits will be canceled with my health coverage. To cancel automatic account withdrawal, Wellmark must receive this request by the 10th of the month prior to my next scheduled withdrawal. To otherwise stop payment, I will notify my bank. I will be responsible for any associated fees from my bank.

H. EFFECTIVE DATES

When adding eligible individuals to existing coverage, effective dates will be:

Event:	**Effective Date:**
Birth	Date of birth
Adoption, placement for adoption or foster care	Date of adoption, placement for adoption or foster care
Appointment as a Legal Guardian	Date of event
Court-ordered Coverage	Date of event
Marriage	First day of the month following the event
Returning from Military Service	Date of discharge or inactive status from the military service or termination of military health coverage or the first of the following month
Gained U.S.A. Citizenship	First of the month following the event
Involuntary loss of creditable coverage*	First of the month following the event

*Involuntary loss of creditable coverage includes:

- Exhaustion of COBRA
- Death of Policyholder / Certificate Holder
- Policyholder / Certificate Holder enrolls in Medicare
- No longer a dependent
- Permanent move to Iowa
- Termination of employment / reduction in hours
- Divorce / Dissolution of Domestic Partnership
- Loss of *hawk-i* eligibility
- Loss of minimum essential coverage
- Loss of group coverage or loss of employer contribution to group coverage

I. AUTHORIZATION, CERTIFICATION AND SIGNATURE

I certify that I have carefully and fully read the Authorization and Certification language appearing below.

I certify that I am legally authorized to make changes in coverage for myself and on behalf of all other persons named on my current policy and in this form, and I further have confirmed with all persons named on my current policy and on this form that my signature is binding to change coverage. If I have made changes in my plan selection, I understand that I am applying for the Health Plan Options indicated on this form which are underwritten by Wellmark, Inc., doing business as Wellmark Blue Cross and Blue Shield of Iowa or Wellmark Health Plan of Iowa, Inc. (collectively, "Wellmark"). I further understand that coverage applied for will not start until this form and the appropriate premium and service fee payment amount, if applicable, are received and accepted by Wellmark.

If I am electing Health Plan Options offered by Wellmark Health Plan of Iowa, Inc., I understand that as a condition of eligibility for benefits under the coverage specified in this form, each person to be covered on one of these Health Plan Options must maintain his/her residency in an Iowa county other than Allamakee, Fayette, or Winneshiek. Failure to maintain such residency by any person named in this application will give Wellmark Health Plan of Iowa, Inc. the right to terminate the coverage specified in this application for that person not maintaining residency by giving that person not less than thirty (30) days notice in advance of termination of coverage and benefits will be denied unless the medical services are related to emergency services or an accidental injury.

The statements and answers set forth in this form are full, true, and correct. I have consulted with each other person named in this form to confirm that information about him/her is full, true, and correct. I understand that Wellmark will rely on the completeness and truthfulness of the information given in the statements made in this form or by telephone or in writing to Wellmark, and that, if I performed an act, practice, or omission that constitutes fraud or I have made an intentional misrepresentation of material fact in this form, Wellmark will be entitled to declare coverage applied for void and to refuse allowance of benefits to any person thereunder.

Special Enrollment Notification Period
For special enrollment events, Wellmark must be notified within 60 days of the event (or 120 days of returning from military service). Please see Section H for effective date information.

Tobacco User Status
If I answered "No" to the tobacco user question for any person listed in Section D, that person is eligible for a special tobacco non-user rate. If this status changes, I must notify Wellmark immediately. Wellmark may require me to recertify this status in the future. If Wellmark determines within the initial two years that this status is incorrect, Wellmark will retroactively collect historical differences in premiums before claims will be paid, and will start applying the tobacco user rate on the first of the month following Wellmark's receipt of this information.

Existing Policyholder Name *(First, Middle, Last)*	Social Security #/Tax Identification Number

I. AUTHORIZATION, CERTIFICATION AND SIGNATURE (CONT'D)

Dental Exclusion Periods
In the event I am adding Blue Dental coverage which is underwritten by Wellmark, Inc. doing business as Wellmark Blue Cross and Blue Shield of Iowa, I certify that I have been informed that there will be a six-month exclusion period before benefits are available for basic restorative services including, but not limited to, fillings, extractions, and oral surgery, and a 12-month exclusion period before benefits are available for major restorative services including, but not limited to endodontics, periodontics, crowns, onlays, and inlays. I understand these dental coverage exclusion periods will not be waived or reduced even if I or any other person named in this form have qualifying existing coverage or qualifying previous coverage.

Eligibility
If I become enrolled in Medicare during the term of this benefits policy, I understand that this benefits policy will provide benefits secondary to Medicare unless application of federal law determines this benefit policy must provide benefits primary to Medicare.

Providing Social Security Numbers or Tax Identification Numbers
In order for Wellmark to report my coverage status to the federal government, I understand 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 that Wellmark will be unable to report and send the information needed to complete federal tax returns. If I have not previously provided the 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. I understand if I do not provide the Social Security numbers or taxpayer identification numbers to Wellmark for this purpose, I may be subject to a $50 penalty per violation imposed by the Internal Revenue Service.

Health Care Reform Mandates
If I currently have a grandfathered health plan, I understand that making a change to my current benefits could potentially change the grandfathered status of my health care plan. If I lose the grandfathered status of my health care plan, I may be required to move to an ACA health plan. If I currently have a pre-ACA non-grandfathered plan, I understand that making a change to my current benefits may require I move to an ACA health plan.

Payment Arrangements
I understand and agree that the amount of my periodic premium payment and fee, if applicable, will change as provided in the policy being applied for and from time to time based on changes in my coverage, including but not limited to, changes in benefits, payment obligations (such as deductible, coinsurance and copayments), the number of covered family members, members' ages, changes in tobacco user status, or other factors that require adjustments to the total premium and fee, if applicable. These changes may occur at times other than at annual or other policy renewal.

I further understand and agree that, if I have elected to authorize automatic premium withdrawals from a deposit account, the automatic withdrawal will change periodically to correspond with the applicable premium and fee. My authorization for automatic premium withdrawals shall include authorization for automatic withdrawal of any changed amount unless I call or provide my bank with written notice not less than three (3) business days before a scheduled withdrawal to stop the payment. If I call my bank to stop payment, I may be required to provide a written request within fourteen (14) days after my call. I will be responsible for any fee assessed by my bank for stop-payment orders that I make.

Coverage Renewability
I understand that coverage is automatically renewed by payment of my premium and applicable fees in advance; that a grace period of 31 days will be granted for the payment of each premium and fee due after the first premium and fees; and that, during this grace period, my policy will continue in force.

I understand that Wellmark may terminate my policy if:

- I fail to pay my premium and service fee when due; or
- I fraudulently use my policy or make an intentional misrepresentation of a material fact under the terms of my policy; or
- I become ineligible for coverage under this policy; or
- Wellmark decides to terminate coverage of similar policies by giving written notice prior to termination. In the event Wellmark terminates individual polices of the same coverage, I will be allowed to transfer to the offered replacement policy.
- I change my residence from the geographic service area served by Wellmark Health Plan of Iowa, Inc. if I am enrolling in a health plan option offered by Wellmark Health Plan of Iowa, Inc.

Existing Policyholder Name *(First, Middle, Last)*	Social Security #/Tax Identification Number

I. AUTHORIZATION, CERTIFICATION AND SIGNATURE (CONT'D)

ACKNOWLEDGEMENT

I have read and understand the Authorization and Certification language and hereby confirm the authority of Wellmark to make automatic withdrawals from my deposit account as described therein. This authorization supersedes and replaces any previous authorizations given by me for automatic premium withdrawal.

I certify that each person covered on a Wellmark Health Plan of Iowa, Inc. plan option is a resident of an Iowa county other than Allamakee, Fayette, or Winneshiek.

Existing Policyholder Signature X_____ Date _____/_____/_____

New Policyholder Signature X _____ Date _____/_____/_____

If applicant is a minor, please sign below.

Parent/Legal Guardian Printed Name _____

Parent/Legal Guardian Signature X _____ Date _____/_____/_____

If child(ren) only policy, list parent's (s')/legal guardian's (s') name(s) _____

Agent Signature, if applicable X_____ Agent No. |_|_|_|_|_|_|_|_|

This completed contract change form (pages 1 through 6) must be signed within the annual open enrollment period or within a special enrollment period. If this form is received later than 15 days after your signature date, eligibility for requested coverage and effective date are subject to change.

Send completed form to:
Wellmark Blue Cross and Blue Shield of Iowa
Mail Station 3W190
PO Box 14527
Des Moines, IA 50306-3527
OR
Fax to: 515-376-9045
OR
E-mail to: INDMEMMAIN@wellmark.com

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: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ 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, निःशुल्क 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).

တ၀်ဒုးသ့ဉ်ညါ–နမ့်ကတိၤကညီကျိာ်.ကျိာ်တ်မၤစၤတ်ဖံးတ်မၤတဖဉ်.လၢတဘဉ်လာ်ဘူးလဲ.အိဉ်လၢနဂီၢ်လီၤ. ဆဲးကျိးဆူ၀၀–၅၂၄–၉၂၄၂မ့တမ့်(TTY:၈၈၈–၇၈၁–၄၂၆၂)တက့ာ်.

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 निःशुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ। 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस्।

ማሳሰቢያ: አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ አገዛ አገልግሎቶች፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 መደም (በTTY: 888-781-4262) ይውለው 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).

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