Providence Health Plan

PO Box 4649, Portland, OR 97208-4649

2024 Washington Application for Individual & Family Insurance

Thank you for choosing Providence Health Plan for your individual health insurance coverage.

THIS FORM IS FOR NEW ENROLLMENT ONLY. DO NOT USE THIS FORM IF:

- **You currently have an active Providence Health Plan Individual & Family insurance plan in the state of Washington. To learn how to make changes to your existing plan, please see the attached Additional Information page.**
- **You're entitled to Medicare Part A and/or enrolled in Medicare Part B. For information about Providence Medicare plans, please visit ProvidenceHealthPlan.com/Medicare.**

For assistance completing your application, please contact the Providence Health Plan Sales team at 503-574-5000 or 800-988-0088 (TTY: 711), 8 a.m. to 5 p.m. (Pacific Time), Monday through Friday. You may also contact your insurance agent/producer for assistance.

Before You Begin

Here's some important information about this form.

Everyone listed on this form will be enrolled in the same single plan. A separate application is required for any family members who want coverage on different plans.

All plans purchased using this application will expire December 31, 2024. All plans under the Affordable Care Act (ACA) are considered to be guaranteed renewable. Providence Health Plan will send you information at the end of the plan year regarding your eligibility for coverage in 2025.

Learn about different plans, compare coverage and check rates at ProvidenceHealthPlan.com.

This form does NOT cancel any active coverage you might already have. To avoid paying two premiums or having overlapping coverage, you need to cancel any currently active coverage you might have on a plan from either the Health Benefit Exchange or an employer, even if the policy is with Providence Health Plan.

Once you've completed this form, submit pages 1-8 to Providence Health Plan. If the form isn't signed, dated, fully completed, or if we need additional information, the date your coverage starts may be delayed. Your application will expire 60 days after the signature date, and we will not accept any postdated applications.

Step 1 of 5: Select Enrollment Period

Select one of the following enrollment options:

Option 1:

☐ I'm enrolling for new coverage during the **Open Enrollment Period (11/1/2023 - 1/15/2024)**.

Open Enrollment is your opportunity to enroll for coverage without requiring a qualifying event. For your coverage to be effective January 1, 2024, Providence Health Plan must receive your completed application no later than 12/15/2023.

Applications received between 12/16/2023 – 1/15/2024 will have coverage effective February 1, 2024. To effectuate coverage, you must submit your initial premium payment by the due date listed in Providence Health Plan's offer of coverage.

Option 2:

☐ I'm enrolling for new coverage during a **Special Enrollment Period (1/1/2024 - 12/31/2024)**.

You must have experienced one of the qualifying events listed below and submit your application and required documentation. Providence Health Plan must receive this completed application and required documentation **within 60 days** of the qualifying event.

Your effective date will be determined based on the type of qualifying event and the date Providence Health Plan receives your completed application, conditioned on timely receipt of your initial premium payment. Your effective date cannot be prior to the qualifying event. Please see the attached **Additional Information page** to learn more.

_____ /_____ /_____

DATE OF QUALIFYING EVENT

If you're applying outside of the Open Enrollment Period you must select a qualifying event:

- ☐ Involuntary loss of individual or group coverage except for failure to pay the premium
- ☐ Marriage or state registered domestic partnership*
- ☐ Birth, adoption, placement for adoption or foster care of a child
- ☐ Qualified Medical Child Support Order (QMCSO) or acquisition of legal guardianship
- ☐ Permanent move to a new Providence Health Plan service area that offers different health plan options
- ☐ Loss of coverage as a dependent due to age
- ☐ Loss of coverage due to end of marriage or state registered domestic partnership*
- ☐ Involuntary loss of Medicaid or CHIP coverage
- ☐ Newly eligible for a state- or federally-sponsored premium assistance program
- ☐ Loss of Advance Premium Tax Credit (APTC), Cost Sharing Reductions (CSR), or cessation of employer contribution to COBRA
- ☐ Newly gains access to an individual coverage HRA (ICHRA) or is newly provided a qualified small employer health reimbursement arrangement (QSEHRA)
- ☐ Survivor of domestic abuse/violence or spousal abandonment and wants to enroll in a health plan separate from the abuser or abandoner

*"State registered domestic partners" means two adults who meet the requirements for a valid state registered domestic partnership as established by RCW 26.60.030, and who have been issued a certificate of state registered domestic partnership by the secretary.

Step 2 of 5: Provide Member Information

Who is this application for? (Select one)

- ☐ **Myself only:** You must be at least 18 years old and reside in our service area.
- ☐ **Myself and my spouse/state registered domestic partner:*** Includes you and your spouse or state registered domestic partner. Both must reside in our service area.
- ☐ **Myself and my children:** Includes you, your dependent children age 25 or younger, and disabled dependents. You, the Policyholder, must reside in our service area.
- ☐ **Myself and my family:** Includes you, your spouse or state registered domestic partner, your dependent children age 25 or younger, and disabled dependents. Both you and your spouse/domestic partner must reside in our service area.
- ☐ **My dependent(s) only:** Includes your spouse or state registered domestic partner, your dependent children age 25 or younger, and disabled dependents. The responsible parent or legal guardian is the Policyholder. All enrolled dependents must reside in our service area.

*"State registered domestic partners" means two adults who meet the requirements for a valid state registered domestic partnership as established by RCW 26.60.030, and who have been issued a certificate of state registered domestic partnership by the secretary.

Applicant/Policyholder Information

The policyholder must be at least 18 years old, is financially responsible for the policy and is the person authorized to make changes to the plan.

LAST NAME _____ FIRST NAME _____ MI _____ DATE OF BIRTH MM/DD/YYYY ____/____/____

SOCIAL SECURITY NUMBER _____ EMAIL ADDRESS _____ PHONE _____

Gender (check one) ☐ Male ☐ Female ☐ Other

How do you identify? (These fields are optional. Your response will help us to better serve all communities.)

☐ Male ☐ Female ☐ Non-binary ☐ Transgender Male ☐ Transgender Female ☐ Decline to answer

Have you used any tobacco products in the last six months? ☐ Yes ☐ No

(Tobacco use is defined as an average of at least four times per week in the last six months, except for religious or ceremonial purposes.)

PHYSICAL ADDRESS (NO P.O. BOX OR RETAIL/BUSINESS ADDRESSES) _____ APARTMENT/UNIT NUMBER _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

MAILING ADDRESS (IF DIFFERENT FROM HOME ADDRESS) _____ APARTMENT/UNIT NUMBER _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

Step 3 of 5: List Dependents

Dependent Information

Please include full, legal names. For all plans, dependent children must be age 25 or younger as of their effective date.

1

LAST NAME _____ FIRST NAME _____ MI _____ DATE OF BIRTH ____/____/____

RELATIONSHIP* _____ SOCIAL SECURITY # ___-___-____

GENDER: ☐ M ☐ F ☐ Other

USES TOBACCO?** ☐ Yes ☐ No

HOW DO YOU IDENTIFY?*** ☐ Male ☐ Female ☐ Non-binary ☐ Transgender Male ☐ Transgender Female ☐ Decline to answer

LIVES WITH POLICYHOLDER? ☐ Yes ☐ No **IF NO, INCLUDE THE DEPENDENT'S PHYSICAL ADDRESS BELOW.**

DEPENDENT'S PHYSICAL ADDRESS _____ APARTMENT/UNIT NUMBER _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

2

LAST NAME _____ FIRST NAME _____ MI _____ DATE OF BIRTH ____/____/____

RELATIONSHIP* _____ SOCIAL SECURITY # ___-___-____

GENDER: ☐ M ☐ F ☐ Other

USES TOBACCO?** ☐ Yes ☐ No

HOW DO YOU IDENTIFY?*** ☐ Male ☐ Female ☐ Non-binary ☐ Transgender Male ☐ Transgender Female ☐ Decline to answer

LIVES WITH POLICYHOLDER? ☐ Yes ☐ No **IF NO, INCLUDE THE DEPENDENT'S PHYSICAL ADDRESS BELOW.**

DEPENDENT'S PHYSICAL ADDRESS _____ APARTMENT/UNIT NUMBER _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

3

LAST NAME _____ FIRST NAME _____ MI _____ DATE OF BIRTH ____/____/____

RELATIONSHIP* _____ SOCIAL SECURITY # ___-___-____

GENDER: ☐ M ☐ F ☐ Other

USES TOBACCO?** ☐ Yes ☐ No

HOW DO YOU IDENTIFY?*** ☐ Male ☐ Female ☐ Non-binary ☐ Transgender Male ☐ Transgender Female ☐ Decline to answer

LIVES WITH POLICYHOLDER? ☐ Yes ☐ No **IF NO, INCLUDE THE DEPENDENT'S PHYSICAL ADDRESS BELOW.**

DEPENDENT'S PHYSICAL ADDRESS _____ APARTMENT/UNIT NUMBER _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

* "State registered domestic partners" means two adults who meet the requirements for a valid state registered domestic partnership as established by RCW 26.60.030, and who have been issued a certificate of state registered domestic partnership by the secretary.

**Tobacco use is defined as an average of a least four times per week, except for religious or ceremonial purposes.

***These fields are optional. Your response will help us to better serve all communities.

Step 3 of 5: List Dependents

Dependent Information (Continued)

Please include full, legal names. For all plans, dependent children must be age 25 or younger as of their effective date. If you have additional dependents to be enrolled, please include them on a separate sheet with this enrollment application.

4

LAST NAME _____ FIRST NAME _____ MI _____ DATE OF BIRTH ____/____/____

RELATIONSHIP* _____ SOCIAL SECURITY # ___-___-_____

GENDER: ☐ M ☐ F ☐ Other

USES TOBACCO?** ☐ Yes ☐ No

HOW DO YOU IDENTIFY?*** ☐ Male ☐ Female ☐ Non-binary ☐ Transgender Male ☐ Transgender Female ☐ Decline to answer

LIVES WITH POLICYHOLDER? ☐ Yes ☐ No **IF NO, INCLUDE THE DEPENDENT'S PHYSICAL ADDRESS BELOW.**

DEPENDENT'S PHYSICAL ADDRESS _____ APARTMENT/UNIT NUMBER _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

5

LAST NAME _____ FIRST NAME _____ MI _____ DATE OF BIRTH ____/____/____

RELATIONSHIP* _____ SOCIAL SECURITY # ___-___-_____

GENDER: ☐ M ☐ F ☐ Other

USES TOBACCO?** ☐ Yes ☐ No

HOW DO YOU IDENTIFY?*** ☐ Male ☐ Female ☐ Non-binary ☐ Transgender Male ☐ Transgender Female ☐ Decline to answer

LIVES WITH POLICYHOLDER? ☐ Yes ☐ No **IF NO, INCLUDE THE DEPENDENT'S PHYSICAL ADDRESS BELOW.**

DEPENDENT'S PHYSICAL ADDRESS _____ APARTMENT/UNIT NUMBER _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

6

LAST NAME _____ FIRST NAME _____ MI _____ DATE OF BIRTH ____/____/____

RELATIONSHIP* _____ SOCIAL SECURITY # ___-___-_____

GENDER: ☐ M ☐ F ☐ Other

USES TOBACCO?** ☐ Yes ☐ No

HOW DO YOU IDENTIFY?*** ☐ Male ☐ Female ☐ Non-binary ☐ Transgender Male ☐ Transgender Female ☐ Decline to answer

LIVES WITH POLICYHOLDER? ☐ Yes ☐ No **IF NO, INCLUDE THE DEPENDENT'S PHYSICAL ADDRESS BELOW.**

DEPENDENT'S PHYSICAL ADDRESS _____ APARTMENT/UNIT NUMBER _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

* "State registered domestic partners" means two adults who meet the requirements for a valid state registered domestic partnership as established by RCW 26.60.030, and who have been issued a certificate of state registered domestic partnership by the secretary.

**Tobacco use is defined as an average of a least four times per week, except for religious or ceremonial purposes.

***These fields are optional. Your response will help us to better serve all communities.

Step 4 of 5: Select a Plan

You can learn more about each of the medical plans listed below by reading their corresponding Summary of Benefits and Coverage (SBC) at **ProvidenceHealthPlan.com/SBC**.

APPLICABLE COUNTIES	NETWORK	MEDICAL PLAN (CHECK ONE)
Benton, Clark, Franklin, Spokane, Thurston, Walla Walla	Choice	☐ Columbia 1500 Gold ☐ Columbia 5000 Silver ☐ Columbia 8900 Bronze

You will need to choose a Medical Home and a Primary Care Provider (PCP) after you enroll. Find a participating Providence Health Plan provider at **ProvidenceHealthPlan.com/FindAProvider** To learn about Medical Homes, please see the attached **Additional Information page.**

Step 5 of 5: Read, Sign & Submit

Certification of Completion and Correctness

I affirm that the answers given in this Application for Coverage are complete and correct. I am providing these answers as part of the application procedure required by Providence Health Plan to enroll for insurance coverage.

I understand that if this application contains any intentional material misstatements or omissions, other than misstatements or omissions related to the use of tobacco products, Providence Health Plan may rescind, modify or cancel the contract, and/or take any other legal action available to it by law. I understand that misstatements or omissions related to tobacco use may result in rate modification, to the extent permissible under state and federal law. I will promptly inform Providence Health Plan in writing if anything changes before my coverage takes effect that makes this application incomplete or incorrect.

I understand and agree that no coverage shall be in force until the effective date determined by Providence Health Plan and that Providence Health Plan may contact me to clarify answers on this application.

As the applicant, I understand I have the right to inspect the information in my file. I understand that I can visit **ProvidenceHealthPlan.com** to educate myself about Providence Health Plan's privacy practices. I understand that I can get a copy of Providence Health Plan's Notice of Privacy Practices by going to **ProvidenceHealthPlan.com/NOPP** or by calling Customer Service at 503-574-7500 or 800-878-4445 (TTY: 711).

Sign on next page →

Signature

1. I understand that this is an individual health insurance contract and I verify that neither my employer nor any third party will be paying the premium on this policy except as permitted by state or federal regulation.
2. I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.
3. I understand that I must update my information with Providence Health Plan anytime there are changes from what I wrote on this application.
4. I verify that neither I nor any of my enrolled dependentsare entitled to Medicare Part A and/or enrolled in Medicare Part B. (The federal government does not allow health plans to issue Individual coverage that duplicates coverage available through Medicare.)
5. I am the parent or legal guardian of all dependent children listed on this application.
6. I verify that the physical address I provided on this application for myself is accurate, as well as any other address provided by me for any dependents included on this application.
7. I affirm that if I choose a medical plan without pediatric dental coverage, I will obtain pediatric dental coverage through a separate Marketplace-certified pediatric dental plan, and that I will notify Providence Health Plan if I do not obtain coverage. I understand that if I do not obtain pediatric dental coverage, Providence Health Plan will discontinue my or any of my enrolled dependents health benefits until reasonable assurance is obtained.
8. I understand that:
   - Providence Health Plan will send me an offer of coverage containing the terms for initial premium payment.
   - I need to pay my initial premium payment by the due date specified on my offer of coverage to effectuate my policy.
   - After my policy has been effectuated, Providence Health Plan will send me a legal contract.
9. I understand that this application does not terminate other coverage through the Health Benefit Exchange, Providence Health Plan or other carriers.

By signing, I agree to the above conditions. Policyholder signature and date required.

Signature is considered valid only if it is hand written ("wet") or e-signed.
A copy of legal guardianship or power of attorney must accompany this form if not signed by the Policyholder.

SIGNATURE OF POLICYHOLDER, LEGAL GUARDIAN OR POWER OF ATTORNEY

DATE _____ /_____ /_____ MM/DD/YYYY

PRINT NAME

☐ Signed by Policyholder Applicant for Spouse or Domestic Partner

SIGNATURE OF SPOUSE OR DOMESTIC PARTNER (IF APPLICABLE)

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 Providence Health Plan.

I have informed the applicant that the effective date of coverage is assigned only by Providence Health Plan and provided the Washington Disclosure Information required. I certify that the information supplied to me by the applicant has been truly and accurately recorded here. **All fields are required.**

PRODUCER NAME

AGENCY NAME

PRODUCER NPN

EMAIL ADDRESS

DATE MM/DD/YYYY

PRODUCER SIGNATURE

Submission Instructions

01 Review your completed application to make sure you didn't miss anything.

Important reminder: if your application is incomplete, lacks a signature or signature date, or if additional information is required, your effective date may be delayed. Your application will expire 60 days after the signature date, and we do not accept any postdated applications.

02 Mail pages 1–8 to: or Fax pages 1–8 to:

Providence Health Plan
P.O. Box 4649
Portland, OR 97208-4649

503-574-8131

03 What happens now?

- Providence Health Plan will send you an offer of coverage that will include the amount of your initial premium payment and when it's due.
- In order for your coverage to take effect, Providence Health Plan must receive your initial premium payment by the due date listed in our offer of coverage.
- Please save a copy of this completed application for your records.

Race/Ethnicity Questionnaire

Providence Health Plan

The following questions are optional. Your responses will help us to better serve all communities.

Which of the following describes your racial or ethnic identity? Please check all that apply.

Hispanic and Latino/a/x

- ☐ Hispanic or Latino/a/x Central American
- ☐ Hispanic or Latino/a/x Mexican
- ☐ Hispanic or Latino/a/x South American
- ☐ Other Hispanic or Latino/a/x

Native Hawaiian or Pacific Islander

- ☐ Guamanian or Chamorro
- ☐ Marshallese
- ☐ Communities of the Micronesian Region
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Tongan
- ☐ Other Pacific Islander

Other

- ☐ Other
- ☐ I don't know.
- ☐ I don't want to answer.

American Indian or Alaska Native

- ☐ American Indian
- ☐ Alaska Native
- ☐ Canadian Inuit, Metis, or First Nation
- ☐ Indigenous Mexican, Central American, or South American

White

- ☐ Caucasian/White (no national affiliation)
- ☐ Eastern European/Slavic
- ☐ Western European
- ☐ Other White (African, Australian, New Zealand descent)

Middle Eastern or North African

- ☐ Middle Eastern
- ☐ North African

Black or African American

- ☐ African American
- ☐ Afro-Caribbean
- ☐ Ethiopian
- ☐ Somali
- ☐ Other African (Black)
- ☐ Afro-Latinx/Bi-racial/Other
- ☐ Other Black

Asian

- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Communities of Myanmar
- ☐ Filipino/a
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ South Asian
- ☐ Vietnamese
- ☐ Other Asian

If you checked more than one category above, is there one you think of as your primary racial or ethnic identity?

- ☐ **Yes** (please specify): _____
- ☐ **No:** I do not have just one primary racial or ethnic identity.
- ☐ **No:** I identify as Biracial or Multiracial.
- ☐ **N/A:** I only checked one category above.
- ☐ **N/A:** I don't know.
- ☐ **N/A:** I don't want to answer.

What is your preferred spoken language?

- ☐ English
- ☐ Spanish
- ☐ Chinese - Other
- ☐ Mandarin
- ☐ Cantonese
- ☐ Vietnamese
- ☐ Russian
- ☐ German
- ☐ French
- ☐ Tagalog
- ☐ Japanese
- ☐ Korean
- ☐ Arabic
- ☐ Decline/Unknown
- ☐ Other

What is your preferred written language?

- ☐ English
- ☐ Spanish
- ☐ Vietnamese
- ☐ Simplified Chinese
- ☐ Russian
- ☐ Other
- ☐ **N/A:** I don't know.
- ☐ **N/A:** I don't want to answer.

Additional Information

What is a Medical Home?

When you enroll in a Columbia plan, you are required to choose a Medical Home (also known as a Primary Care Home). A Medical Home is a cooperative, patient-centered clinic made up of providers and staff who work with you to address your physical and behavioral health needs and goals. The Medical Home you choose coordinates all elements of your care across hospitals, specialists, pharmacies, home health services, and community resources to ensure greater accessibility, shorter wait times, and an integrative approach to your health.

I'm signing up during a Special Enrollment Period due to a qualifying event. When will my coverage take effect?

If the qualifying event is birth, adoption, placement for adoption or foster care of a child, or a court order, coverage will be effective from the date of the event. All other qualifying events will be effective on the first day of the month following Providence Health Plan's receipt of your completed application. If you would prefer a prospective effective date, please call Membership Accounting at 503-574-5791 or 888-816-1300 (TTY: 711) for further instructions. For further instructions and details related to a Special Enrollment Period, visit **ProvidenceHealthPlan.com/QE**.

How do I make changes to an existing plan?

If you are an active Individual & Family Plan policyholder in the state of Washington and would like to make changes to your current plan, visit **ProvidenceHealthPlan.com/Forms** to complete an Individual & Family Plan Change Form.

This application form is only for new enrollment in an Individual & Family Plan purchased directly from Providence Health Plan. That means if you are an active member and submit this application for new enrollment, you will be enrolled in a new policy which will result in duplicate coverage and two premium payments.

Providence Health Plan

Non-discrimination Statement

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex.

Providence Health Plan and Providence Health Assurance:

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, 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, you can call us at 503-574-7500 or 800-878-4445 (TTY: 711).

If you believe that Providence Health Plan and Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Ronni Nichuals, Non-discrimination Coordinator
P.O. Box 4158
Portland, OR 97208-4158

Phone: 503-574-6236
Fax: 503-574-8757
Email: Ronni.Nichuals@providence.org

If you need help filing a grievance, call us at 503-574-7500 or 800-878-4445 (TTY: 711) for assistance.

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

Phone: 800-368-1019 or 800-537-7697 (TTY)

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

Members of Oregon Plans may file a complaint with the Division of Financial Regulation at 888-877-4894 or visit **https://drf.oregon.gov/pages/index.aspx**.

Members of Washington Plans may file a complaint with the Washington Office of the Insurance Commissioner electronically through the Office of the Insurance Commissioner Complaint portal available at **https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status**, or by phone at 800-562-6900 or 800-537-7697 (TTY: 711) or visit **www.insurance.wa.gov**. Complaint forms are available at **https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx**.

DO NOT RETURN THIS PAGE TO PROVIDENCE HEALTH PLAN

Language Access Information

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-878-4445 (TTY: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

Russian: ВНИМАНИЕ: Если Вы говорите по-русски, то Вам доступны услуги бесплатной языковой поддержки. Звоните 1-800-878-4445 (телетайп: 711).

Vietnamese: CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Xin gọi số 1-800-878-4445 (TTY: 711).

Traditional Chinese: 注意：如果您說中文，您可以免費獲得語言支援服務。請致電 1-800-878-4445 (TTY: 711)。

Kushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-878-4445 (TTY: 711).

Farsi:

توجه: اگر به زبان فارسی صحبت می‌کنید، تسهیلات زبانی به صورت رایگان به شما ارائه می‌شود. با 1-800-878-4445 (TTY: 711) تماس بگیرید.

Ukrainian: УВАГА! Якщо Ви розмовляєте українською мовою, для Вас доступні безкоштовні послуги мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

Japanese: お知らせ: 日本語での通話をご希望の場合、言語支援サービスを無料でご利用いただけます。1-800-878-4445 (TTY: 711) まで、お電話ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंले निम्न भाषा सहायता सेवाहरू नि:शुल्क रूपमा उपलब्ध छन् । 1-800-878-4445 (TTY: 711) मा फोन गर्नुहोस् ।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii gratuite de asistență lingvistică. Sunați 1-800-878-4445 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

Hmong: LUS CEEB TOOM: Yog tias koj hais lus Hmoob, cov kev pab txhais lus, muaj kev pab dawb rau koj. Hu rau 1-800-878-4445 (TTY: 711).

Cambodian: កំណត់សម្គាល់៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ អាចមានសេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃពីលោកអ្នក។ សូមហៅទូរស័ព្ទលេខ 1-800-878-4445 (TTY: 711)។

Laotian: ເຊີນຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ຈະມີການຊ່ວຍເຫຼືອ ດ້ານພາສາ ໂດຍບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ໂທ 1-800-878-4445 (TTY: 711).