2018 Washington Individual Enrollment Application and Change Request Form

Thank you for considering BridgeSpan Health Company 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.

Visit bridgespanhealth.com to review details of the plans offered.

This application is for health care coverage purchased directly through BridgeSpan Health Company. Washington law (RCW 48.43.510) requires an offer of certain health plan information before purchase or selection of a health plan. You can review that information at bridgespanhealth.com or request it from our Customer Service Department by calling 1 (800) 750-0878. Available information concerns benefits, required preauthorization, premiums and costsharing, in-network providers, appeals and grievances, accreditation, and confidentiality. If you wish to purchase coverage through the Health Benefit Exchange, you must apply directly through them.

If you need help completing your application or have questions, contact your insurance producer or call us at 1 (800) 750-0878.

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 Section 3: Qualifying events).

- ☐ I'm applying to become a new BridgeSpan member
- ☐ I'm a current BridgeSpan 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 BridgeSpan 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.

I request coverage to begin in the month of _____. (Effective date may vary based on eligibility. Coverage is not guaranteed.)

Section 2: Eligibility

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

- A resident of Washington, with a primary residence in Washington 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 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.)

When can you apply?

1. Open enrollment: Every fall, Washington holds open enrollment for individuals applying for coverage that may start on Jan. 1. You can find this year's dates on bridgespanhealth.com. We need to receive your application 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 Section 3 to learn more.

Section 3: Qualifying events

Complete Section 3 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 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.	• Copy of birth certificate; adoption or placement papers; or marriage or domestic partnership certification.
☐ You lost coverage due to divorce or termination of domestic partnership.	• Copy of divorce decree or a signed/dated statement of domestic partnership termination.
☐ 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.
☐ Your COBRA coverage exhausted.	• A letter from the COBRA administrator or prior insurance company verifying that you exhausted COBRA.
☐ You enrolled or did not receive coverage on a Qualified Health Plan due to an error by the Health Benefit Exchange, the Qualified Health Plan, or Health and Human Services.	• Documentation from the Health Benefit 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 Health Benefit Exchange reflecting the change.

Section 3: Qualifying events, continued

Which of these applies to you?	Include the following:
☐ Washington State Insurance Pool (WSHIP) discontinues your health plan.	• Evidence of discontinuation from WSHIP.
☐ 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: — Washington driver's license — Washington 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
☐ Your plan is no longer offered to the class of similarly situated persons.	• Proof of change of offer.
☐ You lost coverage because the person you had coverage through lost his or her coverage (unless the loss was due to fraud or material misrepresentation).	• Certificate of Coverage from the carrier or coverage dates from the employer or company letterhead. • Employer letter on company letterhead with the qualifying event and event date.
☐ Health Benefit Exchange terminated your Qualified Health Plan because of loss of eligibility, non-payment of premiums (and any grace period has expired), permissible rescission, or Qualified Health Plan termination or decertification.	• Certificate of Coverage or evidence of other creditable coverage.

Section 4: Subscriber information (policy holder)

Last name	First name	M.I.	Social Security number	Gender ☐ M ☐ F
Date of birth (mm/dd/yyyy) (mm/dd/yyyy)	Language preference if other than English (optional) ☐ Spanish ☐ Other (please specify)			Tobacco user* ☐ Y ☐ N
Residential street address	City	State	ZIP	County
Mailing address (if different from street address)	City	State	ZIP	County
Billing address (if different from mailing address)	City	State	ZIP	County

Home phone	Cell phone	Work phone	Email
(xxx) xxx-xxxx	(xxx) xxx-xxxx	(xxx) xxx-xxxx	Email address

Preferred communication method for application processing: ☐ Secure email ☐ US Postal Service

Do you reside, work or attend school outside the state of Washington at any time of the year? ☐ Y ☐ N	If yes, percentage of time out of state	Indicate the reason: ☐ Reside ☐ Work ☐ School (provide current registrar information) ☐ Other, please provide reason:

Will you have other medical and/or dental insurance or Medicare, while covered on this plan?
☐ Yes (complete the info. below) ☐ No

Insurance company	Policy number	Effective date (mm/dd/yyyy)	Type of coverage
		(mm/dd/yyyy)	☐ Employer group ☐ Individual ☐ Medicare ☐ Other (describe)

If any enrolling family member has other coverage in addition to BridgeSpan, we may coordinate benefits between the multiple health plans.

* A tobacco user is someone over 18 who has used tobacco in any form (other than religious or ceremonial use) four or more times per week in the past six months.

Section 5: Family information

Please list the names of everyone who is eligible who you want to cover. A dependent can be your spouse/domestic partner, children under age 26 or a child of any age who is disabled. If you are applying for coverage for children only, please submit one application per child.

Last name	First name	M.I.	Social Security number	Gender ☐ M ☐ F
Date of birth (mm/dd/yyyy) (mm/dd/yyyy)	Language preference if other than English (optional) ☐ Spanish ☐ Other (please specify)			Tobacco user* ☐ Y ☐ N
Relationship: ☐ Spouse ☐ Registered domestic partner ☐ Non-registered domestic partner** ☐ Dependent child under age 26 ☐ Disabled child				
Does this person reside, work or attend school outside the state of Washington at any time of the year? ☐ Y ☐ N	If yes, percentage of time out of state	Indicate the reason: ☐ Reside ☐ Work ☐ School (provide current registrar information) ☐ Other, please provide reason:		
Will this person have other medical and/or dental insurance or Medicare, while covered on this plan? ☐ Yes (complete the info. below) ☐ No				
Insurance company	**Policy number**	**Effective date (mm/dd/yyyy)**	**Type of coverage**	
		(mm/dd/yyyy)	☐ Employer group ☐ Individual ☐ Medicare ☐ Other (describe)	

If any enrolling family member has other coverage in addition to BridgeSpan, we may coordinate benefits between the multiple health plans.

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**Non-registered domestic partners must submit an Affidavit of Domestic Partnership.

Section 5: Family information, continued

Last name	First name	M.I.	Social Security number	Gender ☐ M ☐ F
Date of birth (mm/dd/yyyy) (mm/dd/yyyy)	Language preference if other than English (optional) ☐ Spanish ☐ Other (please specify)			Tobacco user* ☐ Y ☐ N
Relationship: ☐ Dependent child under age 26 ☐ Disabled child				
Does this person reside, work or attend school outside the state of Washington at any time of the year? ☐ Y ☐ N	If yes, percentage of time out of state	Indicate the reason: ☐ Reside ☐ Work ☐ School (provide current registrar information) ☐ Other, please provide reason:		
Will this person have other medical and/or dental insurance or Medicare, while covered on this plan? ☐ Yes (complete the info. below) ☐ No				
Insurance company	**Policy number**	**Effective date (mm/dd/yyyy)**	**Type of coverage**	
		(mm/dd/yyyy)	☐ Employer group ☐ Individual ☐ Medicare ☐ Other (describe)	

Last name	First name	M.I.	Social Security number	Gender ☐ M ☐ F
Date of birth (mm/dd/yyyy) (mm/dd/yyyy)	Language preference if other than English (optional) ☐ Spanish ☐ Other (please specify)			Tobacco user* ☐ Y ☐ N
Relationship: ☐ Dependent child under age 26 ☐ Disabled child				
Does this person reside, work or attend school outside the state of Washington at any time of the year? ☐ Y ☐ N	If yes, percentage of time out of state	Indicate the reason: ☐ Reside ☐ Work ☐ School (provide current registrar information) ☐ Other, please provide reason:		
Will this person have other medical and/or dental insurance or Medicare, while covered on this plan? ☐ Yes (complete the info. below) ☐ No				
Insurance company	**Policy number**	**Effective date (mm/dd/yyyy)**	**Type of coverage**	
		(mm/dd/yyyy)	☐ Employer group ☐ Individual ☐ Medicare ☐ Other (describe)	

If any enrolling family member has other coverage in addition to BridgeSpan, we may coordinate benefits between the multiple health plans.

*A tobacco user is someone over 18 who has used tobacco in any form (other than religious or ceremonial use) four or more times per week in the past six months.

Section 5: Family information, continued

Last name	First name	M.I.	Social Security number	Gender ☐ M ☐ F
Date of birth (mm/dd/yyyy) (mm/dd/yyyy)	Language preference if other than English (optional) ☐ Spanish ☐ Other (please specify)			Tobacco user* ☐ Y ☐ N
Relationship: ☐ Dependent child under age 26 ☐ Disabled child				
Does this person reside, work or attend school outside the state of Washington at any time of the year? ☐ Y ☐ N	If yes, percentage of time out of state	Indicate the reason: ☐ Reside ☐ Work ☐ School (provide current registrar information) ☐ Other, please provide reason:		
Will this person have other medical and/or dental insurance or Medicare, while covered on this plan? ☐ Yes (complete the info. below) ☐ No				
Insurance company	**Policy number**	**Effective date (mm/dd/yyyy)**	**Type of coverage**	
		(mm/dd/yyyy)	☐ Employer group ☐ Individual ☐ Medicare ☐ Other (describe)	

Last name	First name	M.I.	Social Security number	Gender ☐ M ☐ F
Date of birth (mm/dd/yyyy)	Language preference if other than English (optional) ☐ Spanish ☐ Other (please specify)			Tobacco user* ☐ Y ☐ N
Relationship: ☐ Dependent child under age 26 ☐ Disabled child				
Does this person reside, work or attend school outside the state of Washington at any time of the year? ☐ Y ☐ N	If yes, percentage of time out of state	Indicate the reason: ☐ Reside ☐ Work ☐ School (provide current registrar information) ☐ Other, please provide reason:		
Will this person have other medical and/or dental insurance or Medicare, while covered on this plan? ☐ Yes (complete the info. below) ☐ No				
Insurance company	**Policy number**	**Effective date (mm/dd/yyyy)**	**Type of coverage**	
			☐ Employer group ☐ Individual ☐ Medicare ☐ Other (describe)	

If any enrolling family member has other coverage in addition to BridgeSpan, we may coordinate benefits between the multiple health plans.

*A tobacco user is someone over 18 who has used tobacco in any form (other than religious or ceremonial use) four or more times per week in the past six months.

If you have more dependents, print an additional page 7 or use a separate piece of paper.

Section 6: Plan options

Below are the plan choices available to you based on your county of residence. Check one box to indicate your health plan selection.

Benton, Franklin, Klickitat, Walla Walla, and Yakima:

- ☐ Gold Essential 1200 EPO RealValue
- ☐ Silver HDHP 3000 EPO RealValue
- ☐ Silver Essential 4000 EPO RealValue
- ☐ Bronze HDHP 6000 EPO RealValue
- ☐ Bronze Essential 7150 EPO RealValue

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 bridgespanhealth.com to learn which doctors and hospitals are in each network.

If you selected a high-deductible health plan (HDHP):

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

- ☐ Yes, I authorize BridgeSpan to share my eligibility and claims information with HealthEquity for the purposes of establishing and administering my HealthEquity Health Savings Account (Social Security number must be provided in Section 4).

  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 7: Payment options

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

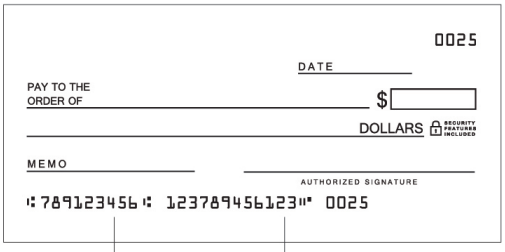
Depending on the timing of your effective date, your first premium payment may have to cover multiple months. If more than one month's premium is due for the first draft, do you authorize BridgeSpan to pull the full amount from your account?

☐ 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 BridgeSpan 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 BridgeSpan.

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)



Transit/ routing number

Account number

SECTION 8: Signatures

Your spouse/domestic partner and dependents age 18 and older must also sign, if applicable. All signatures apply to "Certification of Completion and Correctness" and "Authorization for Use and Disclosure of Protected Health Information."

Certification of Completion and Correctness

- The answers I provided in this application for enrollment are complete and correct.
- I understand that BridgeSpan relies on these answers when making coverage and rating decisions.
- It is a crime to knowingly provide false, incomplete or misleading information for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of benefits.
- If coverage is terminated due to fraud or intentionally misleading statements, BridgeSpan will reimburse my premiums minus any amount paid for my claims; if the amount BridgeSpan has paid in claims is greater than the premiums I paid, I will have to reimburse BridgeSpan for the difference.
- I will inform BridgeSpan in writing if anything happens before my effective date that makes this application incomplete or incorrect.
- I do not have coverage until BridgeSpan approves my application and assigns an effective date.
- BridgeSpan may contact me to clarify information in this application.
- I understand that I have the right to inspect the information in my file.
- I understand that if I answered "No" to being a tobacco user and my answer changes to "Yes" any time after submitting this application, I must notify BridgeSpan. A surcharge will be applied.*

Authorization for Use and Disclosure of Protected Health Information

I understand that BridgeSpan may request or disclose health information about me or my covered dependents for the purpose of facilitating health care, payments or benefit administration, or as required by law.

This health information may be related to treatment or services performed by:

- A doctor, 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
- Another insurance carrier or health plan

Health information may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, lab reports, dental records, or hospital records (including nursing records and progress notes). This authorization may not be used for psychotherapy notes; such notes will require a separate authorization.

For more information, please see the BridgeSpan Consumer Privacy Notice available at bridgespanhealth.com or by calling 1 (855) 857-9943.

* A surcharge is applied to your premium for each person covered by your plan who uses tobacco. If we receive false information about tobacco usage or if you fail to notify BridgeSpan of a change in tobacco usage, BridgeSpan can collect unpaid surcharges and take any other available action.

SECTION 8: Signatures, continued

Signatures are required for all applicants age 18 or older	
Signature of subscriber (parent/legal guardian). Subscriber must also sign if adding spouse/domestic partner or child.*	Date (mm/dd/yyyy)
Signature of applicant's legal spouse or eligible domestic partner **	Date (mm/dd/yyyy)
Signature of dependent age 18 or older ***	Date (mm/dd/yyyy)
Signature of dependent age 18 or older ***	Date (mm/dd/yyyy)
Signature of dependent age 18 or older ***	Date (mm/dd/yyyy)
Signature of dependent age 18 or older ***	Date (mm/dd/yyyy)

*If not the subscriber, I am the: ☐ Parent ☐ Power of attorney ☐ Legal guardian
(If you are the legal guardian or power of attorney for the applicant, attach legal documentation.)
**If not the legal spouse or eligible domestic partner, I am the: ☐ Power of attorney ☐ Legal guardian
***If not the dependent, I am the: ☐ Parent ☐ Power of attorney ☐ Legal guardian

Please print your name if you check any of the boxes above:

_____

Section 9: Comments

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

Section 10: 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 BridgeSpan. I have informed the applicant that the effective date of coverage is assigned only by BridgeSpan. **I certify that the information supplied to me by the applicant has been truly and accurately recorded here.**

Name (please print or type)	BridgeSpan producer number	
Mailing address	Email Email address	Phone number (xxx) xxx-xxxx
Signature (required)		Date (required) (mm/dd/yyyy)

Congratulations you're almost done!

Mail, fax or email this form to BridgeSpan Health.

Mail:

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

Fax:

1-877-369-3410

Email:

BSH-Email@bridgespanhealth.com

Questions?

Talk to your producer. Call us at 1 (800) 750-0878.

New to BridgeSpan?

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

BridgeSpan 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 BridgeSpan, and other services. These incentives may have an indirect impact on your rates. Please talk to your producer to learn more.

NONDISCRIMINATION NOTICE

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

BridgeSpan Health:
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:

Customer Service
1-855-857-9943 (TTY: 711)

If you believe that BridgeSpan Health 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:

Customer Service
Civil Rights Coordinator
M/S CS B32B, P.O. Box 1271
Portland, OR 97207-1271
1-855-857-9943, (TTY: 711)
Fax: 1-888-309-8784
CS@BridgeSpanHealth.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 1-855-857-9943 (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 1-855-857-9943 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-857-9943 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-857-9943 (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 1-855-857-9943 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-857-9943 (телетайп: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-857-9943 (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。1-855-857-9943（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 1-855-857-9943 (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 1-855-857-9943 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-857-9943 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-855-857-9943 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-855-857-9943 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-855-857-9943 (TTY: 711)

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