Application for Health Insurance Open Enrollment Period

Purpose

The purpose of this form is to help you apply for health insurance during Open Enrollment. Filling out this form means you are applying for an individual or family plan with Sharp Health Plan.

Instructions

One application is required and all enrollees must be on the same plan design. A separate application is required if any family members want a different plan design, or if a child is enrolling without a parent. If a child is enrolling without a parent, the information must be filled out in the subscriber section of the application

Submit

By Mail or In Person:

Sharp Health Plan
Attention: IFP Sales
8520 Tech Way, Suite 200
San Diego, CA 92123

By Fax:
Attention: IFP Sales
1-858-499-8246

Expedite this application by applying online at **sharphealthplan.com/get-a-quote.**

Make a Payment

To pay your premium with your debit or credit card, please visit sharphealthplan.com/payment, or mail your check or money order to:

Sharp Health Plan
P.O. Box 57248
Los Angeles, CA 90074-7248

If you need assistance, we're here to help.

You can call our IFP Sales Team at 1-858-499-8211 or email us at IFPSales@sharp.com.
We are available to assist you Monday through Friday, 8 a.m. to 5 p.m.

Preliminary Information

Are you currently enrolled in a Sharp Health Plan Individual or Family Plan? ☐ Yes ☐ No

If yes, please enter your subscriber identifier number (provided on renewal letter):

Are you making any changes to your current policy? ☐ Yes - Changes to plan design ☐ Yes - Add dependents ☐ No changes

Step 1a. Subscriber Information (policy holder) Please print.

First name:	Middle initial:	Last name:

Birth date: MM/DD/YY (/ /)	Social Security number: – –	Marital status: ☐ Single ☐ Married ☐ Widowed ☐ State registered domestic partner ☐ Child only application	Sex: ☐ M ☐ F

Home address (P.O. Box is not allowed):		
City:	State:	ZIP code:
Billing address (If different from above):		
City:	State:	ZIP code:

Best phone number to reach you: ☐ Home ☐ Cell ☐ Work ( )	Other phone number: ☐ Home ☐ Cell ☐ Work ( )
Email address:	
Do you want to get information about this application by email? ☐ Yes ☐ No	Are you willing to receive information from Sharp Health Plan by email and/or text? For text, message or data rates may apply. ☐ Yes ☐ No
Please note any communication assistance or special needs:	
Preferred spoken or written language (if not English):	
Do you currently have health coverage with another carrier? (If yes, please fill out the following fields) ☐ Yes ☐ No	Is this an employer-sponsored health plan? ☐ Yes ☐ No
Carrier name:	Type of coverage (e.g., Medicare):

To find a Sharp Health Plan-affiliated doctor who meets your needs, and their provider ID, please visit **sharphealthplan.com** and select "Find a Doctor," or call Customer Care at 1-800-359-2002.

Primary care physician (If left blank, Sharp Health Plan will assign a PCP.):		Are you an existing patient with this doctor? ☐ Yes ☐ No
Name:	Provider ID:	

If this is a child under the age of 18, who is financially responsible for applicant?		
Name:	Signature: x	Date:

Pediatric Dental

Please note applicants under age 19 will automatically be enrolled in a pediatric dental plan with Access Dental Plan. To find an Access Dental Plan dentist, visit **www.PremierLife.com**, select "Find a Dentist" and choose the Individual Dental HMO plan for your area.

Primary care dentist provider ID:	Primary care dentist office ID:	Are you an existing patient with this dentist? ☐ Yes ☐ No

DHMO benefit plans are underwritten by Access Dental Plan, a wholly-owned subsidiary of The Guardian Life Insurance Company of America. Access Dental Plan is a specialized health care service plan licensed in the State of California under the Knox-Keene Act of 1975.

Pediatric Vision

Please note applicants under age 19 will automatically be enrolled on a pediatric vision plan. Services are provided by Vision Service Plan (VSP). To search a list of available eye doctors, go to **www.vsp.com/advantage**.

Step 1b. Person Two

Complete the following information for each person you wish to add to this policy. Otherwise, skip to Step 2.

First name:		Middle initial:	Last name:	
Birth date: MM/DD/YY (/ /)	Social Security number: – –	Relationship to subscriber: ☐ Spouse ☐ Child ☐ State registered domestic partner		Sex ☐ M ☐ F
☐ Address is same as subscriber	Home address (P.O. Box is not allowed):			
City:		State:	ZIP code:	
Billing address (If different from above):				
City:		State:	ZIP code:	
Best phone number: ☐ Home ☐ Cell ☐ Work ( )		Other phone number: ☐ Home ☐ Cell ☐ Work ( )		
Email address:				
Preferred spoken or written language (if not English):				
Does this person currently have health coverage? (If yes, please fill out the fields below.) ☐ Yes ☐ No				
Will this person be covered by this health insurer during their policy with Sharp Health Plan? ☐ Yes ☐ No		Is this an employer-sponsored health plan? ☐ Yes ☐ No		
Carrier name:		Type of coverage (e.g., Medicare):		

To find a Sharp Health Plan-affiliated doctor who meets your needs, and their Provider ID, please visit **sharphealthplan.com** and select "Find a Doctor," or call Customer Care at 1-800-359-2002.

Primary care physician (If left blank, Sharp Health Plan will assign a PCP.):		Are you an existing patient with this doctor? ☐ Yes ☐ No	
Name:	Provider ID:		
Is this person a child under the age of 18? ☐ Yes ☐ No If yes, who is financially responsible for applicant?			
Name:	Signature: x		Date:

Pediatric Dental

Please note applicants under age 19 will automatically be enrolled in a pediatric dental plan with Access Dental Plan. To find an Access Dental Plan dentist, visit **www.PremierLife.com**, select "Find a Dentist" and choose the Individual Dental HMO plan for your area.

Primary care dentist provider ID:	Primary care dentist office ID:	Are you an existing patient with this dentist? ☐ Yes ☐ No

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Pediatric Vision

Please note applicants under age 19 will automatically be enrolled on a pediatric vision plan. Services are provided by Vision Service Plan (VSP). To search a list of available eye doctors, go to **www.vsp.com/advantage**.

Step 1b. Person Three Complete the following information for each person you wish to add to this policy. Otherwise, skip to Step 2.

First name:	Middle initial:	Last name:	
Birth date: MM/DD/YY (/ /)	Social Security number: – –	Relationship to subscriber: ☐ Spouse ☐ Child ☐ State registered domestic partner	Sex ☐ M ☐ F
☐ Address is same as subscriber	Home address (P.O. Box is not allowed):		

City:	State:	ZIP code:
Billing address (If different from above):		
City:	State:	ZIP code:

Best phone number: ☐ Home ☐ Cell ☐ Work ( )	Other phone number: ☐ Home ☐ Cell ☐ Work ( )
Email address:	
Preferred spoken or written language (if not English):	
Does this person currently have health coverage? (If yes, please fill out the fields below.) ☐ Yes ☐ No	
Will this person be covered by this health insurer during their policy with Sharp Health Plan? ☐ Yes ☐ No	Is this an employer-sponsored health plan? ☐ Yes ☐ No
Carrier name:	Type of coverage (e.g., Medicare):

To find a Sharp Health Plan-affiliated doctor who meets your needs, and their Provider ID, please visit **sharphealthplan.com** and select "Find a Doctor," or call Customer Care at 1-800-359-2002.

Primary care physician (If left blank, Sharp Health Plan will assign a PCP.):		Are you an existing patient with this doctor? ☐ Yes ☐ No
Name:	Provider ID:	

Is this person a child under the age of 18? ☐ Yes ☐ No If yes, who is financially responsible for applicant?

Name:	Signature: x	Date:

Pediatric Dental

Please note applicants under age 19 will automatically be enrolled in a pediatric dental plan with Access Dental Plan. To find an Access Dental Plan dentist, visit **www.PremierLife.com**, select "Find a Dentist" and choose the Individual Dental HMO plan for your area.

Primary care dentist provider ID:	Primary care dentist office ID:	Are you an existing patient with this dentist? ☐ Yes ☐ No

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Pediatric Vision

Please note applicants under age 19 will automatically be enrolled on a pediatric vision plan. Services are provided by Vision Service Plan (VSP). To search a list of available eye doctors, go to **www.vsp.com/advantage**.

Step 1b. Person Four
Complete the following information for each person you wish to add to this policy. Otherwise, skip to Step 2.

First name:	Middle initial:	Last name:

Birth date: MM/DD/YY (/ /)	Social Security number: – –	Relationship to subscriber: ☐ Spouse ☐ Child ☐ State registered domestic partner	Sex ☐ M ☐ F
☐ Address is same as subscriber	Home address (P.O. Box is not allowed):		

City:	State:	ZIP code:
Billing address (If different from above):		
City:	State:	ZIP code:

Best phone number: ☐ Home ☐ Cell ☐ Work ( )	Other phone number: ☐ Home ☐ Cell ☐ Work ( )
Email address:	
Preferred spoken or written language (if not English):	
Does this person currently have health coverage? (If yes, please fill out the fields below.) ☐ Yes ☐ No	
Will this person be covered by this health insurer during their policy with Sharp Health Plan? ☐ Yes ☐ No	Is this an employer-sponsored health plan? ☐ Yes ☐ No
Carrier name:	Type of coverage (e.g., Medicare):

To find a Sharp Health Plan-affiliated doctor who meets your needs, and their Provider ID, please visit **sharphealthplan.com** and select "Find a Doctor," or call Customer Care at 1-800-359-2002.

Primary care physician (If left blank, Sharp Health Plan will assign a PCP.):		Are you an existing patient with this doctor? ☐ Yes ☐ No
Name:	Provider ID:	

Is this person a child under the age of 18? ☐ Yes ☐ No If yes, who is financially responsible for applicant?		
Name:	Signature: x	Date:

Pediatric Dental
Please note applicants under age 19 will automatically be enrolled in a pediatric dental plan with Access Dental Plan. To find an Access Dental Plan dentist, visit **www.PremierLife.com**, select "Find a Dentist" and choose the Individual Dental HMO plan for your area.

Primary care dentist provider ID:	Primary care dentist office ID:	Are you an existing patient with this dentist? ☐ Yes ☐ No

DHMO benefit plans are underwritten by Access Dental Plan, a wholly-owned subsidiary of The Guardian Life Insurance Company of America. Access Dental Plan is a specialized health care service plan licensed in the State of California under the Knox-Keene Act of 1975.

Pediatric Vision
Please note applicants under age 19 will automatically be enrolled on a pediatric vision plan. Services are provided by Vision Service Plan (VSP). To search a list of available eye doctors, go to **www.vsp.com/advantage**.

Step 2. Plan Selection

When selecting a plan, you must ensure that you either live or work in a ZIP code that is within that plan's network. To find a list of ZIP codes associated with each network, please visit **sharphealthplan.com/networks-by-zip**. Once you have confirmed your network, you must then select a benefit plan from the list below.

Plan Name (select one)	Metal Tier	Network
☐ Sharp Platinum 90 HMO Performance	Platinum	Performance
☐ Sharp Platinum 90 HMO Premier	Platinum	Premier
☐ Sharp Gold 80 HMO Performance	Gold	Performance
☐ Sharp Gold 80 HMO Premier	Gold	Premier
☐ Sharp Silver 70 HMO Premier	Silver	Premier
☐ Sharp Silver 70 HMO Performance	Silver	Performance
☐ Sharp Bronze 60 HMO Performance	Bronze	Performance
☐ Sharp Bronze 60 HDHP HMO Premier	Bronze	Premier
☐ Sharp Minimum Coverage HMO Performance*	Minimum Coverage	Performance

☐ I confirm that I live or work in a ZIP code within the plan network of the benefit plan that I have selected.

Additionally, each plan has a designated group of physicians and hospitals associated with it, known as a plan medical group (PMG). The plan you select will determine the doctors that are available to you. To find a Sharp Health Plan-affiliated doctor who meets your needs, please visit **sharphealthplan.com** and select "Find a Doctor" to find a doctor near you, or call Customer Care at 1-800-359-2002. Please be sure to select a doctor that is affiliated with the plan network for the benefit plan you would like to enroll in. **If you leave the primary care physician (PCP) field blank in Step 1, then Sharp Health Plan will assign a PCP to you automatically.**

Effective date of coverage

What is the requested effective date of your medical policy? ____

During Open Enrollment (October 15 – January 15), the following effective dates will apply:

Complete Application Received	Effective Date
Oct. 15, 2018 – Dec. 15, 2018	Jan. 1, 2019
Dec. 16, 2018 – January 15, 2019	Feb. 1, 2019

For all application dates, your first premium payment must be received prior to your effective date in order to activate your coverage.

*Minimum coverage plans are available to individuals under the age of 30, as of the effective date of coverage. They are also available to those that have received a certificate of exemption from Covered California due to affordability or hardship. If an applicant is 30 years of age or older, the certificate of exemption must be provided to Sharp Health Plan in order to process the application.

Step 3. Broker Section

Did you work with a broker? ☐ Yes ☐ No

Broker name:	Agency name:	License number:

Address (P.O. Box is not allowed):

City:	State:	ZIP code:

Phone number: ( )	Email address:

Notice to Agent, Broker, Representative: If you have assisted the applicant in submitting this application, the law requires that you attest to this assistance. If you state any material fact you know to be false, you are subject to a civil penalty of up to ten thousand dollars ($10,000), as authorized under California Health and Safety Code section 1389.8(c) or Insurance Code section 10119.3.

Select one:

☐ I assisted the applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information, and the applicant understood the explanation.

☐ I did not assist the applicant in any way in completing or submitted this application. All information was completed by the applicant with no assistance or advice from me.

Agent, broker or representative signature: x	Date:

Step 4. Disclosures and Signatures

Please read the following carefully. Each applying family member age 18 and older is required to review the completed application and provide their own signature on the following page. Keep a copy of this application for your records.

Access Dental Disclosures

I understand that if I have indicated that coverage under the Plan is to be provided only for the dependent child on this form, I am responsible for payment of the required Premium and compliance with all of the provisions and conditions of the Disclosure Form/ Contract.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. Access Dental Plan will not require that an HIV test be required as a condition of obtaining coverage. In accordance with California Health and Safety Code section 120980, Access Dental Plan complies in all respects with the prohibition against the unauthorized disclosures of an HIV test.

RIGHT OF REIMBURSEMENT: I, on my behalf of my Dependent(s) listed on this Enrollment Application, hereby agree that in the event any dental services provided to me or my Dependent(s) covered by Access Dental Plan are the primary financial responsibility of another party because of other dental coverage, I will fully inform Access Dental Plan and will execute such assignments, liens or other documents which may be necessary to enable Access Dental Plan to recover the value of services and supplies provided.

NOTICE: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud and may be subject to fines and confinement in prison.

In accordance with the disclosure requirements of California Health & Safety Code, Section 1363 (h), this is to advise you that Access Dental Plan's ratio of health care expenses to premiums received for the last calendar year with respect to Access Dental Plan's Individual & Family Plans was 62.0%.

MANDATORY BINDING ARBITRATION: I understand that any dispute or controversy that may arise between me and Access Dental Plan shall be submitted to binding arbitration held in accordance with the commercial arbitration rules of the American Arbitration Association in lieu of a jury or court trial, and that should any dispute arise, neither Access Dental Plan nor I may pursue any claims as a plaintiff or class member in any purported class or representative proceeding, and instead must pursue any such claims in an individual capacity. Both Access Dental Plan and I expressly waive any right to initiate or arbitrate a class action against one another relative to any disputes relating to or arising in any way out of my enrollment with Access Dental Plan's affiliates. The arbitration proceeding will take place in Sacramento, California or, if that location is prohibitive or significantly inconvenient to the parties, at an alternate location selected by the American Arbitration Association.

(continued on next page)

Step 4, continued

Sharp Health Plan Disclosures

- I alone am responsible for the accuracy and completeness of the information provided on this application. I have personally reviewed all information provided on this application, even if I did not fill out the application myself. To the best of my knowledge and belief, all information on this application is accurate, true and complete. If Sharp Health Plan determines that there is fraud (by act, practice or omission) or an intentional misrepresentation of material fact in the information on this application, I understand that coverage may be rescinded as allowed by law.
- Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud and may be subject to fines and confinement in prison. In accordance with the disclosure requirements of California Health & Safety Code, Section 1363 (h), this is to advise you that Premier Access' ratio of health care expenses to premiums received for the last calendar year with respect to the Premier Access Individual & Family Plans was 60.0%.
- In order to determine fraud, I understand that I may be subject to an audit by Sharp Health Plan, at which time I will need to provide proof of residency, date of birth and dependent eligibility (if applicable). I further understand that I must provide Sharp Health Plan with any new information that arises after the submission of this application but before my enrollment with Sharp Health Plan begins.
- If I indicated in Step 1 that I have a language preference other than English and have completed the English version of this application (or version other than in my language preference), I confirm that I understand the questions on this application.
- I understand that California law prohibits an HIV test from being required or used by health care plans as a condition of obtaining coverage.
- Depending on income level and family size, I understand that I may be eligible for financial assistance to help pay for health coverage if I purchase my coverage through Covered California. Sharp Health Plan benefit plans are available through Covered California. I must apply during an open or special enrollment period. Open enrollment is from November 1st through December 15th. Special enrollment periods for all individuals enrolling through Covered California are from October 15th through October 31st and from December 16th through January 15th. An application submitted during these two special enrollment periods will be treated the same as an application submitted during the open enrollment period. However, I understand that in order for coverage to begin on January 1st, I must submit my application on or before December 15th of the preceding calendar year. If I have a life change such as marriage, divorce, a new child or loss of a job, I can apply at the time the life change occurs ("Special Enrollment period").
- **I understand that any dispute or controversy that may arise regarding the performance, interpretation or breach of the agreement between myself (and/or any enrolled dependent) and Sharp Health Plan, whether arising in contract, tort or otherwise, must be submitted to arbitration in lieu of a jury or court trial if not satisfactorily resolved through Sharp Health Plan's grievance process.**

Subscriber (or person financially responsible for subscriber if under 18)		
Name:	Signature: x	Date:
Person Two (over 18) (if applicable)		
Name:	Signature: x	Date:
Person Three (over 18) (if applicable)		
Name:	Signature: x	Date:
Person Four (over 18) (if applicable)		
Name:	Signature: x	Date:

Nondiscrimination Notice

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

Sharp Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Information in other formats (such as large print, audio, accessible electronic formats, or other formats) free of charge
- 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, contact Customer Care at 1-800-359-2002.

If you believe that Sharp Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance with our Civil Rights Coordinator at:

- Address: Sharp Health Plan Appeal/Grievance Department 8520 Tech Way, Suite 200 San Diego, CA 92123-1450
- Telephone: 1-800-359-2002 (TTY: 711) Fax: (619) 740-8572

You can file a grievance in person or by mail, fax, or you can also complete the online Grievance/Appeal form on the Plan's website **sharphealthplan.com**. Please call our Customer Care team at 1-800-359-2002 if you need help filing a grievance. You can also file a discrimination complaint if there is a concern of discrimination based on race, color, national origin, age, disability, or sex 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, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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

The California Department of Managed Health Care is responsible for regulating health care service plans. If your Grievance has not been satisfactorily resolved by Sharp Health Plan or your Grievance has remained unresolved for more than 30 days, you may call toll-free the Department of Managed Care for assistance:

- 1-888-HMO-2219 Voice
- 1-877-688-9891 TDD

The Department of Managed Care's Internet Web site has complaint forms and instructions online: **http://www.hmohelp.ca.gov**.

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call Sharp Health Plan right away at 1-858-499-8300 or 1-800-359-2002.

IMPORTANTE: ¿Puede leer esta carta? Si no le es posible, podemos ofrecerle ayuda para que alguien se la lea. Además, usted también puede obtener esta carta en su idioma. Para ayuda gratuita, por favor llame a Sharp Health Plan inmediatamente al 1-858-499-8300 o 1-800-359-2002.

Language Assistance Services

English
ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-359-2002 (TTY:711).

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-359-2002 (TTY:711).

繁體中文 (Chinese)
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 1-800-359-2002 (TTY:711)。

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-359-2002 (TTY:711).

Tagalog (Tagalog – Filipino):
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-359-2002 (TTY:711).

한국어 (Korean):
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-359-2002 (TTY:711) 번으로 전화해 주십시오.

Հայերեն (Armenian):
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-359-2002 (TTY (հեռատիպ)՝ 711).

فارسی (Farsi):
توجه :اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY:711) 1-800-359-2002 تماس بگیرید.

Русский (Russian):
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.
Звоните 1-800-359-2002 (телетайп: 711).

日本語 (Japanese):
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。1-800-359-2002 (TTY:711) まで、お電話にてご連絡ください。

ةيبرعلا (Arabic):
ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. تصل برقم 1-800-359-2002 (رقم هاتف الصم والبكم: 711).

ਪੰਜਾਬੀ (Punjabi):
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-359-2002 (TTY:711) 'ਤੇ ਕਾਲ ਕਰੋ।

ខ្មែរ (Mon Khmer, Cambodian):
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-359-2002 (TTY: 711)។

Hmoob (Hmong):
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-359-2002 (TTY:711).

हिंदी (Hindi):
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-338-9551 (TTY: 711) पर कॉल करें।

ภาษาไทย (Thai):
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-359-2002 (TTY:711).