KAISER PERMANENTE®

342481868

Individual and Family Plans

Account Change Form

California

Instructions

- There are different types of plan changes and account changes you can make with this form. Please fill out your personal information in Section A. Then select what changes you'd like to make in Section B, and continue on to fill out any other sections related to those changes.
- If you're adding a dependent to your plan, any other coverage they have won't be automatically canceled. To avoid paying 2 premiums or having a gap in coverage, make sure to cancel any other coverage they have as of the day before their new coverage starts.
- If you're making a plan change due to a special enrollment period, go to **kp.org/specialenrollment** or call **1-800-464-4000** to learn what proof you may need to submit for your qualifying life event – and when your plan effective date will be. You may have more than one event. Choose the one with the best plan effective date for you.
- Note: If you or any dependent you're applying for are entitled to Medicare Part A or enrolled in Medicare Part B, you're not eligible to switch Kaiser Permanente for Individuals and Families (KPIF) plans.

A. Fill out your information

Please select one: I'm the ☐ subscriber, ☐ spouse/domestic partner, or dependent child 18 and older, or ☐ parent or legal guardian
If you're making a change, please update the boxes below with your new information.

First name

MI

Gender:
☐ Male ☐ Female
☐ Undeclared

Last name

Date of birth (mm/dd/yyyy)
/ /

Medical record number (if any)

Social Security number (if any)
- -

Phone
- -

Home address (no P.O. boxes, please)

City

State

ZIP code

Mailing address ☐ Check if the same as the home address.

City

State

ZIP code

B. What change(s) do you want to make?

- Please check the boxes below for the changes you wish to make, and on the next page, list each family member affected. We won't make any changes for any family members on your account you don't list.
- Subscribers (or the parent or legal guardian for subscribers under 18) can make all the changes below for any family members. Dependents can make some of the changes, only for themselves – see those changes marked with an asterisk (*) below.

You can make the following changes any time during the year. *(Note: For these changes, you can skip Sections D and E.)*

- ☐ I'm ending my coverage and I wish to have my spouse/domestic partner as the subscriber.
- ☐ I'm ending my coverage on a family plan and wish to continue on my own on an individual plan.*
- ☐ I wish to change the subscriber.
- ☐ I wish to change the parent/legal guardian on a child-only account.
- ☐ I wish to end medical coverage for myself* or for a family member.
- ☐ I'm ending my coverage but wish to keep my child(ren) on the plan.
- ☐ I'm ending my and my spouse's/domestic partner's coverage but wish to keep our child(ren) on the plan.
- ☐ I wish to make the changes shown in Section A. (If you're changing your name, please include legal documentation of the change.)*

You can make the following changes only during open enrollment or a special enrollment period.
(Restrictions apply for special enrollment periods. See **kp.org/specialenrollment** for more information.)

- ☐ I wish to combine accounts.
- ☐ I wish to add medical coverage for a family member.
- ☐ I wish to change plans.*
- ☐ I wish to add optional adult dental coverage (for members 19 and older).*
- ☐ I wish to end optional adult dental coverage*

C. Which family members are affected by the change? (Please list below.)

If you have more than 4 dependents with a change, attach a copy of this page and complete the information for those dependents.

Spouse/domestic partner

☐ Add medical coverage ☐ End medical coverage ☐ Add optional adult dental coverage ☐ End optional adult dental coverage

First name | MI | Last name

Choose one: ☐ Spouse ☐ Domestic partner

Social Security number (if any) ___-___-___

Medical record number (if any)

Date of birth (mm/dd/yyyy) ___/___/___

Gender: ☐ Male ☐ Female ☐ Undeclared

Dependent 1

☐ Add medical coverage ☐ End medical coverage ☐ Add optional adult dental coverage ☐ End optional adult dental coverage

First name | MI | Last name

Gender: ☐ Male ☐ Female ☐ Undeclared

Social Security number (if any) ___-___-___

Medical record number (if any)

Date of birth (mm/dd/yyyy) ___/___/___

Dependent 2

☐ Add medical coverage ☐ End medical coverage ☐ Add optional adult dental coverage ☐ End optional adult dental coverage

First name | MI | Last name

Gender: ☐ Male ☐ Female ☐ Undeclared

Social Security number (if any) ___-___-___

Medical record number (if any)

Date of birth (mm/dd/yyyy) ___/___/___

Dependent 3

☐ Add medical coverage ☐ End medical coverage ☐ Add optional adult dental coverage ☐ End optional adult dental coverage

First name | MI | Last name

Gender: ☐ Male ☐ Female ☐ Undeclared

Social Security number (if any) ___-___-___

Medical record number (if any)

Date of birth (mm/dd/yyyy) ___/___/___

Dependent 4

☐ Add medical coverage ☐ End medical coverage ☐ Add optional adult dental coverage ☐ End optional adult dental coverage

First name | MI | Last name

Gender: ☐ Male ☐ Female ☐ Undeclared

Social Security number (if any) ___-___-___

Medical record number (if any)

Date of birth (mm/dd/yyyy) ___/___/___

D. When are you making a change?

Select one option: ☐ Open enrollment **(skip to Section E)** ☐ A special enrollment period (continue below)

Choose the life event that made you eligible for a special enrollment period (please choose only one):

- ☐ Loss of health care coverage (write the last full day you had coverage)*
- ☐ Gaining or becoming a dependent through marriage or domestic partnership registration
- ☐ Gaining or becoming a dependent through the birth of a child, adoption, foster care, or placement for adoption or foster care
  Note: In this case, you also need to choose between 2 effective date options:
  - ☐ The date of birth, adoption, foster care, or placement for adoption or foster care
  - ☐ The first day of the month after we receive the form
- ☐ Losing a dependent through divorce, dissolution of domestic partnership, or legal separation
- ☐ Death of the subscriber or a dependent
- ☐ Child support order or other court order to cover a dependent
- ☐ Permanent relocation
- ☐ Release from incarceration
- ☐ Change in eligibility for employer health coverage
- ☐ Determination by Covered California
- ☐ Change in eligibility for a Health Reimbursement Account (HRA)
- ☐ Misinformation about coverage
- ☐ Provider network changes
- ☐ Contract violation

Please write the date of your qualifying life event. ☐☐ / ☐☐ / ☐☐☐☐ (mm/dd/yyyy)

Proof of eligibility is required. Please visit **kp.org/specialenrollment** or call **1-800-464-4000** for more information.

*If your qualifying life event is loss of Kaiser Permanente coverage, we may review your prior membership records to check when and why you lost coverage.

E. Choose your health plan

If you indicated that you would like to change plans or add coverage for a family member, please select the plan you would like here. Each family member you listed in Section C will be moved to the plan you select. If you wish to enroll family members in different plans, please submit a separate application for each plan.

- ☐ Kaiser Permanente - Bronze 60 HDHP HMO
- ☐ Kaiser Permanente - Bronze 60 HMO
- ☐ Kaiser Permanente - Bronze 60 HDHP HMO 6800/40%
- ☐ Kaiser Permanente - Silver 70 HMO Off Exchange
- ☐ Kaiser Permanente - Silver 70 HMO 2500/45
- ☐ Kaiser Permanente - Silver 70 HDHP HMO 3000/15%
- ☐ Kaiser Permanente - Gold 80 HMO Coinsurance
- ☐ Kaiser Permanente - Gold 80 HMO
- ☐ Kaiser Permanente - Platinum 90 HMO
- ☐ Kaiser Permanente - Minimum Coverage HMO*

*To purchase a Minimum Coverage HMO plan, applicants must be younger than 30 on the effective date, or provide a certificate of exemption that shows hardship or lack of affordable coverage. We won't be able to process your account change without the certificate of exemption if you are 30 and older. To see if you qualify, please go to **marketplace.cms.gov/applications-and-forms/hardship-exemption.pdf** and follow the instructions.

F. Choose your optional adult dental plan

Dental coverage is included in your health plan for child members until the end of the month in which the member turns 19. Kaiser Permanente offers an optional dental insurance plan to adults, which includes those individuals whose eligibility for pediatric dental services has ended. This optional coverage is available for an additional charge.

You can enroll in or end adult dental coverage in the optional dental insurance plan during open enrollment, annual member renewal, or a special enrollment period. Our optional adult dental coverage is underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc. (KFHP), and administered by Delta Dental of California, one of the nation's largest and most experienced dental benefits providers.

- ☐ Add optional adult dental coverage.†
- ☐ End optional adult dental coverage.†

†Once enrolled, I understand I can't cancel my dental coverage without also canceling my health plan coverage, except during open enrollment or a special enrollment period.

G. Sign the form

- I understand that Kaiser Foundation Health Plan, Inc., will rely on the information I provide in this form, and that if any information is found to be fraudulent or intentionally misrepresented, Kaiser Foundation Health Plan, Inc., may choose to terminate my coverage back to the coverage effective date.
- I verify that I am not entitled to Medicare Part A or enrolled in Medicare Part B.

Note: The subscriber and all dependents 18 and older making a change must sign the form. If there are more than 4 dependents 18 and older signing, please attach a copy of this page with the additional signatures.

X _____ Date (mm/dd/yyyy) __/__/____

Subscriber/new subscriber (parent or legal guardian for subscribers under 18)

X _____ Date (mm/dd/yyyy) __/__/____

Spouse/domestic partner

X _____ Date (mm/dd/yyyy) __/__/____

Dependent (18 and older)

X _____ Date (mm/dd/yyyy) __/__/____

Dependent (18 and older)

X _____ Date (mm/dd/yyyy) __/__/____

Dependent (18 and older)

X _____ Date (mm/dd/yyyy) __/__/____

Dependent (18 and older)

All plans are offered and underwritten by Kaiser Foundation Health Plan, Inc., One Kaiser Plaza, Oakland, CA 94612.

H. Sign the Kaiser Foundation Health Plan, Inc., arbitration agreement

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Membership Agreement, Evidence of Coverage, and Disclosure Form*.

X _____ Date (mm/dd/yyyy) __/__/____

Primary applicant (parent or legal guardian for children under 18)

X _____ Date (mm/dd/yyyy) __/__/____

Spouse/domestic partner

X _____ Date (mm/dd/yyyy) __/__/____

Dependent (18 and older)

X _____ Date (mm/dd/yyyy) __/__/____

Dependent (18 and older)

X _____ Date (mm/dd/yyyy) __/__/____

Dependent (18 and older)

X _____ Date (mm/dd/yyyy) __/__/____

Dependent (18 and older)

A copy of your agreement with your signatures is as valid as the original. If signatures are missing, we will cancel your account or plan change. If there are more than 4 dependents 18 and older signing, please attach a copy of this page with the additional signatures. The applicant or his or her authorized representative may request a copy of the completed form. For more information, please call **1-800-464-4000.**

Contact information

Mail to: Kaiser Permanente P.O. Box 23127 San Diego, CA 92193-9921	**Or fax toll-free to:** Membership Administration **1-855-355-5334**	**Questions? Call** **1-800-464-4000** (TTY **711**)

Nondiscrimination Notice

Kaiser Permanente does not discriminate on the basis of age, race, ethnicity, color, national origin, cultural background, ancestry, religion, sex, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, source of payment, genetic information, citizenship, primary language, or immigration status.

Language assistance services are available from our Member Services Contact Center 24 hours a day, seven days a week (except closed holidays). Interpreter services, including sign language, are available at no cost to you during all hours of operation. Auxiliary aids and services for individuals with disabilities are available at no cost to you during all hours of operation**.** We can also provide you, your family, and friends with any special assistance needed to access our facilities and services. You may request materials translated in your language, and may also request these materials in large text or in other formats to accommodate your needs at no cost to you. For more information, call **1-800-464-4000** (TTY users call **711**).

A grievance is any expression of dissatisfaction expressed by you or your authorized representative through the grievance process. For example, if you believe that we have discriminated against you, you can file a grievance. Please refer to your *Evidence of Coverage or Certificate of Insurance* or speak with a Member Services representative for the dispute-resolution options that apply to you. This is especially important if you are a Medicare, Medi-Cal, MRMIP, Medi-Cal Access, FEHBP, or CalPERS member because you have different dispute-resolution options available.

You may submit a grievance in the following ways:

- By completing a Complaint or Benefit Claim/Request form at a Member Services office located at a Plan Facility (please refer to *Your Guidebook* or the facility directory on our website at **kp.org** for addresses)
- By mailing your written grievance to a Member Services office at a Plan Facility (please refer to *Your Guidebook* or the facility directory on our website at **kp.org** for addresses)
- By calling our Member Service Contact Center toll free at **1-800-464-4000** (TTY users call **711**)
- By completing the grievance form on our website at **kp.org**

Please call our Member Service Contact Center if you need help submitting a grievance.

The Kaiser Permanente Civil Rights Coordinator will be notified of all grievances related to discrimination on the basis of race, color, national origin, sex, age, or disability. You may also contact the Kaiser Permanente Civil Rights Coordinator directly at One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612.

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 *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 *hhs.gov/ocr/office/file/index.html***.**

Aviso de no discriminación

Kaiser Permanente no discrimina a ninguna persona por su edad, raza, etnia, color, país de origen, antecedentes culturales, ascendencia, religión, sexo, identidad de género, expresión de género, orientación sexual, estado civil, discapacidad física o mental, fuente de pago, información genética, ciudadanía, lengua materna o estado migratorio.

La Central de Llamadas de Servicio a los Miembros brinda servicios de asistencia con el idioma las 24 horasdel día, los siete días de la semana (excepto los días festivos). Se ofrecen servicios de interpretación sin costo alguno para usted durante el horario de atención, incluido el lenguaje de señas. Se ofrecen aparatos y servicios auxiliares para personas con discapacidades sin costo alguno durante el horario de atención. También podemos ofrecerle a usted, a sus familiares y amigos cualquier ayuda especial que necesiten para acceder a nuestros centros de atención y servicios. Puede solicitar los materiales traducidos a su idioma, y también los puede solicitar con letra grande o en otros formatos que se adapten a sus necesidades sin costo para usted. Para obtener más información, llame al **1-800-788-0616** (los usuarios de la línea TTY deben llamar al **711**).

Una queja es una expresión de inconformidad que manifiesta usted o su representante autorizado a través del proceso de quejas. Por ejemplo, si usted cree que ha sufrido discriminación de nuestra parte, puede presentar una queja. Consulte su *Evidencia de Cobertura (Evidence of Coverage)* o *Certificado de Seguro (Certificate of Insurance)*, o comuníquese con un representante de Servicio a los Miembros para conocer las opciones de resolución de disputas que le corresponden. Esto tiene especial importancia si es miembro de Medicare, Medi-Cal, el Programa de Seguro Médico para Riesgos Mayores (Major Risk Medical Insurance Program MRMIP), Medi-Cal Access, el Programa de Beneficios Médicos para los Empleados Federales (Federal Employees Health Benefits Program, FEHBP) o CalPERS, ya que dispone de otras opciones para resolver disputas.

Puede presentar una queja de las siguientes maneras:

- Completando un formulario de queja o de reclamación/solicitud de beneficios en una oficina de Servicio a los Miembros ubicada en un centro del plan (consulte las direcciones en *Su Guía* o en el directorio de centros de atención en nuestro sitio web en **kp.org/espanol**)
- Enviando por correo su queja por escrito a una oficina de Servicio a los Miembros en un centro del plan (consulte las direcciones en *Su Guía* o en el directorio de centros de atención en nuestro sitio web en **kp.org/espanol**)
- Llamando a la línea telefónica gratuita de la Central de Llamadas de Servicio a los Miembros al **1-800-788-0616** (los usuarios de la línea TTY deben llamar al **711**)
- Completando el formulario de queja en nuestro sitio web en **kp.org/espanol**

Llame a nuestra Central de Llamadas de Servicio a los Miembros si necesita ayuda para presentar una queja.

Se le informará al coordinador de derechos civiles de Kaiser Permanente (Civil Rights Coordinator) de todas las quejas relacionadas con la discriminación por motivos de raza, color, país de origen, género, edad o discapacidad. También puede comunicarse directamente con el coordinador de derechos civiles de Kaiser Permanente en One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612.

También puede presentar una queja formal de derechos civiles de forma electrónica ante la Oficina de Derechos Civiles (Office for Civil Rights) en el Departamento de Salud y Servicios Humanos de los Estados Unidos (U.S. Department of Health and Human Services) mediante el portal de quejas formales de la Oficina de Derechos Civiles (Office for Civil Rights Complaint Portal), en *ocrportal.hhs.gov/ocr/portal/lobby.jfs (en inglés)* o por correo postal o por teléfono a: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (línea TDD). Los formularios de queja formal están disponibles en *hhs.gov/ocr/office/file/index.html (en inglés)*.

無歧視公告

Kaiser Permanente禁止以年齡、人種、族裔、膚色、原國籍、文化背景、血統、宗教、性別、性別認同、性別表達、性取向、婚姻狀況、生理或心理殘障、付款來源、遺傳資訊、公民身份、主要語言或移民身份為由而歧視任何人。

會員服務聯絡中心每週七天每天24小時提供語言協助服務（節假日除外）。本機構在全部營業時間內免費為您提供口譯，包括手語服務，以及殘障人士輔助器材和服務。我們還可為您和您的親友提供使用本機構設施與服務所需要的任何特別協助。您還可免費索取翻譯成您的語言的資料，以及符合您需求的大號字體或其他格式的版本。若需更多資訊，請致電 **1-800-757-7585**（TTY專線使用者請撥**711**）。

申訴指任何您或您的授權代表透過申訴程序來表達不滿的做法。例如，如果您認為自己受到歧視，即可提出申訴。若需瞭解適用於自己的爭議解決選項，請參閱《承保範圍說明書》*(Evidence of Coverage)* 或《保險證明書》*(Certificate of Insurance)*，或咨詢會員服務代表。如果您是 Medicare、Medi-Cal、高風險醫療保險計劃 (Major Risk Medical Insurance Program, MRMIP)、Medi-Cal Access、聯邦僱員健康保險計劃 (Federal Employees Health Benefits Program, FEHBP) 或 CalPERS 會員，採取上述行動尤其重要，因為您可能有不同的爭議解決選項。

您可透過以下方式提出申訴：

- 在健康保險計劃服務設施的會員服務處填寫《投訴或福利索賠/申請表》（地址見《健康服務指南》(Your Guidebook) 或我們網站**kp.org**上的服務設施名錄）
- 將書面申訴信郵寄到健康保險計劃服務設施的會員服務處（地址見《健康服務指南》或我們網站**kp.org**上的服務設施名錄）
- 致電我們的會員服務聯絡中心，免費電話號碼是**1-800-757-7585**（TTY專線請撥**711**）
- 在我們的網站上填寫申訴表，網址是**kp.org**

如果您在提交申訴時需要協助，請致電我們的會員服務聯絡中心。

涉及人種、膚色、原國籍、性別、年齡或殘障歧視的一切申訴都將通知Kaiser Permanente的民權事務協調員。您也可與Kaiser Permanente的民權事務協調員直接聯絡，地址：
One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612。

您還可以電子方式透過民權辦公室的投訴入口網站向美國健康與公共服務部民權辦公室提出民權投訴，網址是 *ocrportal.hhs.gov/ocr/portal/lobby.jsf* 或者按照如下資訊採用郵寄或電話方式聯絡：U.S. Department of Health and Human Services, 200 Independence Avenue SW,
Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697（TDD）。
投訴表可從網站 *hhs.gov/ocr/office/file/index.html* 下載。

Language Assistance Services

English: Language assistance is available at no cost to you, 24 hours a day, 7 days a week. You can request interpreter services, materials translated into your language, or in alternative formats. Just call us at **1-800-464-4000**, 24 hours a day, 7 days a week (closed holidays). TTY users call **711**.

Arabic: خدمات الترجمة الفورية متوفرة لك مجانًا على مدار الساعة كافة أيام الأسبوع. بإمكانك طلب خدمة الترجمة الفورية أو ترجمة وثائق للغتك أو لصيغ أخرى. ما عليك سوى الاتصال بنا على الرقم **1-800-464-4000** على مدار الساعة كافة أيام الأسبوع (مغلق أيام العطلات). لمستخدمي خدمة الهاتف النصي يرجي الاتصال على الرقم (**711**).

Armenian: Ձեզ կարող է անվճար օգնություն տրամադրվել լեզվի հարցում՝ օրը 24 ժամ, շաբաթը 7 օր: Դուք կարող եք պահանջել բանավոր թարգմանչի ծառայություններ, Ձեր լեզվով թարգմանված կամ այլընտրանքային ձևաչափով պատրաստված նյութեր: Պարզապես զանգահարեք մեզ՝ **1-800-464-4000** հեռախոսահամարով՝ օրը 24 ժամ՝ շաբաթը 7 օր (տոն օրերին փակ է): TTY-ից օգտվողները պետք է զանգահարեն **711**:

Chinese: 您每週 7 天，每天 24 小時均可獲得免費語言協助。您可以申請口譯服務、要求將資料翻譯成您所用語言或轉換為其他格式。我們每週 7 天，每天 24 小時均歡迎您打電話 **1-800-757-7585** 前來聯絡（節假日 休息）。聽障及語障專線 (TTY) 使用者請撥 **711**。

Farsi: خدمات زبانی در 24 ساعت شبانروز و 7 روز هفته بدون اخذ هزینه در اختیار شما است. شما می توانید برای خدمات مترجم شفاهی، ترجمه جزوات به زبان شما و یا به صورتهای دیگر درخواست کنید. کافیست در 24 ساعت شبانروز و 7 روز هفته (به استثنای روزهای تعطیل) با ما به شماره **1-800-464-4000** تماس بگیرید. کاربران TTY با شماره **711** تماس بگیرند.

Hindi: बिना किसी लागत के दुभाषिया सेवाएँ, दिन के 24 घंटे, सप्ताह के सातों दिन उपलब्ध हैं। आप एक दुभाषिये की सेवाओं के लिए, बिना किसी लागत के सामग्रियों को अपनी भाषा में अनुवाद करवाने के लिए, या वैकल्पिक प्रारूपों के लिए अनुरोध कर सकते हैं। बस केवल हमें **1-800-464-4000** पर, दिन के 24 घंटे, सप्ताह के सातों दिन (छुट्टियों वाले दिन बंद रहता है) कॉल करें। TTY उपयोगकर्ता **711** पर कॉल करें।

Hmong: Muajkwc pab txhais lus pub dawb rau koj, 24 teev ib hnub twg, 7 hnub ib lim tiam twg. Koj thov tau cov kev pab txhais lus, muab cov ntaub ntawv txhais ua koj hom lus, los yog ua lwm hom.Tsuas hu rau **1-800-464-4000**, 24 teev ib hnub twg, 7 hnub ib lim tiam twg (cov hnub caiv kaw). Cov neeg siv TTY hu **711**.

Japanese: 当院では、言語支援を無料で、年中無休、終日ご利用いただけます。通訳サービス、日本語に翻訳された資料、あるいは資料を別の書式でも依頼できます。お気軽に **1-800-464-4000** までお電話ください（祭日を除き年中無休）。TTY ユーザーは **711** にお電話ください。

Khmer: ជំនួយភាសា គឺមានឥតអស់ថ្លៃដល់អ្នកទ្បើយ 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ។ អ្នកអាចស្នើសុំសេវាអ្នកបកប្រែ សំភារៈដែលបានបកប្រែទៅជាភាសាខ្មែរ ឬជាទំរង់ផ្សឹងទៀត។ គ្រាន់តែទូរសំព្ទមកយើង តាមលេខ **1-800-464-4000** បាន 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ (បិទថ្ងៃបុណ្យ)។ អ្នកប្រើ TTY ហៅលេខ **711**។

Korean: 요일 및 시간에 관계없이 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하는 통역 서비스, 귀하의 언어로 번역된 자료 또는 대체 형식의 자료를 요청할 수 있습니다. 요일 및 시간에 관계없이 **1-800-464-4000** 번으로 전화하십시오 (공휴일 휴무). TTY 사용자 번호 **711**.

Laotian: ການຊ່ວຍເຫຼືອດ້ານພາສາມີໃຫ້ໂດຍບໍ່ເສັງຄ່າ ແກ່ທ່ານ, ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ. ທ່ານ ສາມາດຮ້ອງຂໍຮັບບໍລິການນາຍພາສາ, ໃຫ້ແປເອກະ ສານເປັນພາສາຂອງທ່ານ, ຫຼື ໃນຮູບແບບອື່ນ. ພຽງ ແຕ່ໂທຣຫາພວກເຮົາທີ່ **1-800-464-4000**, ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ (ປິດວັນພັກຕ່າງໆ). ຜູ້ໃຊ້ສາຍ TTY ໂທຣ **711**.

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Navajo: Saad bee áká'a'ayeed náhóló t'áá jiik'é, naadiin doo bibąą' dįį' ahéé'iikeed tsosts'id yiskąąjį damoo ná'ádleehjį. Atah halne'é áká'adoolwołígíí jóki, t'áadoo le'é t'áá hóhazaadjį hadilyąą'go, éí doodaii' nááná lá ał'ąą ádaat'ehígíí bee hádadilyaa'go. Kojį hodiilnih **1-800-464-4000**, naadiin doo bibąą' dįį' ahéé'iikeed tsosts'id yiskąąjį damoo ná'ádleehjį (Dahodiyin biniiyé e'e'aahgo éí da'deelkaal). TTY chodeeyoolínígíí kojį hodiilnih **711**.

Punjabi: ਬਿਨਾਂ ਕਿਸੀ ਲਾਗਤ ਦੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫਤੇ ਦੇ 7 ਦਿਨ, ਦੁਭਾਸ਼ੀਆ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਉਪਲਬਧ ਹੈ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਦੀ ਮਦਦ ਲਈ, ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਅਨੁਵਾਦ ਕਰਵਾਉਣ ਲਈ, ਜਾਂ ਕਿਸੇ ਵੱਖ ਫਾਰਮੈਟ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਬਸ ਸਿਰਫ਼ ਸਾਨੂੰ **1-800-464-4000** ਤੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ (ਛੁੱਟੀਆਂ ਵਾਲੇ ਦਿਨ ਬੰਦ ਰਹਿੰਦਾ ਹੈ) ਫ਼ੋਨ ਕਰੋ। TTY ਦਾ ਉਪਯੋਗ ਕਰਨ ਵਾਲੇ **711** 'ਤੇ ਫ਼ੋਨ ਕਰਨ।

Russian: Мы бесплатно обеспечиваем Вас услугами перевода 24 часа в сутки, 7 дней в неделю. Вы можете воспользоваться помощью устного переводчика, запросить перевод материалов на свой язык или запросить их в одном из альтернативных форматов. Просто позвоните нам по телефону **1-800-464-4000**, который доступен 24 часа в сутки, 7 дней в неделю (кроме праздничных дней). Пользователи линии TTY могут звонить по номеру **711**.

Spanish: Contamos con asistencia de idiomas sin costo alguno para usted 24 horas al día, 7 días a la semana. Puede solicitar los servicios de un intérprete, que los materiales se traduzcan a su idioma o en formatos alternativos. Solo llame al **1-800-788-0616**, 24 horas al día, 7 días a la semana (cerrado los días festivos). Los usuarios de TTY, deben llamar al **711**.

Tagalog: May magagamit na tulong sa wika nang wala kang babayaran, 24 na oras bawat araw, 7 araw bawat linggo. Maaari kang humingi ng mga serbisyo ng tagasalin sa wika, mga babasahin na isinalin sa iyong wika o sa mga alternatibong format. Tawagan lamang kami sa **1-800-464-4000**, 24 na oras bawat araw, 7 araw bawat linggo (sarado sa mga pista opisyal). Ang mga gumagamit ng TTY ay maaaring tumawag sa **711**.

Thai: เรามีบริการล่ามฟรีสำหรับคุณตลอด 24 **ชั่วโมง ทุกวันตลอดชั่วโมงทำการของเราคุณสามารถขอให้ล่าม ช่วยตอบคำถามของคุณที่เกี่ยวกับความคุ้มครองการดูแล สุขภาพของเราและคุณยังสามารถขอให้มีการแปลเอกสา รเป็นภาษาที่คุณใช้ได้โดยไม่มีการคิดค่าบริการเพียงโทร หาเราที่หมายเลข 1-800-464-4000 ตลอด** 24 **ชั่วโมงทุกวัน (ปิดให้บริการในวันหยุดราชการ) ผู้ใช้** TTY **โปรดโทรไปที่ 711**

Vietnamese: Dịch vụ thông dịch được cung cấp miễn phí cho quý vị 24 giờ mỗi ngày, 7 ngày trong tuần. Quý vị có thể yêu cầu dịch vụ thông dịch, tài liệu phiên dịch ra ngôn ngữ của quý vị hoặc tài liệu bằng nhiều hình thức khác. Quý vị chỉ cần gọi cho chúng tôi tại số **1-800-464-4000**, 24 giờ mỗi ngày, 7 ngày trong tuần (trừ các ngày lễ). Người dùng TTY xin gọi **711**.

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