GEISINGER HEALTH PLAN GEISINGER COLLEGE OF HEALTH SCIENCES STUDENT HEALTH PLAN

100 North Academy Avenue Danville, PA 17822

Enrollment Application for Individual & Family Health Care Coverage

 Affordable private health insurance plans that offer comprehensive coverage to help you stay well You may qualify for a free or low-cost program
 Use this application to apply for anyone in your family If someone is helping you fill out this application, you may need to complete Appendix A
Apply faster online at <u>www.GeisingerMarketplace.com</u>
 Blue or black ink pen Social Security numbers Policy numbers for any current health insurance
 Send your completed, signed application to the address on page 10. We'll follow-up with you within 7-10 days. If you don't hear from us, call 800-918-5154.
 Online: www.GeisingerMarketplace.com Phone: Call to speak with a Health Plan advisor at 800-918-5154 En Español: Llame a nuestro centro de ayuda gratis al 800-918-5154

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Step 1 Tell us about yourself (primary applicant).

Please DO NOT include any genetic information such as family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic diseases for which you believe you may be at risk.

1. Name: Prefix, First Name, Middle Init	ial, Last name, & Suffix				
2. Residential address (Leave blank if ye	ou don't have one.)				Apartment or suite number
4. City	5. Sta	te	6. Zip code		7. County
8. Mailing address (if different from resid	dential address)				9. Apartment or suite number
10 City	11. Sta	ate	12. Zip code		13. County
14. Phone number (preferred)	15. Mo	obile number			16. Work number
17. Date of birth (mm/dd/yyyy)	18. Se	ex assigned at birth:		ot recorded noose not to	on birth certficate disclose
19. Social security number (SSN)	,		20. Are you pregnant? a. If yes, how many expected during		
21. Have you used tobacco on average (applies to persons 21 years of age		week within the pas	t six (6) months? Yes	s No	
22. Primary Care Physician (PCP) Information a. Are you an established patient with lf yes, please complete the follow	th a PCP: Yes	□ No			
b. PCP Name (first/last):		c. P	CP Phone Number: ()	
d. PCP Practice Location (Mailing ac	ddress):		City		State Zip
23. Email address:			· · · · · · · · · · · · · · · · · · ·		·
(The email address you provide on this member satisfaction surveys. Please not the Health Plan. You will be given an	ote that if you provide you	ur e-mail address, it v	will be stored in a secure		
24. Marital status: Single Separated	Married □ Divorce Widowed	ed	25. Are you a U.S. citiz	en or U.S. N	lational? ☐ Yes ☐ No
26. If you aren't a U.S. citizen or U.S. na If Yes, fill in your document type and		ole immigration statu	s?	No	
a. Immigration document type:			b. Document ID Number	er:	
c. Have you lived in the U.S. since 1 d. Are you, or your spouse or parent			S. military? ☐ Yes	□ No	
The information below may be used to identify properties for all members. It does not impact plan option		-			
SEX (LEGAL/ADMINISTRATIVE)	PRONOUNS	PREFERRED LANG			
☐ MALE ☐ FEMALE ☐ X OR NON-BINARY☐ CHOOSE NOT TO DISCLOSE	□ SHE/HER/HERS □ HE/HIM/HIS	□ ENGLISH □ SPANISH		RUSSIAN CHINESE	□ GERMAN □ HINDI
ETHNICITY	□ THEY/THEM/THEIRS □ MY NAME	□ NEPALI		ARABIC	
☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO ☐ CHOOSE NOT TO DISCLOSE	CHOOSE NOT TO DISCLOSE NOT LISTED:	☐ YIDDISH, PENNSY	'LVANIA DUTCH OR OTHER WE	EST GERMANIC	CLANGUAGES
SEXUAL ORIENTATION	GENDER IDENTITY	_		RACE	_
STRAIGHT (NOT LESBIAN OR GAY)	□ MALE □ FEMALE □ TRANSGENDER MALE (FEM.	ALE TO MALE)			INDIAN OR ALASKA NATIVE ASIAN
□ LESBIAN OR GAY □ BISEXUAL	☐ TRANSGENDER MALE (M.	,		☐ WHITE	☐ BLACK OR AFRICAN AMERICAN WAIIAN OR OTHER PACIFIC ISLANDER
□ SOMETHING ELSE	☐ GENDERQUEER (NEITHER E	EXCLUSIVELY MALE NOR	FEMALE)	□ TWO OR M	ORE RACES
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□ CHOOSE NOT TO □ ARMY		JARD 🗆 ARMY RESER\	/E NAVY RESERVE	□ PEACE TIN	IE □ WWII □ VIETNAM WAR
WE HONOR VETERANS CEREMONY	DISABLED VETERAN				ZE DISABILITY
□ YES □ NO	□ YES □ NO	,		□ YES □ NC	

The following person(s) in your family may be eligible for coverage:

•	Yourself	•	Your spouse under an existing marriage legally recognized under the laws of the Commonwealth of Pennsylvania
•	Your domestic partner who needs health coverage (A completed and notarized Declaration of Fact form is required to be submitted)	•	Your children or your spouse's children (married or unmarried) who have not yet attained age 26 (Dependents of the Domestic Partner are not eligible)
•	Your disabled children or your spouse's disabled children age 26 or older (A completed Dependent Certification form is required to be submitted)	•	Please DO NOT include any genetic information such as family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic diseases for which you believe your dependents may be at risk.

Complete Step 2 for each person in your family applying for coverage under this policy. Start with your spouse or domestic partner and then add other adults and children. If you have more than 5 people in your family, you'll need to make a copy of the pages and attach them. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

Complete Step 2 for your spouse or domestic partner, and eligible children.

		1								
DEPENDENT 1		LEGAL NAME: (LAST, I	FIRST M.I.):				BIRTH D	ATE: (MM/DI	D/YYYY.):	
CHECK ONE: ADD REMOVE			BSCRIBER/POLICY HOLDER ESTIC PARTNER† CHILD		soc	IAL SECURITY NUMBER:				
☐ CHANGING PLAN		☐ LEGAL CUSTODIAN/	LEGAL GUARDIAN 🗆 OTHER†*		GEIS	SINGER MEDICAL RECORD NU	MBER:			
MARITAL STATUS	MARRIED - DATE	OF MARRIAGE	☐ DIVORCED - DATE OF DIVORCE	=		OTHER CHANGE OF STATU	JS/LEGAL QU	JALIFYING E	VENT DATE:	
RESIDENTIAL ADDRES	SS: (CHECK HE	ERE IF SAME AS PRIMAR	RY APPLICANT)							
			Street/Apartment/Suite #			City		State	Zip	Country
ARE YOU PREGNANT	? □ YES	□ NO A. IF YES,	HOW MANY BABIES ARE EXPECTED DURING	THIS P	REGI	NANCY?				
		BACCO ON AVERAGE 1 years of age and older)	OF FOUR OR MORE TIMES PER WEEK WITHI	N THE P	AST:	SIX (6) MONTHS?	□ NO			
PRIMARY CARE PHYSICIAN (PCP) INFORMATION	A PCP?	STABLISHED WITH	IF YES, PCP NAME:			PCP PHONE: (CTICE LOCAT ADDRESS):	TION
U.S. CITIZENSHIP HAVE YOU LIVED IN THE U.S. SINCE 1996? YES NO	ARE YOU U.S. C NATIONAL?	CITIZEN OR U.S.	IF YOU ARE NOT A U.S. CITIZEN OR U.S. NATION/ STATUS? ☐ YES ☐ NO IF YES, FILL IN YOUR DOCUMEN				DOCUMEN	T TYPE	DOCUMEN.	T ID NUMBER
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DEPENDENT 2		LEGAL NAME: (LAST, F	FIRST M.I.):			BIRTH D	ATE: (MM/DE)/YYYY.):	
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☐ ADD ☐ REMOVE ☐ CHANGING PLAN		☐ SPOUSE ☐ DOM☐ LEGAL CUSTODIAN/	ESTIC PARTNER† □ CHILD LEGAL GUARDIAN □ OTHER†*	GEI	SINGER MEDICAL RECORD NU	MRFR.			
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□ YES □ NO			□ YES □ NO			□ YES □	NO			
DEPENDENT 5		LEGAL NAME: (LAST, F	FIRST M.I.):			BIRTH D	ATE: (MM/DE	/YYYY.):		
CHECK ONE: ADD REMOVE CHANGING PLAN			BSCRIBER/POLICY HOLDER ESTIC PARTNER†		CIAL SECURITY NUMBER:	MDED.				
MARITAL STATUS	MARRIED - DATE		DIVORCED - DATE OF DIVORCE	GE	OTHER CHANGE OF STATU		IAI IEYING E	VENT DATE:		
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			Street/Apartment/Suite #		City		State	Zip	Country	
ARE YOU PREGNANT		,	HOW MANY BABIES ARE EXPECTED DURING TH OF FOUR OR MORE TIMES PER WEEK WITHIN TI			□ NO				
		years of age and older)		IL FAST	TSIX (0) MONTHS: 1123					
PRIMARY CARE PHYSICIAN (PCP) INFORMATION	A PCP?	STABLISHED WITH	IF YES, PCP NAME:		PCP PHONE: ()			TICE LOCATION ADDRESS):	N	
U.S. CITIZENSHIP HAVE YOU LIVED IN THE U.S. SINCE 1996? YES NO	ARE YOU U.S. C NATIONAL?		IF YOU ARE NOT A U.S. CITIZEN OR U.S. NATIONAL, E STATUS? YES NO IF YES, FILL IN YOUR DOCUMENT TY			DOCUMEN	IT TYPE	DOCUMENT ID	NUMBER	
			ication, enrollment and coverage barriers, and di cost or eligibility. Consumer-reported race and et						vices for all	
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□ MALE □ FEMALE □ NOT RECORDED ON BIRTH CERTIFICATE	☐ X OR NON-BII	□ FEMALE NARY ΓTO DISCLOSE	☐ THEY/THEM/THEIRS ☐ MY NAME ☐ CHOOSE NOT TO DISCLOSE	ENGLI SPANI NEPAL YIDDIS	SH SIGN LANGUAGE CLI VIETNAMESE CA	CHINESE RABIC				
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IF YES, YEARS OF SE	RVICE:	_ COAST GUARD	DISABLED VETERAN		□ MULTIPLE BRANCHES		NIZE DISAE			

Step 3 Insurance plan options

Please review the plan options listed below and check the box of the specific plan you've selected. The selected will apply to the applicant and his/her approved eligible dependents.	plan option
Requested effective date (mm/yyyy):	
INSURANCE PLAN OPTIONS	
Geisinger Premier HMO. The Premier HMO network is made up of the highest performing providers. (Choose one)	
☐ Premier HMO 10/20/500	
☐ Premier HMO 30/60/6000	

Geisinger Marketplace All-Access Value. To be eligible for the "Value" plan, applicants and dependents must be less than 30 years of age prior to their plan effective date <u>or</u> possess a certification that he/she is exempt from the requirements to maintain minimum essential coverage.

Geisinger Marketplace Premier HMO. The Premier HMO network is made up of the highest performing providers and generally has a lower cost than our other network options.

Geisinger Marketplace Extra HMO gives members access to the Health Plan's entire network of participating providers and also offers "ProvenHealth Navigator" medical practice sites where the member can receive primary care services for a lower primary care physician office visit copayment.

Geisinger Marketplace All-Access QHDHP PPO has lower premiums and higher deductibles than a traditional insurance plan. You will pay more of the cost for healthcare services up front until you meet your deductible, at which point your plan pays for most of the covered services. This plan may be paired with a health savings account (HSA), a type of savings account that lets you set aside money on a pre-tax basis to pay for qualified medical expenses; this will help you pay for those upfront costs until you meet the deductible. In order to contribute funds into a health savings account, you must be enrolled in a QHDHP plan.

For Agent/Broker use only:	
Is this an ICHRA policy? □Yes □No	If yes, should autopay be setup? ☐Yes ☐No

STEP 4 Your family's health coverage

Answer these questions for each person in your family applying for coverage under this policy. 1. Is anyone enrolled in health coverage, including outpatient prescription drug coverage, now from the following? ☐ YES. ☐ NO. If yes, check the type of coverage and write the person(s)' name(s) next to the coverage they have. ☐ Employer insurance Name of health insurance: CHIP ☐ Medicare Part A Policy number: ☐ Medicare Part B ☐ Medicare Part D Is this COBRA coverage? ☐ Yes ☐ No TRICARE (Don't check if you have direct care or Line of Duty) Is this a retiree health plan? Yes No Other Name of health insurance: ----☐ VA health care programs ____ Policy number: Peace Corps _____ Is this a limited-benefit plan (like a school accident policy)? ☐ Yes ☐ No 2. Is anyone listed on this application offered health coverage from a job? Check YES even if the coverage is from someone else's job, such as a parent or spouse. ☐ YES. Is this a state employee benefit plan? ☐ Yes ☐ No NO.

Step 5

Read & sign this application

READ THESE NOTICES CAREFULLY BEFORE SIGNING THIS APPLICATION.

I understand, agree, and represent that:

This application is for individual coverage with Geisinger Health Plan or Geisinger Quality Options, Inc. (collectively referred to as the "Health Plan"). This is NOT an application for group coverage.

This application is subject to acceptance by the Health Plan and I agree to immediately notify the Health Plan of any change(s) to the information contained within this application following submission of the application. Furthermore, I understand that the application process may include follow-up telephone calls by the Health Plan and/or requests for additional documentation to the Applicant for the purpose of verifying information contained within this application, and that my obligation to provide truthful and accurate information to the Health Plan extends to any such follow-up communications.

If a policy is issued, benefits (including state and federal mandates) will be available subject to the exclusions, limitations, and other conditions of the policy and any subsequent amendments to those documents, if applicable.

Rates for the policy issued to Applicant will only be changed at time of renewal by the Health Plan, after approval from all applicable regulatory authorities and upon thirty (30) days prior notice to Applicant or as permitted by law; provided, however, in the event Applicant has made a material misstatement in the application that would have resulted in the issuance of a different premium, the Health Plan may retroactively revise the premium to reflect the appropriate premium for the actual level of risk subject to the three (3) year time limit on the defense noted below. The Health Plan will notify Applicant, in writing, if anyone listed on this application is rejected for coverage.

If this application is accepted by the Health Plan, payment of the first month's premium is required to effectuate enrollment. The first month's premium is due no earlier than the coverage effective date and no later than thirty-one (31) calendar days from the coverage effective date. The grace period for premium payment is thirty-one (31) days or three (3) months depending upon your receipt of an advance premium tax credit. If the premium is not paid, coverage terminates on the last day of the grace period or, if you are in receipt of an advance premium tax credit, to the last day of the first month of the 3-month grace period, as applicable.

In the event your enrollment is terminated and you owe premiums ("past-due premiums) to either Geisinger Health Plan or Geisinger Quality Options, Inc., in order to effectuate new coverage, the Health Plan may require you to pay any past-due premiums owed for a period not to exceed twelve (12) months prior to the requested effective date of new coverage and a new binder payment. Payment of past-due premiums may be required if you are applying for coverage either with Geisinger Health Plan and you owe past-due premiums to Geisinger Quality Options, Inc., or if you are applying for coverage with Geisinger Quality Options, Inc., and you owe past-due premiums to Geisinger Health Plan. For example, if you owe past-due premiums for prior coverage with Geisinger Health Plan, you may be required to pay those premiums, and the new binder payment, before you may enroll in new coverage with either Geisinger Quality Options, Inc., you may be required to pay those premiums, and the new binder payment, before you may enroll in new coverage with either Geisinger Quality Options, Inc. or Geisinger Health Plan. Please note: If you pay only the binder payment for new coverage, the payment will be applied to past-due premiums owed to either health plan entity, and you will not be enrolled in the new coverage.

I have read this document, or it has been read to me. I understand that I should retain a duplicate copy of this application for my own records. A photographic copy of this acknowledgement shall be as valid as the original.

I authorize the Health Plan to electronically transmit the information contained herein. If this application was taken over the phone or on the computer, I acknowledge that I, myself, have not actually signed this application but instead hereby authorize the Health Plan to print an electronic acknowledgement on the signature line of the application and I agree that such printing shall be treated as a valid signature for all purposes of this form. I acknowledge that the Health Plan has verified my identity for this purpose in accordance with any applicable law or regulation.

The information recorded above is true and correct to the best of my knowledge and belief. I understand that if I make any material misstatement during the application process, the Health Plan may cancel the policy or deny claims, provided such material misstatement is discovered by GHP within three (3) years of the policy effective date. I also understand that if I make any fraudulent representation or

intentional misrepresentation of a material fact during the application process, the Health Plan may render the policy void from inception.
In the event the Health Plan elects to void this policy, the Policyholder/Subscriber will forfeit any charges paid to the extent of any liability
incurred by the Health Plan.
Fraud Statement
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

By signing below, I acknowledge that I have read and understand this document and I am signing of my own free will.

Date	Signature of Applicant
Date	Health Plan Representative

STEP 6 Mail completed application.

Mail your signed application to:

Geisinger Health Plan

2266 Wilkes-Barre Township Marketplace
Wilkes-Barre Township, PA 18702

APPENDIX A

Assistance with completing this application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative for purposes of this application, contact customer service at 800-447-4000. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (Prefix, F	irst Name, Middle Initial, Last Nam	e, Suffix)
2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone Number		
() –		
8. Email address:		
9. What is the best time to call?		
☐ Morning ☐ Afternoon ☐ Evening ☐ Anytime	between 8 A.M. and 8 P.M.	
By signing, you allow this person to sign your a you on all future matters with this agency related		about this application, and act for
10. Your signature		11. Date (mm/dd/yyyy)
For certified application counselors, na	vigators, agents, and brokers	only.
Complete this section if you're a certified appli somebody else.		
Application start date (mm/dd/yyyy)		
2. First name, Middle name, Last name, & Suffix	(
3. Organization name		4. ID number (if applicable)

HEALTH PLAN PREMIUM AUTHOR	IZATION FORM			
Applicant:Last Name	First Name	Middle Initial	Official Use Only	AR 32-51
Address:Street	City	State Zip	Policyholder's ID Nur	nber
Phone Number (Daytime): ()				
PART 1. INITIAL PREMIUM PAYME Please choose one of the following: EFT (Electronic funds transfer) - Complet Credit card - Complete part 3 below		ent will be processed imm	nediately upon Application approv	val.)
PART 2. EFT (ELECTRONIC FUN	NDS TRANSFER) INFOR	RMATION		
Complete this section if applicable.				
Address on account:Street		City	State	Zip
Bank Name: Checking account Savings account Bank routing number (ABA) (9-digit #): Bank account number (DDA): (Bank routing and account numbers are left)	ount	- —	State	Σip
the payment is received. I understand that copremium will be debited immediately following applicable, I am accepting the terms of this agriculture. The Health Plan reserves the right to rethe Health Plan or the policyholder terminates. PART 3. CREDIT CARD INFORM Complete this section if applicable.	ng the receipt of the Application eement. If use/terminate electronic payme it. Joint accounts require the s	on. I understand that with ent services at any time. T	h my Application signature and s his agreement remains in full forc	signature below, se and effect until
Complete this section if applicable. Credit Card Type: USA Maste	erCard Discover			
Cardholder's name (exactly as it appears	on the card):			
Cardholder's address (as it appears on the	ne statement):			
	Street	City		ip
Account number:		Card Expiration I	Date	
<u></u>	<u> </u>	/		
PART 4.				
This section must be completed by the a	ippropriate person(s).			
Applicant's signature:			Date:	
Payer's signature (if different from Applic	cant):		Date:	
By signing this agreement, I accept the t	erms of this payment author	ization form.		
*Authorized signature of joint account ho By signing this agreement, I accept the Important policyholder informatio Your initial premium payment must be Once enrolled, policyholders will be invoiced in	on and terms e submitted with your Applic nonthly and may make payment	cation. Your 1 st month's p ts by visiting www.thehea	oremium payment will be process lthplan.com	ed immediately.
Do not cancel other coverage present enrollment has been approved and you a date of coverage.	-		_	•

Discrimination is against the law

Geisinger Health Plan and Geisinger Quality Options, Inc. (collectively referred to as the "Health Plan") comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation.

The Health Plan:

- 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, call the Health Plan at 800-447-4000 or TTY: 711.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with:

Civil Rights Grievance Coordinator Geisinger Health Plan Appeals Department 100 North Academy Avenue, Danville, PA 17822-3220

Phone: 866-577-7733, TTY: 711 Fax: 570-271-7225

GHPCivilRights@thehealthplan.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Grievance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue SW., Room 509F HHH Building, Washington, DC 20201 Phone: 800-368-1019, 800-537-7697 (TDD)

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

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 800-447-4000 or TTY: 711.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-447-4000 (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 800-447-4000 (TTY:711)。

CHÚ Ý: Nếu ban nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho ban. Goi số 800-447-4000 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-447-4000 (телетайп: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-447-4000 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-447-4000 (TTY: 711) 번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-447-4000 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 4000-447-800 (رقم هاتف الصم والبكم: 711.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-447-4000 (ATS: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-447-4000 (TTY: 711).

સચના: જો તમે ગુજરાતી બોલતા હો. તો નિ:શુલ્ક ભાષા સહ્યય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 800-447-4000 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-447-4000 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, qen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-447-4000 (TTY: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ សេវាជំនួយផ្នែកភាសា ដោយមិនគិកឈ្លួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-447-4000 (TTY: 71))។

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-447-4000 (TTY: 711).

HPM 50 alb: Nondiscrimination dev. 9.12.16 Y0032 16242 2 File and Use 9/2/16