

2026 Oregon Individual & Family Change Form

This form is for **current Providence Health Plan Individual & Family Policyholders**. Changes to your Providence Health Plan coverage can **only** be requested by the Policyholder. To complete an application for new enrollment, please visit ProvidenceHealthPlan.com/Shop or call our Sales team at **503-574-5000** or **800-988-0088 (TTY: 711)**.

To fill out and submit a change form online, visit ProvidenceHealthPlan.com/INDChange2026.

Don't use this form if you purchased your plan through the Health Insurance Marketplace®—you'll need to contact the Health Insurance Marketplace® at HealthCare.gov or call **800-318-2596**.

Requesting changes to my policy

Keep in mind that some changes require a Qualifying Event. Experiencing a Qualifying Event grants you a 60-day Special Enrollment Period to make changes to your policy by submitting this change form. You may also use this form to report or correct your policy information without experiencing a Qualifying Event. Please see the "Make Changes to Your Plan" section for a list of Qualifying Events to determine if the change you want requires one.

When will my change(s) go into effect?

This form is for changes effective January 1, 2026 through December 31, 2026. For all Qualifying Events and changes, coverage will be effective the first day of the month following the receipt of your completed change form as long as we receive your form **within 60 days** of the Qualifying Event.

Please refer to the example effective dates table below.

DATE WE RECEIVE YOUR CHANGE FORM:	EFFECTIVE DATE OF CHANGE:
March 1 - 31	Your change will be effective April 1 .
April 1 - 30	Your change will be effective May 1 .

Please note: If you have an active recurring payment arrangement with Providence Health Plan, any changes to your premium rate may not update prior to when your recurring payment is processed. If your request results in a lower premium, your account will be credited on your next month's invoice. If your request results in a higher premium, Providence Health Plan will bill you for the additional amount.

Termination of your medical (and dental) coverage will be effective on the last day of the monthly period through which your premium was paid at the time this form is received.

If the Qualifying Event is birth, adoption, placement for adoption or foster care of a child, or a court order, coverage will be effective from the date of the event. If you would instead prefer a prospective (coverage) effective date based on the table above, please clearly indicate this on your form.

Please review the form to check that you've finished filling out all the required sections. If this form is incomplete for any reason—if it's missing Policyholder information, a valid signature by the Policyholder, Qualifying Event, etc.—or if additional information is required, this may delay or void your requested changes. Your change form will expire **60 days after** the signature date.

Policyholder Information

This section needs to be completed for all plan change and cancellation requests.

If this information is incomplete, your change form may be returned, causing a delay.

LAST NAME

FIRST NAME

MI

SUBSCRIBER ID NUMBER

SOCIAL SECURITY NUMBER

_____/_____/_____
DATE OF BIRTH (MM/DD/YYYY)

GENDER: Male Female Other

HOW DO YOU IDENTIFY? (These fields are optional. Your response will help us to better serve all communities.)

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

PHYSICAL ADDRESS (NO P.O. BOX OR RETAIL/BUSINESS ADDRESSES) This is a new address

CITY

COUNTY

STATE

ZIP CODE

MAILING ADDRESS (IF DIFFERENT FROM PHYSICAL ADDRESS) This is a new address

CITY

COUNTY

STATE

ZIP CODE

HOME/CELL PHONE

WORK/OTHER PHONE (OPTIONAL)

EMAIL ADDRESS

Have you used any tobacco products in the last six months? Yes No
(Tobacco use is defined as an average of at least four times a week, except for religious or ceremonial purposes.)

Option 1: Cancellation

Complete this section only if you want to cancel your Individual & Family Plan coverage.

I want to cancel my Individual & Family Plan coverage.

Checking this box will end the health insurance coverage for all enrolled members on your plan. Termination of your medical (and dental) coverage will be effective on the last day of the monthly period through which the premium was paid at the time this form is received.

Sign, date, and submit only this page to complete your request to cancel your coverage.

Signature is considered valid only if it is handwritten ("wet") or e-signed.

A copy of legal guardianship or power of attorney must accompany this form if not signed by the Policyholder.

SIGNATURE OF POLICYHOLDER, LEGAL GUARDIAN OR POWER OF ATTORNEY

_____/_____/_____
TODAY'S DATE (MM/DD/YYYY)

Option 2: Make changes to your 2026 plan

Select one or more changes you want to make to your plan.

I want to make the following changes that don't require a Qualifying Event:

- | | |
|---|---|
| <input type="checkbox"/> Cancel my dental plan only | <input type="checkbox"/> Change my address after moving within the same service area: |
| <input type="checkbox"/> Remove dependent(s) | |
| <input type="checkbox"/> Report changes or corrections to a member's personal information (i.e., name, birthdate, tobacco status, etc.) | _____/_____/_____
DATE OF MOVE (REQUIRED) |

If you only have changes that DO NOT require a Qualifying Event, continue to the next page →

I want to make changes after having experienced a Qualifying Event:

- | | |
|---|---|
| <input type="checkbox"/> Change my medical plan | <input type="checkbox"/> Change my address after moving to a new service area |
| <input type="checkbox"/> Add dependent(s) | <input type="checkbox"/> Add Individual & Family Dental coverage |

Date of Qualifying Event: ____/____/____

Name of family member who experienced the Qualifying Event: _____

Select the Qualifying Event:

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

Providence Health Plan must receive your completed change form and required documentation **within 60 days** of your Qualifying Event. Refer to [ProvidenceHealthPlan.com/QE](https://www.providencehealthplan.com/QE) for additional information regarding Special Enrollment Periods (SEPs).

*A Domestic Partner must be 18 years of age or older; at least one partner must be a resident of Oregon; and neither partner can presently be in a marriage or a legally recognized registered domestic partnership.

Choose a new medical plan:

Changing your medical plan and/or adding a dental plan outside of Open Enrollment requires a Qualifying Event.

To make the following changes to your medical plan, check one box below. If there are no changes, leave this section blank.

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

Applicable Counties	Network	Medical Plan (Check One)
Clackamas, Hood River, Multnomah, Washington, Yamhill (zip codes 97123 and 97132 only)	Connect*	<input type="checkbox"/> Connect 1500 Gold <input type="checkbox"/> Connect 6000 Silver <input type="checkbox"/> Connect 9800 Bronze <input type="checkbox"/> Connect Direct 6000 Silver
Benton, Clackamas, Clatsop, Crook, Deschutes, Douglas, Hood River, Jackson, Jefferson, Lane, Lincoln, Linn, Marion, Multnomah, Polk, Washington, Yamhill	Choice*	<input type="checkbox"/> Providence Oregon Standard Gold <input type="checkbox"/> Providence Oregon Standard Silver <input type="checkbox"/> Providence Oregon Standard Bronze <input type="checkbox"/> Providence Oregon Direct Silver <input type="checkbox"/> HSA-E Qualified 7500 Bronze
All Oregon counties	Signature	<input type="checkbox"/> Providence Oregon Standard Gold <input type="checkbox"/> Providence Oregon Standard Silver <input type="checkbox"/> Providence Oregon Standard Bronze <input type="checkbox"/> Providence Oregon Direct Silver <input type="checkbox"/> HSA-E Qualified 7500 Bronze

*If you choose a Connect or Choice Network plan, you'll need to choose a medical home and a primary care provider (PCP) after you enroll. Find an in-network provider at [ProvidenceHealthPlan.com/FindAProvider](https://www.providencehealthplan.com/FindAProvider).

Add or cancel dental coverage:

In order to purchase a dental plan, you **must** purchase one of the medical plans listed above. Individual & Family Dental plan coverage is applicable to **all Oregon counties**.

Dental Plan (Check One)

- | | |
|--|--|
| <input type="checkbox"/> Add Individual & Family Dental plan
(Requires a Qualifying Event) | <input type="checkbox"/> Cancel Individual & Family Dental plan
(Medical coverage will still be in effect) |
|--|--|

Things to Know About Our Dental Plan:

- Everyone on your medical plan will be enrolled, and there's an additional monthly premium of **\$42** applied to each covered member on the policy.
- **For Connect plans:** coverage for children age 18 or younger will be supplemental to the pediatric dental coverage already included under the medical plan.
- For more information about dental benefits and coverage, visit [ProvidenceHealthPlan.com/INDDental2026](https://www.providencehealthplan.com/INDDental2026).

Pediatric Dental Disclaimer: Our Standard, HSA Qualified and Providence Oregon Direct medical plans DO NOT include pediatric dental coverage. Under the health care reform law (the Affordable Care Act or ACA), if you purchase one of these plans outside of the Health Insurance Marketplace®, we must have reasonable assurance that you have obtained separate pediatric dental coverage through a Marketplace-certified pediatric dental plan. This requirement applies whether you obtain coverage for children or adults. Marketplace-certified pediatric dental plans can be found through the Health Insurance Marketplace® at [HealthCare.gov](https://www.healthcare.gov).

Change Information for My Dependents

Only changes reflected on this form will be updated on your plan. If you are not making any changes, return this page blank. Adding a dependent outside of Open Enrollment requires a Qualifying Event. Make sure you use full, legal names. For a child-only plan, children must be age 20 or younger as of their effective date. For all other plans, children must be age 25 or younger as of their effective date.

1 CHECK ONE:

Add

Remove

Update

LAST NAME

FIRST NAME

MI

DATE OF BIRTH

RELATIONSHIP*

SOCIAL SECURITY #

GENDER: M F Other

USES TOBACCO?** Yes No

HOW DO YOU IDENTIFY?***

Male Female Non-binary

Transgender Male Transgender Female Decline to answer

LIVES WITH POLICYHOLDER?

Yes No

If no, include the dependent's physical address below

DEPENDENT'S PHYSICAL ADDRESS

APARTMENT/UNIT NUMBER

CITY

STATE

ZIP

COUNTY

2 CHECK ONE:

Add

Remove

Update

LAST NAME

FIRST NAME

MI

DATE OF BIRTH

RELATIONSHIP*

SOCIAL SECURITY #

GENDER: M F Other

USES TOBACCO?** Yes No

HOW DO YOU IDENTIFY?***

Male Female Non-binary

Transgender Male Transgender Female Decline to answer

LIVES WITH POLICYHOLDER?

Yes No

If no, include the dependent's physical address below

DEPENDENT'S PHYSICAL ADDRESS

APARTMENT/UNIT NUMBER

CITY

STATE

ZIP

COUNTY

3 CHECK ONE:

Add

Remove

Update

LAST NAME

FIRST NAME

MI

DATE OF BIRTH

RELATIONSHIP

SOCIAL SECURITY #

GENDER: M F Other

USES TOBACCO?** Yes No

HOW DO YOU IDENTIFY?***

Male Female Non-binary

Transgender Male Transgender Female Decline to answer

LIVES WITH POLICYHOLDER?

Yes No

If no, include the dependent's physical address below

DEPENDENT'S PHYSICAL ADDRESS

APARTMENT/UNIT NUMBER

CITY

STATE

ZIP

COUNTY

*A Domestic Partner must be 18 years of age or older; at least one partner must be a resident of Oregon; and neither partner can presently be in a marriage or a legally recognized registered domestic partnership.

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

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

Change Information for My Dependents Continued

Only changes reflected on this form will be updated on your plan. If you are not making any changes, return this page blank. Adding a dependent outside of Open Enrollment requires a Qualifying Event. Make sure you use full, legal names. For a child-only plan, children must be age 20 or younger as of their effective date. For all other plans, children must be age 25 or younger as of their effective date. If you have additional family members to be enrolled, please include them on a separate sheet with this change form.

4 CHECK ONE:

 Add Remove Update

LAST NAME

FIRST NAME

MI

DATE OF BIRTH

RELATIONSHIP*

SOCIAL SECURITY #

GENDER: M F OtherUSES TOBACCO?** Yes No

HOW DO YOU IDENTIFY?***

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

LIVES WITH POLICYHOLDER?

 Yes No**If no, include the dependent's physical address below**

DEPENDENT'S PHYSICAL ADDRESS

APARTMENT/UNIT NUMBER

CITY

STATE

ZIP

COUNTY

5 CHECK ONE:

 Add Remove Update

LAST NAME

FIRST NAME

MI

DATE OF BIRTH

RELATIONSHIP*

SOCIAL SECURITY #

GENDER: M F OtherUSES TOBACCO?** Yes No

HOW DO YOU IDENTIFY?***

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

LIVES WITH POLICYHOLDER?

 Yes No**If no, include the dependent's physical address below**

DEPENDENT'S PHYSICAL ADDRESS

APARTMENT/UNIT NUMBER

CITY

STATE

ZIP

COUNTY

6 CHECK ONE:

 Add Remove Update

LAST NAME

FIRST NAME

MI

DATE OF BIRTH

RELATIONSHIP*

SOCIAL SECURITY #

GENDER: M F OtherUSES TOBACCO?** Yes No

HOW DO YOU IDENTIFY?***

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

LIVES WITH POLICYHOLDER?

 Yes No**If no, include the dependent's physical address below**

DEPENDENT'S PHYSICAL ADDRESS

APARTMENT/UNIT NUMBER

CITY

STATE

ZIP

COUNTY

*A Domestic Partner must be 18 years of age or older; at least one partner must be a resident of Oregon; and neither partner can presently be in a marriage or a legally recognized registered domestic partnership.

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

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

Read, Sign & Submit

Certification of Completion and Correctness

I affirm that I am requesting a change in coverage for myself and/or my enrolled family dependents and that the answers given in this change form are complete and correct. I am providing these answers as part of the procedure required by Providence Health Plan to request a change in my insurance coverage. I understand and agree that no change in coverage shall be in force until the effective date determined by Providence Health Plan and that Providence Health Plan may contact me to clarify this request.

As a member, I understand I have the right to inspect the information in my file. I understand that I can visit ProvidenceHealthPlan.com to educate myself about Providence Health Plan's privacy practices. I understand that I can get a copy of Providence Health Plan's Notice of Privacy Practices by going to ProvidenceHealthPlan.com/NOPP or by calling Customer Service at **503-574-7500** or **800-878-4445 (TTY: 711)**, 8 a.m. to 5 p.m. (Pacific Time), Monday through Friday.

Signature

1. I understand that this is an Individual & Family health insurance plan. I verify that neither my employer nor any third party will be paying the premium on this policy except as permitted by state or federal regulation.
2. I am the parent or legal guardian of all dependent children listed on this change form.
3. I verify that the physical address I provided on this change form for myself is accurate, as well as any other address provided by me for any dependents.
4. I understand that I must update my information with Providence Health Plan if anything changes.
5. I verify that any newly enrolled dependent(s) are not entitled to Medicare Part A and/or enrolled in Medicare Part B. (The federal government does not allow health plans to issue an Individual & Family health insurance plan that duplicates coverage available through Medicare.)
6. I affirm that if I choose a medical plan without pediatric dental coverage, I will obtain pediatric dental coverage through a separate Marketplace-certified pediatric dental plan, and that I will notify Providence Health Plan if I do not obtain coverage.

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

Signature is considered valid only if it is handwritten ("wet") or e-signed.

A copy of legal guardianship or power of attorney must accompany this form if not signed by the Policyholder.

SIGNATURE OF POLICYHOLDER, LEGAL GUARDIAN OR POWER OF ATTORNEY

_____/_____/_____
TODAY'S DATE (MM/DD/YYYY)

PRINT NAME

Signed by Policyholder for Spouse or Domestic Partner

SIGNATURE OF SPOUSE OR DOMESTIC PARTNER (IF APPLICABLE)

Submission Options

Return completed form electronically:

Log in to your myProvidence account and send us a secure message with a copy of your completed change form attached.

Or email it to PHIndividualForms@Providence.org

Mail completed form to:

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

Fax completed form to:

503-574-8131

Race/Ethnicity Questionnaire

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

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

Hispanic and Latino/a/x

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

Native Hawaiian or Pacific Islander

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

Other

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

American Indian or Alaska Native

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

White

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

Middle Eastern or North African

- Middle Eastern
- North African

Black or African American

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

Asian

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

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

Yes (please specify): _____

No: I do not have just one primary racial or ethnic identity.

No: I identify as Biracial or Multiracial.

N/A: I only checked one category above.

N/A: I don't know.

N/A: I don't want to answer.

What is your preferred spoken language?

- | | | | |
|--|-------------------------------------|-----------------------------------|--|
| <input type="checkbox"/> English | <input type="checkbox"/> Cantonese | <input type="checkbox"/> French | <input type="checkbox"/> Arabic |
| <input type="checkbox"/> Spanish | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Tagalog | <input type="checkbox"/> Decline/Unknown |
| <input type="checkbox"/> Chinese - Other | <input type="checkbox"/> Russian | <input type="checkbox"/> Japanese | <input type="checkbox"/> Other |
| <input type="checkbox"/> Mandarin | <input type="checkbox"/> German | <input type="checkbox"/> Korean | |

What is your preferred written language?

- | | | | |
|----------------------------------|---|----------------------------------|--|
| <input type="checkbox"/> English | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Russian | <input type="checkbox"/> N/A: I don't know. |
| <input type="checkbox"/> Spanish | <input type="checkbox"/> Simplified Chinese | <input type="checkbox"/> Other | <input type="checkbox"/> N/A: I don't want to answer. |

Non-discrimination Statement

Discrimination is against the law. Providence Health Plan ("PHP") does not discriminate or treat people unfairly based on:

- Age
- Gender identity
- Religion
- Color
- Language proficiency
- Sex
- Disability
- Race
- Pregnancy
- National origin
- Sexual orientation

You have the following rights:

- To get free help from a qualified language interpreter.
- To get written information in the language you speak.
- To get information in a way you understand, including:
 - free help from a qualified sign language interpreter,
 - written information in large print, audio, Braille, or other formats, or
 - other reasonable modifications.

Contact the Civil Rights Coordinator at PHP if you:

- Need reasonable modifications, appropriate auxiliary aids and services, or language assistance services,
- Believe PHP failed to provide services and discriminated against you, or
- Want to file a grievance.

Please contact our Civil Rights Coordinator in one of these ways:

1) You can call us.

Toll-Free: **1-800-878-4445** Oregon: **1-503-574-7500**

Hearing Impaired members may call our TTY line at 711.

2) You can mail or email us.

Providence Health Plan Attn: Civil Rights Coordinator

PO Box 4158 Portland, OR 97208-4158

Email: **PHPAppealsandGrievances@providence.org**

3) You also have a right to file a complaint with the following:

U.S. Department of Health and Human Services, Office for Civil Rights

Web portal: **<https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>**

Email: **OCRComplaint@hhs.gov**

Phone: **1-800-368-1019, 1-800-537-7697 (TTY: 711)**

Mail: U.S. Department of Health and Human Services

200 Independence Avenue SW, Room 509F,

HHH Bldg., Washington, DC 20201

Oregon Division of Financial Regulation

Web: **<https://dfr.oregon.gov/Pages/index.aspx>**

Email: **DFR.InsuranceHelp@dcbs.oregon.gov**

Phone: **1-888-877-4894**

Non-Discrimination Statement Rev 10.15.2024

<https://www.providencehealthplan.com/non-discrimination-and-communication-assistance>

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-878-4445 (TTY: 711) or speak to your provider.

Español (Spanish)

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-878-4445 (TTY: 711) o hable con su proveedor.

中文 (Simplified Chinese)

注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-800-878-4445 文本电话：711 或咨询您的服务提供商。

中文 (Traditional Chinese)

注意：如果您說中文，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-878-4445 (TTY：711) 或與您的提供者討論。

Việt (Vietnamese)

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-878-4445 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn."

РУССКИЙ (Russian)

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-878-4445 (TTY: 711) или обратитесь к своему поставщику услуг.

Deutsch (German)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzen zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-878-4445 (TTY: 711) an oder sprechen Sie mit Ihrem Provider."

Français (French)

ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-878-4445 (TTY : 711) ou parlez à votre fournisseur.

Tagalog (Filipino)

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga lib्रेng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-878-4445 (TTY: 711) o makipag-usap sa iyong provider.”

日本語 (Japanese)

注: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル(誰もが利用できるよう配慮された)な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-800-878-4445 (TTY:711)までお電話ください。または、ご利用の事業者にご相談ください。

한국어 (Korean)

주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-878-4445 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

(Arabic) العربية

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-800-878-4445 (711) أو تحدث إلى مقدم الخدمة”.

हिंदी (Hindi)

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-878-4445 (TTY: 711)पर कॉल करें या अपने प्रदाता से बात करें।”

(Farsi) فارسي

توجه: اگر فارسی صحبت می کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب های قابل دسترس، به طور رایگان موجود می باشند. با شماره 1-800-878-4445 (تله تایپ: 711) تماس بگیرید یا با ارائه دهنده خود صحبت کنید.

ភាសាខ្មែរ (Khmer)

សូមយកចិត្តទុកដាក់: ប្រសិនបើអ្នកនិយាយ ភាសាខ្មែរ សេវាកម្មជំនួយភាសាភាគតិចត្រូវតែមានសម្រាប់អ្នក។ ជំនួយ និងសេវាកម្មដែលជាការជួយដ៏សមរម្យ ក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ដែលអាចចូលប្រើប្រាស់បាន ក៏អាចរកបានដោយឥតគិតថ្លៃផងដែរ។ ហៅទូរសព្ទទៅ 1-800-878-4445 (TTY: 711) ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។”

Português do Brasil (Brasillian Portugese)

ATENÇÃO: Se você fala Português, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-878-4445 (TTY: 711) ou fale com seu provedor.”