

2026 Washington 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.

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 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 coverage will be effective on the last day of the monthly period through which 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 change(s) that don't require a Qualifying Event:

- Remove dependent(s)
- Report changes or corrections to a member's personal information (i.e., name, birthdate, tobacco status, etc.)
- Change my address after moving within the same service area:
- _____/_____/_____
- DATE OF MOVE (REQUIRED)

If you only have changes that DO NOT require a Qualifying Event, continue to "Change Information for My Dependents" on page 4.

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

- Change my medical plan Add dependent(s)

Date of Qualifying Event:

Name of family member who experienced the Qualifying Event:

_____/_____/_____

Select the Qualifying Event:

- Involuntary loss of individual or group coverage except for failure to pay the premium
- Marriage or state registered domestic partnership*
- Birth, adoption, placement for adoption or foster care of a child
- Qualified Medical Child Support Order (QMCSO) or acquisition of legal guardianship
- Permanent move to a new Providence Health Plan service area that offers different health plan options
- Loss of coverage as a dependent due to age
- Loss of coverage due to end of marriage or state registered domestic partnership
- Involuntary loss of Medicaid or CHIP coverage
- Newly eligible for a state- or federally-sponsored premium assistance program
- Loss of Advance Premium Tax Credit (APTC), Cost Sharing Reductions (CSR), or cessation of employer contribution to COBRA
- Newly gains access to an individual coverage HRA (ICHRA) or is newly provided a qualified small employer health reimbursement arrangement (QSEHRA)
- 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.

*"State registered domestic partners" means two adults who meet the requirements for a valid state registered domestic partnership as established by RCW 26.60.030, and who have been issued a certificate of state registered domestic partnership by the secretary.

Choose a new medical plan:

Changing your medical 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)
Benton, Clark, Franklin, Spokane, Thurston, Walla Walla	Choice	<input type="checkbox"/> Columbia 1500 Gold <input type="checkbox"/> Columbia 5000 Silver <input type="checkbox"/> Columbia 9200 Bronze

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).

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 all plans, dependent 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

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

HOW DO YOU IDENTIFY?***

USES TOBACCO?** Yes No

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

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

HOW DO YOU IDENTIFY?***

USES TOBACCO?** Yes No

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

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

HOW DO YOU IDENTIFY?***

USES TOBACCO?** Yes No

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

*"State registered domestic partners" means two adults who meet the requirements for a valid state registered domestic partnership as established by RCW 26.60.030 and who have been issued a certificate of state registered domestic partnership by the secretary.

**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 all plans, dependent 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

LAST NAME FIRST NAME MI DATE OF BIRTH

Remove

RELATIONSHIP* SOCIAL SECURITY # GENDER: M F Other

Update

Male Female Non-binary USES TOBACCO? ** Yes No

HOW DO YOU IDENTIFY? ***

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

LAST NAME FIRST NAME MI DATE OF BIRTH

Remove

RELATIONSHIP* SOCIAL SECURITY # GENDER: M F Other

Update

Male Female Non-binary USES TOBACCO? ** Yes No

HOW DO YOU IDENTIFY? ***

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

LAST NAME FIRST NAME MI DATE OF BIRTH

Remove

RELATIONSHIP* SOCIAL SECURITY # GENDER: M F Other

Update

Male Female Non-binary USES TOBACCO? ** Yes No

HOW DO YOU IDENTIFY? ***

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

**State registered domestic partners means two adults who meet the requirements for a valid state registered domestic partnership as established by RCW 26.60.030 and who have been issued a certificate of state registered domestic partnership by the secretary.

**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 understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.
3. I am the parent or legal guardian of all dependent children listed on this change form.
4. 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.
5. I understand that I must update my information with Providence Health Plan if anything changes.
6. 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.)
7. Providence Columbia plans DO NOT include pediatric dental coverage. I affirm that I will obtain pediatric dental coverage, for dependents under age 19, through a separate Exchange-certified pediatric dental plan, and that I will notify Providence Health Plan if I do not obtain coverage. I understand that if I do not obtain pediatric dental coverage, Providence Health Plan will discontinue my or any of my enrolled dependents health benefits until reasonable assurance is obtained.

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 PHPIndividualForms@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

Providence Health Plan ("PHP") complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity or sexual identity. PHP does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity or sexual orientation.

Providence 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, contact Customer Service at: **1-800-878-4445 (TTY: 711)**

If you believe that PHP 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:

Providence Health Plan and Providence Health Assurance

Civil Rights Coordinator, Manager, Appeals and Grievances
PO Box 4158 Portland, OR 97208-4158

Phone: **1-800-878-4445 (TTY 711)**, Fax: **503-574-8757**

Email: **PHPAppealsandGrievances@providence.org**

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator, Manager, Appeals and Grievances 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, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD).

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

The Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at

<https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>,

or by phone at: **1-800-562-6900, 360-586-0241 (TDD).**

Complaint forms are available at:

<https://fortress.wa.gov/oic/online services/cc/pub/complaintinformation.aspx>

WA Non-Discrimination Statement Rev 12.27.24

<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 Sprachassistentendienste 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 libreng 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، فستوفر 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 Portuguese)

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.”