2023 Oregon Individual & Family Change Form

Providence Health Plan

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)**.

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

To fill out a Change Form online, visit **ProvidenceHealthPlan.com/members/IndChange2023**.

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, 2023 through December 31, 2023. 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 the first of the month when recurring payments are 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, 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.

DO NOT RETURN THIS PAGE TO PROVIDENCE HEALTH PLAN

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 _____ FIRST _____ MI _____

SUBSCRIBER ID NUMBER _____ SOCIAL SECURITY NUMBER ___ – ___ – _____ DATE OF BIRTH ___/___/_____

GENDER (CHECK ONE) ☐ Male ☐ Female ☐ Other

HOW DO YOU IDENTIFY? ☐ Transgender Male ☐ Transgender Female ☐ Non-binary ☐ Decline to answer

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

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 6 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 ___/___/_____

Option 2: Make changes to your 2023 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:

- ☐ Cancel my dental plan only
- ☐ 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 the next page →

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

- ☐ Change my medical plan
- ☐ Add dependent(s)
- ☐ Change my address after moving to a new service area
- ☐ Add Providence Progressive Dental coverage

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 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 domestic partnership*
- ☐ Involuntary loss of Medicaid or CHIP coverage
- ☐ Loss of Advance Premium Tax Credit (APTC) or Cost Sharing Reductions (CSR), or cessation of employer contribution to COBRA
- ☐ Newly eligible for a state- or federally-sponsored premium assistance program
- ☐ 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** for additional information regarding Special Enrollment Periods (SEPs).

*A Domestic Partner must be a member of the Policyholder's same sex, 18 years of age or older, and must have legally registered a Declaration of Domestic Partnership and obtained a Certificate of Registered Domestic Partnership in accordance with Oregon state law.

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**.

Applicable Counties	Network	Medical Plan (Check One)
Clackamas, Hood River, Multnomah, Washington, Yamhill **(zip codes 97123 and 97132 only)**	**Connect***	☐ Connect 1500 Gold ☐ Connect 5000 Silver ☐ Connect 9000 Bronze ☐ Connect Direct 5000 Silver
Benton, Clackamas, Clatsop, Crook, Deschutes, Douglas, Hood River, Jackson, Jefferson, Lane, Lincoln, Linn, Marion, Multnomah, Polk, Washington, Yamhill	**Choice***	☐ Providence Oregon Standard Gold ☐ Providence Oregon Standard Silver ☐ Providence Oregon Standard Bronze ☐ Providence Oregon Direct Silver ☐ HSA Qualified 7050 Bronze
Baker, Columbia, Coos, Curry, Gilliam, Grant, Harney, Josephine, Klamath, Lake, Malheur, Morrow, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Wheeler	**Signature**	☐ Providence Oregon Standard Gold ☐ Providence Oregon Standard Silver ☐ Providence Oregon Standard Bronze ☐ Providence Oregon Direct Silver ☐ HSA Qualified 7050 Bronze

*If you choose a Connect or Choice plan, you will need to choose a Medical Home and a Primary Care Provider (PCP) after you enroll. Find a participating Providence Health Plan provider at **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. Providence Progressive Dental coverage is applicable to **all Oregon counties.**

Dental Plan (Check One)

☐ **Add** Providence Progressive Dental (Requires a Qualifying Event)

☐ **Cancel** Providence Progressive Dental (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 **$32** applied to each covered member on the policy.
- **For Connect plans:** coverage for children 18 and 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**.

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 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 Federal Health Insurance Marketplace at **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, leave 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?*** ☐ Transgender Male ☐ Transgender Female ☐ Non-binary ☐ 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?*** ☐ Transgender Male ☐ Transgender Female ☐ Non-binary ☐ 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?*** ☐ Transgender Male ☐ Transgender Female ☐ Non-binary ☐ 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 a member of the Policyholder's same sex, 18 years of age or older, and must have legally registered a Declaration of Domestic Partnership and obtained a Certificate of Registered Domestic Partnership in accordance with Oregon state law.
**Tobacco use is defined as an average of a 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, leave 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 # ___-___-____ USES TOBACCO?** ☐ Yes ☐ No

GENDER: ☐ M ☐ F ☐ Other

HOW DO YOU IDENTIFY?*** ☐ Transgender Male ☐ Transgender Female ☐ Non-binary ☐ 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 # ___-___-____ USES TOBACCO?** ☐ Yes ☐ No

GENDER: ☐ M ☐ F ☐ Other

HOW DO YOU IDENTIFY?*** ☐ Transgender Male ☐ Transgender Female ☐ Non-binary ☐ 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 # ___-___-____ USES TOBACCO?** ☐ Yes ☐ No

GENDER: ☐ M ☐ F ☐ Other

HOW DO YOU IDENTIFY?*** ☐ Transgender Male ☐ Transgender Female ☐ Non-binary ☐ 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 a member of the Policyholder's same sex, 18 years of age or older, and must have legally registered a Declaration of Domestic Partnership and obtained a Certificate of Registered Domestic Partnership in accordance with Oregon state law.
**Tobacco use is defined as an average of a 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/notice-of-privacy-practice** 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

_____

PRINT NAME

☐ Signed by Policyholder for Spouse or Domestic Partner

_____

SIGNATURE OF SPOUSE OR DOMESTIC PARTNER (IF APPLICABLE)

Submission Options

Mail completed form to:
Providence Health Plan
P.O. Box 4649
Portland, OR 97208-4649

OR

Fax completed form to:
503-574-8131

Race/Ethnicity Questionnaire

Providence Health Plan

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?

- ☐ English
- ☐ Spanish
- ☐ Chinese - Other
- ☐ Mandarin
- ☐ Cantonese
- ☐ Vietnamese
- ☐ Russian
- ☐ German
- ☐ French
- ☐ Tagalog
- ☐ Japanese
- ☐ Korean
- ☐ Arabic
- ☐ Decline/Unknown
- ☐ Other

What is your preferred written language?

- ☐ English
- ☐ Spanish
- ☐ Vietnamese
- ☐ Simplified Chinese
- ☐ Russian
- ☐ Other
- ☐ **N/A:** I don't know.
- ☐ **N/A:** I don't want to answer.

Providence Health Plan

Non-discrimination Statement

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Providence Health Plan and Providence Health Assurance:

Provide 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)

Provide free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you are a Medicare member who needs these services, call **503-574-8000** or **800-603-2340**. All other members can call **503-574-7500** or **800-878-4445**. Hearing impaired members may call our TTY line at 711.

Filing a Grievance

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan
and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

DO NOT RETURN THIS PAGE TO PROVIDENCE HEALTH PLAN

Language Access Information

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-603-2340 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-603-2340 (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 1-800-603-2340 (TTY: 711)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-603-2340 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-603-2340 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-603-2340 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-603-2340 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-603-2340 (телетайп: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-603-2340 (TTY: 711)។

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます. 1-800-603-2340 (TTY:711）まで、お電話にてご連絡ください.

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-603-2340 (መስማት ለተሳናቸው: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-603-2340 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-603-2340 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-603-2340 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-603-2340 (TTY: 711).

ໂປດຊາບ: ຖ້າ າວ່ າ ທ່ ານເວ້ າພາສາ ລາວ, ການ ບໍ ລິການຊ່ ວຍເຫຼ ອດ້ ານພາສາ, ໂດຍ ບ່ ເສັ ຽຄ່ າ, ແມ່ ນມພ້ ອມໃຫ້ ທ່ ານ. ໂທຣ 1-800-603-2340 (TTY: 711).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-603-2340 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-603-2340 (ATS: 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-603-2340 (TTY: 711)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-603-2340 (TTY: 711) تماس بگیرید.