Employee application
Illinois groups

Please complete entire form in **BLACK INK**

☐ HMO offered by Quartz Health Benefit Plans Corporation
☐ POS jointly offered by Quartz Health Benefit Plans Corporation and Quartz Health Insurance Corporation
☐ PPO offered by Quartz Health Insurance Corporation

2650 Novation Parkway • Fitchburg, WI 53713-3399
(800) 362-3310 • Fax (608) 643-2564
QuartzBenefits.com

I. Employee information (Please do not use abbreviations or nicknames on this application)

Employee's Last name	First name	MI

Language (preferred spoken and written). Please check one:
☐ English
☐ Spanish
☐ Hmong
☐ German
☐ Chinese
☐ American Sign Language
☐ Other (please specify) _____

Race (defined as a person's identification with one or more social groups). Please select all that apply:
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Pacific Islander
☐ White
☐ Declines to answer
☐ Unavailable

Ethnicity (refers to shared cultural characteristics such as language, ancestry, practices, and beliefs. For this application, ethnicity is broken out into two categories: Hispanic or Latino and Not Hispanic or Latino). Please check one:
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Declines to answer
☐ Unavailable

Social Security Number or Tax ID Number
(SSN/TIN is required for IRS tax reporting regarding your health plan.) ____ ____ ____ – ____ ____ – ____ ____ ____ ____

Street address	Apt. #	City	State	ZIP code	County
Mailing address (if different)		**City**	**State**	**ZIP code**	**County**

Date of birth (mm/dd/yyyy)	Sex	Marital status	Primary phone number
____ /____ /____	☐ Male ☐ Female	☐ Single ☐ Divorced ☐ Married (date: ____ /____ /____) ☐ Domestic partnership (date: ____ /____ /____)	( )

Height/Weight:	Email:

Plan: ☐ HMO ☐ POS ☐ PPO

Type of coverage ☐ Employee ☐ Employee and spouse/partner in civil union ☐ Employee and children ☐ Family
☐ **WAIVING COVERAGE (skip to section V. Waiver of group coverage)**
If married and only selecting coverage for yourself, please complete section V. for your spouse/partner in civil union/children.

Primary care clinic name:	Primary care clinic city:

II. Employer information

Requested effective date of coverage: _____ /_____ /_____

Date employed: _____ /_____ /_____ Hours employee works per week on average:

Employment status: ☐ Active ☐ Retired ☐ Leave of absence
☐ COBRA/Continuation effective date _____ /_____ /_____

COBRA Reason: ☐ End of employment ☐ Death of employee ☐ Entitlement to medicare
☐ Reduction in hours of employment ☐ Divorce or legal separation ☐ Loss of dependent child status

Name of employer group:

III. Dependent information (Please list all other members to be covered)

Dependent's Last name	First name	MI

Social Security Number or Tax ID Number
(SSN/TIN is required for IRS tax reporting regarding your health plan.) ____ ____ ____ – ____ ____ – ____ ____ ____ ____

Does dependent live at the same address as you? ☐ Yes ☐ No If **No** list address:

Mailing address _____

Apt. # _____ City _____ State _____ ZIP code _____ County _____

Relationship to you	Date of birth *(mm/dd/yyyy)* ____/____/_____	Sex ☐ Male ☐ Female

Primary care clinic name:	Primary care clinic city:

Language (preferred spoken and written). Please check one:	Race (defined as a person's identification with one or more social groups). Please select all that apply:	Ethnicity (refers to shared cultural characteristics such as language, ancestry, practices, and beliefs. For this application, ethnicity is broken out into two categories: Hispanic or Latino and Not Hispanic or Latino). Please check one:
☐ English ☐ Spanish ☐ Hmong ☐ German ☐ Chinese ☐ American Sign Language ☐ Other (please specify) _____	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Declines to answer ☐ Unavailable	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declines to answer ☐ Unavailable

Dependent's Last name	First name	MI

Social Security Number or Tax ID Number
(SSN/TIN is required for IRS tax reporting regarding your health plan.) ____ ____ ____ – ____ ____ – ____ ____ ____ ____

Does dependent live at the same address as you? ☐ Yes ☐ No If **No** list address:

Mailing address _____

Apt. # _____ City _____ State _____ ZIP code _____ County _____

Relationship to you	Date of birth *(mm/dd/yyyy)* ____/____/_____	Sex ☐ Male ☐ Female

Primary care clinic name:	Primary care clinic city:

Language (preferred spoken and written). Please check one:	Race (defined as a person's identification with one or more social groups). Please select all that apply:	Ethnicity (refers to shared cultural characteristics such as language, ancestry, practices, and beliefs. For this application, ethnicity is broken out into two categories: Hispanic or Latino and Not Hispanic or Latino). Please check one:
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III. Dependent information (Please list all other members to be covered)

Dependent's Last name	First name	MI

Social Security Number or Tax ID Number
(SSN/TIN is required for IRS tax reporting regarding your health plan.) ____ ____ ____ – ____ ____ – ____ ____ ____ ____

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Mailing address _____

Apt. # _____ City _____ State _____ ZIP code _____ County _____

Relationship to you	Date of birth *(mm/dd/yyyy)* ____/____/_____	Sex ☐ Male ☐ Female

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Mailing address _____

Apt. # _____ City _____ State _____ ZIP code _____ County _____

Relationship to you	Date of birth *(mm/dd/yyyy)* ____/____/_____	Sex ☐ Male ☐ Female

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Social Security Number or Tax ID Number
(SSN/TIN is required for IRS tax reporting regarding your health plan.) ____ ____ ____ – ____ ____ – ____ ____ ____ ____

Does dependent live at the same address as you? ☐ Yes ☐ No If **No** list address:

Mailing address _____

Apt. # _____ City _____ State _____ ZIP code _____ County _____

Relationship to you	Date of birth *(mm/dd/yyyy)* ____/____/_____	Sex ☐ Male ☐ Female

Primary care clinic name:	Primary care clinic city:

Language (preferred spoken and written). Please check one:	Race (defined as a person's identification with one or more social groups). Please select all that apply:	Ethnicity (refers to shared cultural characteristics such as language, ancestry, practices, and beliefs. For this application, ethnicity is broken out into two categories: Hispanic or Latino and Not Hispanic or Latino). Please check one:
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Dependent's Last name	First name	MI

Social Security Number or Tax ID Number
(SSN/TIN is required for IRS tax reporting regarding your health plan.) ____ ____ ____ – ____ ____ – ____ ____ ____ ____

Does dependent live at the same address as you? ☐ Yes ☐ No If **No** list address:

Mailing address _____

Apt. # _____ City _____ State _____ ZIP code _____ County _____

Relationship to you	Date of birth *(mm/dd/yyyy)* ____/____/_____	Sex ☐ Male ☐ Female

Primary care clinic name:	Primary care clinic city:

Language (preferred spoken and written). Please check one:	Race (defined as a person's identification with one or more social groups). Please select all that apply:	Ethnicity (refers to shared cultural characteristics such as language, ancestry, practices, and beliefs. For this application, ethnicity is broken out into two categories: Hispanic or Latino and Not Hispanic or Latino). Please check one:
☐ English ☐ Spanish ☐ Hmong ☐ German ☐ Chinese ☐ American Sign Language ☐ Other (please specify) _____	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Declines to answer ☐ Unavailable	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declines to answer ☐ Unavailable

Note: If you are waiving your right to this group coverage, you do not need to complete the General information and medical information.

IV. General information and medical information

1. Have you or any dependent ever been insured by Quartz? ☐ Yes ☐ No
   If yes, give subscriber name_____ Dates previously covered by Quartz _____
2. Will you or any of your dependents continue to have other insurance after the Quartz effective date of this policy? ☐ Yes ☐ No
   If yes, complete the following information:
   Name(s) of insured _____ Employer _____
   Insurance company _____ Insurance company phone # _____
   Subscriber # _____ Group # _____
   Effective date of coverage_____
3. Are you or any family member(s) enrolled in Medicare? ☐ Yes ☐ No
   If yes, please answer the following and attach a copy of your Medicare card.
   Name _____ Name _____
   Medicare #_____ Medicare #_____
   Effective date, part A _____ Effective date, part A _____
   Effective date, part B _____ Effective date, part B _____
   Effective date, part C *(Medicare advantage)* _____ Effective date, part C *(Medicare advantage)* _____
   Effective date, part D_____ Effective date, part D_____
   Reason for Medicare: ☐ Age 65 ☐ Disability ☐ End stage renal disease ☐ Disability and ESRD
4. Are you or any dependent now disabled or unable to perform normal activities? ☐ Yes ☐ No
   If yes, name of person _____ Type of disability _____ Date of disability_____
5. Have you or any dependent incurred health claims in excess of $5,000 during the last 24 months? ☐ Yes ☐ No
   If yes, name of person _____ Reason_____
6. Within the last 24 months have you or any dependent listed above consulted about, received treatment for or been diagnosed with: cancer, stroke, diabetes, heart condition (including hypertension), vascular disease, behavioral health (mental, anxiety or emotional disorder), muscular or systemic disease (such as arthritis or lupus), alcohol or drug use, liver, kidney, lung (such as COPD or asthma) or intestinal disorder? ☐ Yes ☐ No
   If yes, please explain on a separate sheet of paper and attach to this form. (You do not need to report genetic tests or test results.)
7. Have you ever been diagnosed by a member of the medical profession as having an immune system disorder, AIDS or ARC?
   ☐ Yes ☐ No
   (You do not need to report HIV test results. You only need to report testing, diagnosis, or treatment done by a physician or an appropriately licensed clinical professional acting within the scope of his/her license.)
8. Are you or any dependents currently taking any medications? ☐ Yes ☐ No
   If yes, please list the medications : _____
   _____
9. Are you or is any dependent listed above pregnant? ☐ Yes ☐ No
   If yes, name(s) _____ Pregnancy due date _____
10. Have you or has any listed dependent scheduled or had any surgeries in the last 12 months? ☐ Yes ☐ No
    Have you or has any listed dependent been hospitalized in the last 12 months? ☐ Yes ☐ No
    Reason for hospitalization or surgery:_____
11. Are you or any dependents listed above involved in a Workers Compensation case? ☐ Yes ☐ No
    If yes, indicate family member involved and start date/accident date: _____
    Insurance company name: _____

I acknowledge that I have read and completed the entire application. If I received assistance in reading or completing this application, I have identified the person(s) who assisted me.

I agree that the answers are, to the best of my knowledge and ability, complete and true. I understand that my answers, together with any supplements or additional pages, are the basis for the certificate or policy that is issued. I agree that no insurance will be effective until the date specified by the insurance company on the certificate or policy. I understand that any material misstatement or omission relied upon by the insurer may result in denial of claim and/or rescission of coverage. I further understand that this contract can be voided if within the first 24 months from the date of the policy or certificate it is determined that I or a dependent made an intentional misrepresentation in the application.

I understand that it may be a crime to submit an application or file a claim based on a false or deceptive statement. I further understand it may be a crime to submit an application that is intended to mislead an insurer or conceal significant information about the applicant. I understand that I may request a copy of this application and the notice of the company's privacy practices. I agree that a photocopy is as valid as an original. A legible facsimile or electronic signature shall have the same force as the original. I agree that Quartz may use the email addresses provided in this document to contact the individuals listed in this document.

I understand that enrollment and/or eligibility for benefits may be conditioned upon my willingness to provide written authorization permitting Quartz to obtain medical records from health care providers who have treated me, my spouse/partner in civil union or any dependents applying for coverage under this application. If medical records are needed, Quartz will provide me with an authorization form.

Applicant's signature: _____Date_____

V. Waiver of group coverage

I hereby elect not to apply for group health plan coverage. I hereby waive group health plan coverage for:

☐ Myself ☐ Spouse/Partner in civil union ☐ Children or other eligible dependents

Reason for waiving coverage:

☐ I/we will be covered under another health benefit plan that is not sponsored by my employer.

☐ Name of insurance co.: _____

☐ Other reason for waiving:_____

I certify that I have been given the opportunity to apply for the Quartz group health benefit plan coverage for which I am eligible. I decline to enroll for such coverage as indicated above, on behalf of the persons listed above. I understand that I may be able to obtain coverage at a later time for reasons listed in the Notice of Special Enrollment Rights. If circumstances in the Notice of Special Enrollment Rights do not apply then me and/or the persons listed above may be able to apply for coverage at open enrollment, if my employer has an open erollment period.

I certify that the information above is, to the best of my knowledge and ability, complete and true.

Applicant's signature: _____ Date_____

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse or partner in civil union) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage or civil union, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage or civil union, or within 60 days of the birth, adoption, or placement for adoption.

Non-Discrimination & Language Access

Quartz is the brand name for a group of companies committed to your health: Quartz Health Benefit Plans Corporation, Quartz Health Insurance Corporation, Quartz Health Plan Corporation, and Quartz Health Plan MN Corporation. These companies are separate legal entities. In this notice, "we" refers to all Quartz companies.

For assistance understanding these materials in a language other than English, call (800) 362-3310, and a Customer Success representative will assist you. TTY users should call 711 or (800) 877-8973.

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex, including sexual orientation and gender identity.

We 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)

We provide free language services to people whose primary language is not English, such as –

- Qualified interpreter
- Information written in other languages

If you need these services, contact Customer Success at (800) 362-3310.

If you believe we failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sexual orientation and gender identity, you can file a grievance with –

Kristie Breunig, Compliance Officer
2650 Novation Parkway
Madison, WI 53713
Phone: (800) 362-3310
TTY: 711 or toll-free (800) 877-8973
Fax: (608) 644-3500
Email: AppealsSpecialists@QuartzBenefits.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Kristie Breunig, Compliance Officer, 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 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
(800) 368-1019; (800) 537-7697 (TDD)

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

Quartz is a Qualified Health Plan issuer in the Health Insurance Marketplace in certain states. To learn more, visit the Health Insurance Marketplace at HealthCare.gov.

For help to translate or understand this, please call (800) 362-3310, TTY: 711 / (800) 877-8973.

Spanish – Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de Quartz. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Hmong – Tsab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb. Tsab ntawv tshaj xo no muaj cov ntsiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog koj qhov kev pab cuam los ntawm Quartz. Saib cov caij nyoog los yog tej hnub tseem ceeb uas sau rau hauv daim ntawv no kom zoo. Tej zaum koj kuj yuav tau ua qee yam uas peb kom koj ua tsis pub dhau cov caij nyoog uas teev tseg rau hauv daim ntawv no mas koj thiaj yuav tau txais kev pab cuam kho mob los yog kev pab them tej nqi kho mob ntawd. Koj muaj cai kom lawv muab cov ntshiab lus no uas tau muab sau ua koj hom lus pub dawb rau koj. Hu rau (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Vietnamese – Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng bàn về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình Quartz. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ trúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Chinese – 本通知含有重要的訊息 本通知對於您透過 Quartz 所提 出的申請或保險有重要的訊息 請在本通知中查看重要的日期 您可能要在特定的截止日期之 前採取行動，以保留您的健康保險或有助於省錢 您有權利免費以您的母語得到幫助和訊息 請致電 (800) 362-3310：711 / (800) 877-8973.

Russian – Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через Quartz. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Laotian – ແຈ້ງການສະບັບນີ້ມີຂໍ້ມູນທີ່ສຳຄັນ.
ແຈ້ງການສະບັບນີ້ມີຂໍ້ມູນທີ່ສຳຄັນກ່ຽວກັບໃບສະໝັກ ຫຼື ການຄຸ້ມຄອງຂອງທ່ານຜ່ານ Quartz. ຊອກຫາວັນທີສຳຄັນ ໃນຫນັງສືແຈ້ງການສະບັບນີ້.ທ່ານອາດຈຳເປັນຕ້ອງປະຕິບັດຕາມເວລາ ທີ່ກຳນົດໄວ້ທີ່ແນ່ນອນເພື່ອຮັກສາໄວ້ການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານ ຫຼື ຊ່ວຍເຫຼືອດ້ານຄ່າໃຊ້ຈ່າຍ.ທ່ານມີສິດທີ່ຈະໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາເບີ (800) 362 3310. TTY / TDD: 711 / (800) 877 8973.

German – Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Quartz. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Arabic – يحتوي هذا الإشعار على معلومات مهمة. يتضمن هذا الإشعار معلومات هامة حول طلبك أو تغطيتك عبر Quartz. ابحث عن التواريخ الرئيسية في هذا الإشعار. قد تحتاج إلى إجراء تدابير معيّنة وفقاً لمواعيد معيّنة من أجل الحفاظ على تغطيتك الصحية أو المساعدة في التكاليف. ليدك الحق في الحصول على هذه المعلومات وعلى المساعدة في لغتك دون أي تكلفة. اتصل على TTY / TDD: 711 / (800) 877-8973 / (800) 362-3310.

French – Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou la couverture par l'intermédiaire de Quartz. Rechercher les dates clés dans le présent avis. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Korean – 본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 Quartz을 통한 커버리지 에 관한 정보를 포함하고 있습니다.본 통지서에서 핵심이 되는 날짜들을 찾으십시오. 귀하는 귀하의 건강 커버리지를 계속유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가있습니다. (800) 362-3310 로 전화하십시오. TTY / TDD: 711 / (800) 877-8973.

Tagalog – Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Quartz. Tingnan ang mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Pennsylvanian Dutch – Die Bekanntmaching gebt wichdichi Auskunft. Die Bekanntmaching gebt wichdichi Auskunft baut dei Application oder Coverage mit Quartz. Geb Acht fer wichdiche Daadem in die Bekanntmachung. Es iss meeglich, ass du ebbes duh muscht, an beschtimmde Deadlines, so ass du dei Health Coverage bhalde kannscht, odder bezaahle helfe kannscht. Du hoscht es Recht fer die Information un Hilf in deinre eegne Schprooch griege, un die Hilf koschtet nix. Kannscht du (800) 362-3310 uffrufe. TTY / TDD: 711 / (800) 877-8973.

Polish – To ogłoszenie zawiera ważne informacje. To ogłoszenie zawiera ważne informacje odnośnie Państwa wniosku lub zakresu świadczeń poprzez Quartz.Prosimy zwrócic uwagę na kluczowe daty zawarte w tym ogłoszeniu aby nie przekroczyć terminów w przypadku utrzymania polisy ubezpieczeniowej lub pomocy związanej z kosztami. Macie Państwo prawo do bezpłatnej informacji we własnym języku. Zadzwońcie pod (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Hindi – **इस सूचना में महत्वपूर्ण जानकारी शामिल है।** इस सूचना में Quartz से जुड़े आपके आवेदन या कवरेज के बारे में महत्वपूर्ण जानकारी शामिल है। इस सूचना में महत्वपूर्ण तारीखों को देखना न भूलें। स्वास्थ्य कवरेज जारी रखने या खर्चे में मदद के लिए आपको कुछ तय तारीखों तक कार्रवाई करनी ज़रूरी है। आपके पास अपनी भाषा में, बिना किसी शुल्क के इस जानकारी और सहायता को पाने का अधिकार है। (800) 362-3310. TTY / TDD: 711 / (800) 877-8973 पर कॉल करें।

Albanian – Ky njoftim përmban informacion të rëndësishëm. Ky njoftim përmban informacion të rëndësishëm për aplikimin ose mbulimin tuaj nëpërmjet Quartz. Kontrolloni për data të rëndësishme në këtë njoftim. Mund t'ju duhet të ndërmerrni veprim brenda afatave të caktuara për të mbajtur mbulimin tuaj shëndetësor ose për ndihmën me koston. Keni të drejtë ta merrni këtë informacion dhe ndihmë falas në gjuhën tuaj. Telefononi numrin (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Somali – FIIRO GAAR AH: Haddii aad ku hadashid af Soomaali, adeegyada caawimada luuqada, ayaa waxaa laguugu siinayaa bilaash, waa laguu heli karaa. 1-800-362-3310 (TTY: 1-800-877-8973) bilbilaa.

Cushite – Oroomiffa XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Amharic – ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ (800) 362-3310. (መስማት ለተሳናቸው: 711 / (800) 877-8973).

Karen – ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အယိ, နမၤနှ်ံ ကျိာ်အတ်မၤစၢၤလ၊ တလၫ်ဘူဉ်လၫ်စ့ၤ နီတမံၤဘဉ်သုန္ဉ်လီၤ. ကိး (800) 362-3310.TTY / TDD: 711 / (800) 877-8973.

Mon-Khmer, Cambodian – ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Serbocroatian – OBAVJEŠTENJE: Ako govorite srpskohrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite (800) 362-3310 TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711 / (800) 877-8973.

Thai – เรียน: ถา้ คุณพดู ภาษาไทยคุณสามารถใชบ้ ริการช่วยเหลือทางภาษาไดฟ้ รี โทร (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Gujarati – સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Urdu – خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Italian – ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Greek – ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.