Employee application Iowa groups

Please complete entire form in BLACK INK

□ HMO offered by Quartz Health Plan Corporation

□ POS offered by Quartz Health Plan Corporation

D PPO offered by Quartz Health Plan 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			МІ		
Social Security Numb (SSN/TIN is required for IRS tax)					
Street address			Apt. #	City	State	ZIP code		County
Mailing address (if di	ferent)		City		State	ZIP code Cour		County
			atus Primary phone number ()				er ()	
Height/Weight:		Email:						
Language (preferred spoken and written). 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: Black or African American White Hispanic or Latino). Please to answer Other Declines to answer Not Hispanic or Latino (please specify) Unavailable Duravailable								
Plan: 🗆 HMO 🗆 POS 🗆 PPO								
Type of coverage Employee Employee and spouse 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/children.								
Primary care clinic name Primary care clinic city								
II. Employer information								
Requested effective date of coverage: / /								
Date employed:	/	/	н	ours employee works p	er week	on average	ə:	
Employment status: (□ Active □ Re	etired 🗆 Le	eave of a	bsence				
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		М	
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 of					
Mailing address					
Apt. # City		State ZIP code _	Co	ounty	
Relationship to you		Date of birth (mm/dd/yyyy)	Sex 🗆 Male 🗆 Female		
Primary care clinic name:	I	Primary care clinic city:			
Language (preferred spoken and written). Please check one: English Spanish Hmong German Chinese American Sign Language Other (please specify)	s identification with one ase select all that apply: aska Native can cific Islander	characteristics s ancestry, practic application, ethr two categories: F	panic or Latino s to answer		
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 of Mailing address		lo list address:			
-	_ 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: English Spanish Hmong	's identification with one ase select all that apply: Ethnicity (refers to shared cultural characteristics such as language, ancestry, practices, and beliefs. For thi application, ethnicity is broken out into two categories: Hispanic or Latino and Hispanic or Latino). Please check one: Cific Islander Hispanic or Latino Not Hispanic or Latino Declines to answer Unavailable Unavailable			1	

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 Does dependent live at the same address of						
Mailing address						
Apt. # City		State ZIP code County				
Relationship to you		Date of birth (mm/dd/yyyy)	Sex □Male □Female	e		
Primary care clinic name:		Primary care clinic city:		1		
Language (preferred spoken and written). Please check one: English Spanish Hmong German Chinese American Sign Language Other (please specify)	's identification with one ase select all that apply: aska Native can cific Islander	characteristics s ancestry, practic application, ethr two categories: H Hispanic or Latin \Box Hispanic or L	spanic or Latino nes to answer			
Dependent's Last name		First name			МІ	
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 of Mailing address		lo list address:				
Apt. # City	State ZIP code _	ounty				
Relationship to you	Date of birth (mm/dd/yyyy)	Sex 🗆 Male 🗆 Female	e			
Primary care clinic name:	Primary care clinic city:					
Language (preferred spoken and written). Please check one: English Spanish Hmong German Chinese American Sign Language Other (please specify)	's identification with one ase 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 N can Hispanic or Latino). Please check one: Hispanic or Latino Not Hispanic or Latino Declines to answer Unavailable			ge, For this out into no and Not		

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 Does dependent live at the same address of						
Mailing address						
Apt. # City		State ZIP code County				
Relationship to you		Date of birth (mm/dd/yyyy)	Sex □Male □Female	e		
Primary care clinic name:		Primary care clinic city:		1		
Language (preferred spoken and written). Please check one: English Spanish Hmong German Chinese American Sign Language Other (please specify)	's identification with one ase select all that apply: aska Native can cific Islander	characteristics s ancestry, practic application, ethr two categories: H Hispanic or Latin \Box Hispanic or L	spanic or Latino nes to answer			
Dependent's Last name		First name			МІ	
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 of Mailing address		lo list address:				
Apt. # City	State ZIP code _	ounty				
Relationship to you	Date of birth (mm/dd/yyyy)	Sex 🗆 Male 🗆 Female	e			
Primary care clinic name:	Primary care clinic city:					
Language (preferred spoken and written). Please check one: English Spanish Hmong German Chinese American Sign Language Other (please specify)	's identification with one ase 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 N can Hispanic or Latino). Please check one: Hispanic or Latino Not Hispanic or Latino Declines to answer Unavailable			ge, For this out into no and Not		

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 in	formation and medical information					
1.	Have you or any dependent ever been insured by Qu						
		Dates previously covered by Quartz					
2.	, .	other insurance after the Quartz effective date of this policy?					
	yes, complete the following information:						
		Employer					
		Insurance company phone #					
	Subscriber #	Group #					
	Effective date of coverage						
3.	Are you or any family member(s) enrolled in Medicar	e? □Yes □No					
	f 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 D					
	Reason for Medicare: 🗆 Age 65 🗆 Disability 🗆 E						
4.	Are you or any dependent now disabled or unable to	-					
		' Type of disability Date of disability					
5.		excess of \$5,000 during the last 24 months?					
		Reason					
6.	, ,	t listed above consulted about, received treatment for or been diagnosed with:					
	ancer, stroke, diabetes, heart condition (including hypertension), vascular disease, behavioral health (mental, anxiety or emotiona						
	sorder), 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 ar	nd attach to this form. (You do not need to report genetic tests or test results.)					
7.		nedical profession as having an immune system disorder, AIDS or ARC?					
	(You do not need to report HIV test results. You only n	eed to report testing, diagnosis, or treatment done by a physician or an					
	appropriately licensed clinical professional acting with	thin the scope of his/her license.)					
8.	Are you or any dependents currently taking any med	ications? 🗆 Yes 🗆 No					
9.	Are you or is any dependent listed above pregnant?	□ Yes □ No Pregnancy due date					
10	If yes, name(s) . Have you or has any listed dependent scheduled or h						
10.							
	Have you or has any listed dependent been hospitaliz						
		Reason for hospitalization or surgery:					
11.							
	, , ,	e/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 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 enrollment 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) 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, 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 within 60 days of the birth, adoption, or placement for adoption.



Notice of Non-Discrimination and Availability of Language Assistance Services and Auxiliary Aids and Services

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 (includes sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes). Quartz does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

We provide reasonable modifications and free appropriate auxiliary aids and services to people with disabilities to communicate effectively with us and to participate in health programs or activities, 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 interpreters
- 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, you can file a grievance with-

Chief Compliance Officer 2650 Novation Parkway Fitchburg, 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, our Chief 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.

ATTENTION: 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 (800) 362-3310, TTY: 711 / (800) 877-8973.

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 (800) 362-3310. TTY: 711 / (800) 877-8973 o hable con su proveedor.

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 (800) 362-3310. TTY: 711 / (800) 877-8973 或咨询您的服务提供商。

Hmong - LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau (800) 362-3310. TTY: 711 / (800) 877-8973 los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob.

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 (800) 362-3310. TTY: 711 / (800) 877-8973 или обратитесь к своему поставщику услуг.

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 dịnh dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số (800) 362-3310. TTY: 711 / (800) 877-8973 hoặc trao đối với người cung cấp dịch vụ của bạn.

Laotian – ເຊັນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມືບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສິມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ (800) 362–3310. TTY: 711 / (800) 877–8973 ຫຼື ລິມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

German – ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie (800) 362–3310. TTY: 711 / (800) 877–8973 an oder sprechen Sie mit Ihrem Provider.

Pennsylvania Dutch - LET OP: als je Nederlands spreekt, zijn er gratis taalhulpdiensten voor je beschikbaar. Passende hulpmiddelen en diensten om informatie in toegankelijke formaten te verstrekken, zijn ook gratis beschikbaar. Bel (800) 362-3310. TTY: 711 / (800) 877-8973 of spreek met je provider."

Polish - UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer (800) 362-3310. TTY: 711 / (800) 877-8973 lub porozmawiaj ze swoim dostawcą.

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 (800) 362-3310. TTY: 711 / (800) 877-8973 ou parlez à votre fournisseur.

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। । (800) 362-3310. TTY / TDD: 711 / (800) 877-8973 पर कॉल करें या अपने प्रदाता से बात करें।

Korean -주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. (800) 362-3310. TTY: 711 / (800) 877-8973 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Albanian - VINI RE: Nëse flisni [shqip], shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi (800) 362-3310. TTY: 711 / (800) 877-8973 ose bisedoni me ofruesin tuaj të shërbimit.

Tagalog - 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 (800) 362-3310. TTY: 711 / (800) 877-8973 o makipag-usap sa iyong provider.

Somali - FIIRO GAAR AH: Haddaad ku hadasho Soomaali, adeegyo kaalmada luuqadda ah oo bilaash ah ayaad heli kartaa. Qalab caawinaad iyo adeegyo oo habboon si loogu bixiyo macluumaadka qaabab la adeegsan karo ayaa sidoo kale bilaa lacag heli karaa. Wac (800) 362-3310. TTY: 711 / (800) 877-8973 ama la hadal bixiyahaaga. Gargaarsi gargaaraa fi tajaajjilli sirrii ta'ee fi odeeffannoo bifa dhaqqabamaa ta'een kennuunis bilisaan ni argama.

Cushite (Oromo) - XIYYEEFFANNOO: Afaan Kushii yoo dubbattan tajaajilli gargaarsa afaanii bilisaan isiniif ni kennama. Gargaarsi gargaaraa fi tajaajilli sirrii ta'ee fi odeeffannoo bifa dhaqqabamaa ta'een kennuunis bilisaan ni argama. (800) 362-3310 bilbili. TTY: 711 / (800) 877-8973 ykn dhiyeessaa keessan waliin haasa'aa.

Amharic - ማሳሰቢይ፡- አማርኛ የሚናንሉ ከሆነ፣ የቋንቋ ድጋፍ አንልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርяት ለማቅረብ ተባቢ የሆኑ ተጨማሪ አንዛዎች እና አንልግሎቶች እንዲሁ በነፃ ይንኛሉ። በስልከ ቁጥር (800) 362-3310. TTY: 711 / (800) 877-8973 ይደውሉ ወይም አንልግሎት አቅራቢዎን ያናግሩ።

Karen – ဆူ– နမ္မာ်ကတိၤ ထာနာ်လီးဖဲအံၤ အဃိ, တၢ်အိဉ်ဒီး ကိုဉ်တာ်ဆီဉ်ထွဲမւစၢၤ လာတလာ ဘူဉ်လာစ္၊လာနဂ်ီးလီ၊. တၢ်အိဉ်ဒီး တာ်မւစၢၤတာ်နာ်ဟူပီးလီဒီး တာ်မၤစၢၤတာ်မၤ လာအ ကြားအဘဉ်

លាកាយុဉ်တစ်ဂ္ဂါတစ်ကို၊ လာတစ်မနော်အီးသံတဖဉ် လာတလာဘူဉ်လာစံ့၊ လာနဂိါလီ၊. ကိး (800) 362–3310. TTY: 711 / (800) 877–8973 မဲ့တမ့်၊ ကတိးတစ်ိဳး နမ္န၊လာဟ္ဉ် န၊တစ်ကွစ်ထွဲမ၊စၢ၊တက္၊်. Mon-Khmer, Cambodian (Khmer) – សូមយកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយ ភាសាខ្មែរ សេវាកម្មជំនួយភាសាគតគិតថ្លៃគឺមានសម្រាប់អ្នក។ ជំនួយ

និងសេវាកម្មដែលជាការជួយដ៍សមរម្យ ក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ដែលអាចចូលប្រើប្រាស់បាន ក៍អាចរកបានដោយឥតគិតថ្លៃជងដែរ។ ហៅទូរសព្ទទៅ (800) 362-3310. TTY: 711 / (800) 877-8973 ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។

Serbo-croatian (Serbian) – ПАЖЊА: Ако говорите српскохрватски, доступне су вам бесплатне језичке услуге. Бесплатна су и одговарајућа помоћна помагала и услуге за пружање информација у приступачним форматима. Позовите (800) 362–3 ТТИ: 711 / (800) 877–8973 или разговарајте са својим провајдером.

Thai - หมายเหตุ: หากคุณใช้ภาษา ไหย เรามีบริการความช่วยเหลือต้านภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโหรติดต่อ (800) 362-3310. TTY: 711 / (800) 877-8973 หรือปรึกษาผู้ให้บริการของคุณ"

Gujarati – ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમારા માટે મફત ભાષા સહાય સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પ્રદાન કરવા માટે યોગ્ય સહાયક સહાય અને સેવાઓ પણ મફતમાં ઉપલબ્ધ છે. કૉલ કરો (800) 362-3310. TTY: / (800) 877-8973 અથવા તમારા પ્રદાતા સાથે વાત કરો.

Urdu - توجہ: اگر آپ اردو بولتے ہیں، تو آپ کے لیے مفت زبان کی مدد کی خدمات دستیاب ہیں۔ قابل ر سائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ (800) 332-350 پر کال – Urdu یا اپنے فراہم کنندہ سے بات کریں۔ 8973-877 (800) / TTY: 711 کریں۔

Italian - ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama I'(800) 362-3310. TTY: 711 / (800) 877-8973 o parla con il tuo fornitore.

Greek - ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες υποστήριξης στη συγκεκριμένη γλώσσα. Διατίθενται δωρεάν κατάλληλα βοηθήματα και υπηρεσίες για παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε το (800) 362-3310. ΤΤΥ: 711 / (800) 877-8973 ή απευθυνθείτε στον πάροχό σας.

Nepali – ध्यान दिनुहोस्: यदि तपाइँ नेपाली बोल्नुहुन्छ भने, तपाइँलाई निःशुल्क भाषा सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक सहायताहरू र सेवाहरू पनि निःशुल्क उपलब्ध छन्। कल (८००) ३६२-३३१०। ७७४: (८००) ८७७-८९७७३ वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।

Ukrainian – УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером (800) 362–3310. ТТҮ: 711 / (800) 877–8973 або зверніться до свого постачальника.

Tibetan - รัฐแตลาวัฐราสานรักษารัฐสาวินาร์สามรูมิการ์สามรูมิการ์สามรูมิการ์สามรูมิการ์สามรูร์สานการ์สามรูมิการ์สามรูมิการ์สามรูมิการ์สามรูมิการ์สามรูมิการ์สามรูมิการ์สามรูมิการ์สามรูมิการ์สามรูมิการ์สามรูมิการ์สามรูมิการ์สามรูมิการ์สามรูมิการ์สามรูมิการ์สามรูมิการ์สามรูมิการ์สามรูมิการ์

Wolof - FÀTTAL: Sooy wax Wolof, ay serwiis yu lay jàppale ci làkk wi doo fay. Ay ndimbal ak ay serwiis yu war ngir joxe leeral ci formaa yu yomb am nañu ci te doo fay. Woowal (800) 362-3310. TTY: 711 / (800) 877-8973 wala nga waxtaan ak sa joxekat.