Employee application
Wisconsin groups

Please complete entire form in BLACK INK

☐ HMO offered by Quartz Health Benefit Plans Corporation
☐ POS offered by Quartz Health Benefit Plans Corporation
☐ PPO offered by Quartz Health Benefit Plans 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)

☐ New ☐ Change	Employee'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.)* ____–____–____

Street address	Apt. #	City	State	ZIP code	County

Mailing address *(if different)*	City	State	ZIP code	County

Date of birth *(mm/dd/yyyy)* ____/____/_____

Sex ☐ Male ☐ Female

Marital status ☐ Single ☐ Divorced ☐ Married/Domestic partnership (date ____/____/_____)

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

Primary phone #	Cell phone #	Opt-In to Text/SMS contact ☐ Yes ☐ No_____
( )	( )	

Email address	Primary care clinic name _____ Primary care clinic city _____

Plan:
☐ HMO (list group number) _____ ☐ POS (list group number) _____ ☐ PPO (list group number) _____

Type of coverage ☐ Employee ☐ Employee and spouse/domestic partner ☐ 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/domestic partner/children.

Reason for enrollment: (check appropriate box)

- ☐ New hire
- ☐ Loss of other coverage*
- ☐ Open enrollment
- ☐ Marriage/domestic partnership (date ____/____/_____)
- ☐ Birth (date ____/____/_____)
- ☐ Adoption/placement for adoption (date ____/____/_____)
- ☐ Part-time to full-time employment (date of change ____/____/_____)
- ☐ COBRA/state continuation
- ☐ Rehire (date ____/____/_____)
- ☐ Return from layoff (date ____/____/_____)
- ☐ Name change/address change/PCP or NP change
- ☐ Transfer to retiree segment
- ☐ Transfer to disability segment
- ☐ Other _____

By checking the box you are confirming your loss of other coverage entitles you to a special enrollment period.

II. Employer information

Name of employer group	Date employed ___/___/_____	Weekly hours	Requested effective date ___/___/_____

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

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:
☐ 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

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:
- ☐ English
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- ☐ 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

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- ☐ Not Hispanic or Latino
- ☐ Declines to answer
- ☐ Unavailable

IV. Other insurance information

1. Are you or your spouse, domestic partner, or child(ren) covered by Medicare (Parts A, B, C, or D)? ☐ Yes ☐ No
If yes, please list name(s)

Reason for Medicare: ☐ Age 65 ☐ Disability ☐ End stage renal disease ☐ Disability and ESRD

Effective date, Part A ____/____/____ Effective date, Part B ____/____/____ Medicare beneficiary identifier (MBI)

Effective date, Part C ____/____/____ Effective date, Part D ____/____/____

2. Are you or any dependents listed above involved in a Workers Compensation case? ☐ Yes ☐ No
If yes, indicate who is involved and start date/accident date and insurance company name

3. Will you or any of your dependents continue to have other insurance after the Quartz effective date of this policy?
If yes, complete the following information

Names of those covered under policy	Employer	
Insurance company	Subscriber #	Group #
Effective date of coverage	Insurance company phone # ( )	
Termination date		

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.

I understand that if I opt-in to Text/SMS contact, I agree and consent that Quartz and its affiliates may text me at the cell phone number included on this application to help keep me Informed about my benefits.

Dental disclaimer

This policy does not include pediatric dental services, which is an essential health benefit under the Affordable Care Act. This dental coverage is available in the insurance market as a stand-alone dental product. Please contact your insurance carrier, agent, Federally Facilitated Marketplace, or state-based Health Care Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental product. By signing this application you are acknowledging this policy does not contain pediatric dental.

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 or domestic partner ☐ 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. 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 domestic partner) 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, domestic partnership, 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 domestic partnership, 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 định 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 đổi với người cung cấp dịch vụ của bạn.
Laotian - ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາບໍ (800) 362-3310. TTY: 711 / (800) 877-8973 ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.
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."
Arabic – 3310-362 (800)1 اتصل على الرقم المجانيّة. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقٍ يمكن الوصول إليها مجانًا. تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. TTY: 711 / (800) 877-8973 أو تحدث إلى مقدم الخدمة".
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। I (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 tajaajilli 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 – ማሳሰቢያ፡- አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል፡፡ መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ አጋዥ እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ፡፡ በስልክ ቁጥር (800) 362-3310. TTY: 711 / (800) 877-8973 ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ፡፡
Karen – ဆူ- နမ့်ကတိၤ ထၢနှာ်လီၤဖဲအံၤ အဃိ, တၢ်အိဉ်ဒီး ကျိာ်တၢ်ဆိဉ်ထွဲမၤစၢၤ လၢတလာ်ဘူဉ်လာ်စ့ၤလၢနှာ်လီၤ. တၢ်အိဉ်ဒီး တၢ်မၤစၢၤတၢ်နှၢ်ဟူဝီးလီဒီး တၢ်မၤစၢၤတၢ်မၤ လၢအ ကြၢးအဘဉ် လၢကဟ့ဉ်တၢ်ဝ့တၢ်ကျိၤ လၢတၢ်မၤနှဉ်အီၤသ့တဖဉ် လၢတလာ်ဘူဉ်လာ်စ့ၤ လၢနှာ်လီၤ. ကိး (800) 362-3310. TTY: 711 / (800) 877-8973 မ့တမ့်ၵတိၤတၢ်ဒီး နပှၤလၢဟ့ဉ် နၤတၢ်ကွၢ်ထွဲမၤစၢၤတက့ၢ်.
Mon-Khmer, Cambodian (Khmer) – សូមយកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ សេវាកម្មជំនួយភាសាឥតគិតថ្លៃគឺមានសម្រាប់អ្នក។ ជំនួយនឹងសេវាកម្មដែលជាការផ្តួយដ៏សមរម្យ ក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ដែលអាចចូលប្រើប្រាស់បាន ក៏អាចរកបានដោយឥតគិតថ្លៃផងដែរ។ 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 ไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ (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۔ (800) 3310-362 پر کال کریں۔ TTY: 711 / (800) 877-8973 یا اپنے فراہم کنندہ سے بات کریں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔
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 l'(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. TTY: 711 / (800) 877-8973 ή απευθυνθείτε στον πάροχό σας.
Nepali – ध्यान दिनुहोस्: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंलाई निःशुल्क भाषा सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक सहायताहरू र सेवाहरू पनि निःशुल्क उपलब्ध छन्। कल (800) 362-3310। TTY: 711 / (800) 877-8973 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. TTY: 711 / (800) 877-8973 або зверніться до свого постачальника.
Tibetan – ཨ་རྟང་ཁྱད་ཆོས་ལྡན་ཡིན་ན། སྐད་ཡིག་ཞབས་ཏོག་ཐམ་པ་རེད། ཡིག་ཆ་ཚན་པ་དང་ཞབས་ཏོག་ཚུ་ཡང་ཁ་སྐད་ཆ་ཚད་ལྡན་པའི་རྣམ་གཞག་ཏུ་ཡོད་པའི་ཐབས་ལམ་ཁག་ཡང་ཐ་མི་འཚལ་བ་ཞིག་ཡོད། ཁ་པར་(800)362-3310 TTY: 711 / (800) 877-8973 ཨང་ཀ་ལ་འབོད་ནས་ཡང་ན་ཁྱེད་ཀྱི་ཞབས་ཏོག་སྤྲོད་མཁན་དང་གསུང་བཤད་གནང་རོགས།
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.