

Individual Enrollment Request Form to Enroll in a Medicare Advantage Plan (Part C) or Medicare Prescription Drug Plan (Part D)

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan or Medicare Prescription Drug Plan
To join a plan, you must:

- ▶ Be a United States citizen or be lawfully present in the U.S.
- ▶ Live in the plan’s service area

Important: To join a Medicare Advantage Plan, you must also have both:

- ▶ Medicare Part A (Hospital Insurance)
- ▶ Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- ▶ Between October 15 – December 7 each year (for coverage starting January 1)
- ▶ Within 3 months of first getting Medicare
- ▶ In certain situations where you’re allowed to join or switch plans
- ▶ Visit Medicare.gov to learn more about when you can sign up for a plan

What do I need to complete this form?

- ▶ Your Medicare Number (the number on your red, white, and blue Medicare card)
- ▶ Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can’t be denied coverage because you don’t fill them out.

Reminders:

- ▶ If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- ▶ Your plan will send you a bill for the plan’s premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:

Quartz Medicare Advantage (HMO)

840 Carolina Street
Sauk City, WI 53590

Once they process your request to join, they’ll contact you.

How do I get help with this form?

Call Quartz Medicare Advantage at **(800) 394-5566**. TTY users can call **711**. Or, call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users can call **1-877-486-2048**.

En español: Llame a Quartz Medicare Advantage al **(800) 394-5566/TTY 711** o a Medicare gratis al **(1-800-633-4227)** y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-NEW. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren’t about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See “What happens next?” on this page to send your completed form to the plan.

2022 Enrollment Application

Effective Date: _____

ELECTION TYPE (PLEASE CHECK ONE.)

- Annual Election Period (AEP) from Oct. 15 – Dec. 7, 2021
- Open Enrollment Period from January 1 – March 31, 2022
- Initial Coverage Election Period (ICEP)
- 5-Star Quality Rating Special Enrollment Period (SEP) from Dec. 8, 2021 to Nov. 30, 2022
- Open Enrollment Period for Institutionalized Individuals (OEPI)
- Special Enrollment Period (Complete SEP Attestation attached)

To enroll in Quartz Medicare Advantage (HMO), please provide the following information:

YOUR PERSONAL INFORMATION

Last Name:	First Name:	MI:
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Date of Birth: (MM/DD/YYYY)	Gender:	Home Phone Number:	Alternate Phone Number:
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Email Address (optional): _____

PERMANENT RESIDENCE STREET ADDRESS (P.O. BOX IS NOT ALLOWED.)

Street Address: _____

City:	State:	ZIP:
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County: _____

MAILING ADDRESS (ONLY IF DIFFERENT FROM YOUR PERMANENT RESIDENCE STREET ADDRESS.)

Address: _____

City:	State:	ZIP:
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PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION

Please take out your red, white, and blue Medicare card to complete this section.

Fill out this information as it appears on your Medicare card.

-OR-

Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

Medicare Number:

Is entitled to:

Effective Date:

HOSPITAL (Part A):

MEDICAL (Part B):

You must have Medicare Parts A and B to join a Medicare Advantage plan.

I AM APPLYING FOR:

- Value** (no Rx) **\$0.00** monthly premium plan
- Elite** (no Rx) **\$50.00** monthly premium plan
- Core D** (with Rx) **\$0.00** monthly premium plan
- Value D** (with Rx) **\$51.00** monthly premium plan
- Elite D** (with Rx) **\$101.00** monthly premium plan

OPTIONAL SUPPLEMENTAL DENTAL BENEFIT

- Yes, I would like to buy the **supplemental dental benefit option** for an additional **\$48.10 per month**.

WHO IS YOUR PRIMARY CARE PROVIDER AND WHAT CLINIC DO YOU GO TO FOR CARE? (OPTIONAL)

Primary Care Provider (please specify):

Clinic Name (please specify):

HOW DID YOU HEAR ABOUT QUARTZ MEDICARE ADVANTAGE?

- Agent/Broker
- Aging and Disability Resource Center (ADRC)
- Employer
- Facebook
- Friend/Relative
- Internet
- Mailing
- Newspaper
- Provider Referral
- Radio
- Television

PREFERRED LANGUAGE? (Spoken and written. Please check one.)

- Chinese
- English
- German
- Hmong
- Spanish
- American Sign Language
- Other (please specify): _____

RACE: Defined as a person's identification with one or more social groups.

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or other 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.

- Hispanic or Latino
- Not Hispanic or Latino
- Declines to Answer
- Unavailable

OTHER FORMATS REQUESTED FOR MEMBER MATERIALS?

- Audio Recording
- Large Print

**PLEASE ANSWER THE FOLLOWING QUESTIONS TO HELP
MEDICARE COORDINATE YOUR BENEFITS:**

1. Are you a resident of a long-term care facility, such as a nursing home? Yes No
2. Are you enrolled in your State Medicaid program? Yes No
 - If yes, please provide your Medicaid number: _____
3. Do you, on your own or through your spouse, have any medical or health insurance other than Medicare, such as private insurance or Workers' Compensation? Yes No
 - If yes, what is the name of your insurance? _____
 - Type of Insurance: Group Individual Medicare Supp Other: _____
 - Are you or your spouse actively working? Yes No
 - Effective date of coverage: _____ Group size of employer: 1-19 20+
4. Will you be keeping this health insurance in addition to Quartz Medicare Advantage? Yes No
 - If no, please provide the end date of the other coverage: _____

Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal Employee Health Benefits coverage, VA Benefits, Senior Care, or State pharmaceutical assistance programs.

5. Will you have other prescription drug coverage in addition to Quartz Medicare Advantage?
 Yes No
 - If yes, name of the other drug coverage: _____
 - ID# for drug coverage: _____
 - Group # for drug coverage: _____

UNDERSTANDING YOUR PLAN

By initialing to the right, you are certifying that you have read and understood all of the statements below. You must agree to all of these terms to enroll in Quartz Medicare Advantage.

_____ Initial Here

1. I must keep Hospital (Part A) and Medical (Part B) to stay enrolled in Quartz Medicare Advantage (HMO).
2. I understand that people with Medicare aren't usually covered under Medicare while out of the country; however, as a Quartz Medicare Advantage member, I'm covered anywhere in the world for urgent and emergency services.
3. I must get all my health care services from Quartz Medicare Advantage network providers, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Quartz Medicare Advantage and other services contained in my Evidence of Coverage document will be covered. Without authorization, **NEITHER MEDICARE NOR QUARTZ MEDICARE ADVANTAGE WILL PAY FOR THE SERVICES.**
4. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options, medical assistance through the State Medicaid program, and the Medicare Savings Program.
5. I acknowledge that I was notified, in advance, that I would be discussing Quartz Medicare Advantage, with and without prescription drug coverage, with the sales representative.
6. By joining this Quartz Medicare Advantage plan or Medicare Prescription Drug plan, I acknowledge that Quartz Medicare Advantage will share my information with Medicare, who may use it to track my enrollment to make payments, and for other purposes allowed by federal law that authorize the collection of this information (see Privacy Act Statement on Page 7).
7. I understand that if I don't have Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.
8. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
9. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
10. I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I've read and understood the application's content. If signed by an authorized representative (as described above), this signature certifies that: 1) This person is authorized under state law to complete this enrollment, and 2) Documentation of this authority is available upon request by Medicare.

PAYING YOUR PLAN PREMIUM

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) with an automatic checking or savings account deduction. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D Income Related Monthly Adjustment Amount (IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. **DO NOT** pay Quartz Medicare Advantage the Part D-IRMAA.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at [socialsecurity.gov/prescriptionhelp](https://www.socialsecurity.gov/prescriptionhelp).

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover. If you don't select a payment option, you will get an invoice.

PLEASE SELECT A PREMIUM PAYMENT OPTION

Automatic deduction – Checking or savings account

(complete Automatic Payment Authorization Form)

- By selecting this option, I authorize Quartz Medicare Advantage (HMO) to initiate electronic fund transfers drawn on my bank account, on the fourth business day of the month, for the payment of my plan premium. I further authorize the bank to debit my bank account on or about the fourth business day of the month.
- I realize that my bank shall be under no obligation to furnish me with any special advice or notice of the payment of any such transaction, other than my monthly bank statement. I realize the electronic funds transfers will begin approximately 30 days after submitting this request. The effective date will be the date shown on the written confirmation I will receive from Quartz Medicare Advantage.
- I understand that if for any reason funds are not available for withdrawal in the account listed on this form, Quartz Medicare Advantage reserves the right to change my billing method to direct billing by sending me an invoice and requiring that my payments be made by check or money order.

Automatic deduction – Monthly Social Security benefit check.

Automatic deduction – Monthly Railroad Retirement Board benefit check.

- The Social Security/Railroad Retirement Board deduction may take two or more months to begin.
- We will send you a confirmation letter with the effective date of this deduction. You are responsible for payment before the effective date of this automatic deduction.
- If Social Security/Railroad Retirement Board does not approve your request for automatic deduction, we will send you an invoice for your monthly premiums.

I will make my own payments – Monthly or Recurring payments.

- Select this option if you choose to pay with a check, credit card, or electronic payments from your checking or savings account that are initiated by you on a monthly or recurring basis. Note: You will receive an invoice with this option. You may submit payment via check or money order using the invoice.

COMPLETE THIS SECTION IF ELECTING AN AUTOMATIC BANK ACCOUNT DEDUCTION

Your Bank Name: _____

Routing Number: _____

Account Number: _____

Checking Savings

The diagram shows a check with the following fields and labels:

- Your Name** (top left)
- Your Address** (top left)
- 01/02** (top center)
- 123** (top right)
- 12-34/1234** (top right)
- 20** (top right)
- PAY TO THE ORDER OF** (middle left)
- \$** (middle right)
- DOLLARS** (middle right)
- Your Bank Name** (bottom left)
- FOR** (bottom left)
- 1234567891** (bottom left)
- 1234567899** (bottom center)
- 0123** (bottom right)
- Routing Number** (label below 1234567891)
- Account Number** (label below 1234567899)
- Check Number** (label below 0123)

READ THIS IMPORTANT INFORMATION

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage plan that will meet your needs. By joining Quartz Medicare Advantage, your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. Read the information that your Medicare Advantage plan sends you and if you have questions, contact your Medicare Advantage plan.

If you currently have health coverage from an employer or union, joining Quartz Medicare Advantage could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Quartz Medicare Advantage. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

RELEASE OF INFORMATION

By joining this Medicare health or prescription drug plan, I acknowledge that Quartz Medicare Advantage will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that Quartz Medicare Advantage will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes, which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this application means that I have read and understood the contents of this application. If signed by an authorized individual (as described above) this signature certifies that 1) this person is authorized under state law to complete this enrollment, and 2) documentation of this authority is available upon request from Quartz Medicare Advantage or Medicare.

Signature: _____ Today's Date: _____

If you are the authorized representative, you must sign above and provide the following information.
A completed Financial Power of Attorney form is required to complete the application. Include with the application and mail all documents to the address listed below.

Last Name:	First Name:	MI:
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Address:

Relationship to Enrollee:	Phone Number:
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AGENT USE ONLY

I understand that I must complete and retain a Scope of Appointment for all sales for the required period of 10 years. I do not need to submit a copy of the Scope of Appointment to Quartz, but Quartz may request a copy of any Scope of Appointment associated with an application, at any time. I understand that I am required to respond timely and cooperate with any requests and disciplinary action, including non-compensation, will be taken if I cannot produce a valid Scope of Appointment.

Name of Staff Member/Agent/Broker (if assisted in enrollment):

Additional Comments:

SUBMIT THIS APPLICATION TO:

**Quartz Medicare Advantage
840 Carolina Street
Sauk City, WI 53583**

Or by email at: MedicareAdvantage@QuartzBenefits.com

Customer Service: (800) 394-5566.

For people who are deaf, hard of hearing or speech impaired, **call TTY 711.**

Monday, - Friday, 8 a.m. - 8 p.m.

October 1 - March 31, seven days a week from 8 a.m. - 8 p.m.

PRIVACY ACT STATEMENT The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Complete only if enrolling using a SEP election

ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD

Typically, you may enroll in a Medicare Advantage plan only during the Annual Enrollment Period (AEP) from Oct. 15 - Dec. 7 of each year. However, some exceptions may allow you to enroll in a Medicare Advantage plan outside of the AEP. Please read the following statements carefully, and check the box next to the one that applies to you. By checking any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- I am new to Medicare.
- I am enrolled in a Medicare Advantage Plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- I currently have a Medicare plan and want to enroll under the 5-Star SEP in this Medicare Advantage plan with a 5-Star Rating during the same year as my enrollment. I can use this SEP only one time a year. Effective dates are the 1st of the month from Jan. 1-Dec. 1, during the year of the plan's 5-Star Rating designation.
- I recently moved outside of the service area for my current plan or I recently moved, and this plan is a new option for me. I moved on (insert date) _____.
- I recently was released from Incarceration. I was released on (insert date) _____.
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.
- I recently obtained lawful presence status in the United States. I got this status on (insert date) _____.
- I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.
- I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.
- I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) _____.
- I recently left a PACE program on (insert date) _____.
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.
- I am leaving employer or union coverage on (insert date) _____.
- I belong to a pharmacy assistance program provided by my state.
- My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.
- I was enrolled in a Special Needs Plan (SNP) but I lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.
- I was affected by a weather-related emergency or major disaster, as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements apply to you or you're not sure you're eligible to enroll, please call Customer Service at (800) 394- 5566 (TTY 711).

NOTICE OF NONDISCRIMINATION

Quartz Medicare Advantage (HMO) is the marketing name operating under the entities of Quartz Health Plan Corporation and Quartz Health Plan MN Corporation. These companies are separate legal entities. In this notice, “we” refers to these companies. We comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex.

- ▶ 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 interpreters
 - Information written in other languages

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

If you believe that we have 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 –

Kristie Meier, Compliance Officer; 840 Carolina Street, Sauk City, WI 53583

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 Meier, 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.



Multi-Language Insert

Multi-Language Interpreter Services

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-394-5566 (TTY: 711).

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-394-5566 (TTY: 711).

Chinese: 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 1-800-394-5566 (TTY: 711)。

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-394-5566 (TTY: 711).

Arabic: ملاحظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية المجانية متاحة من أجلك، يُرجى الاتصال على الرقم 1-800-394-5566 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-394-5566 (телетайп: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-394-5566 (711)번으로 전화해 주십시오.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-394-5566 (TTY: 711).

Pennsylvania Dutch: Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzsch, kansch du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-394-5566 (TTY: 711).

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-394-5566 (TTY: 711).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-394-5566 (ATS : 711).

Amharic: ማሳሰቢያ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶቻችን በ18 ሊያገለግሉት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-800-394-5566 (መስማት ለተሳናቸው: 711)።

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-394-5566 (TTY: 711) पर कॉल करें।

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-394-5566 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-394-5566 (TTY: 711).