Please call and allow us to assist you with your application

562-756-1330

Avoid headaches and delays by allowing our office to assist you. You'll be surprised at how easy completing an application can be! Once your application is complete, please mail it to:

3532 Katella Ave #201
Los Alamitos Ca 90720

You may fax your application to: 562-394-0301

Thank you!

KAISER PERMANENTE®

Application for health coverage

Individual and Family Plans

Who can use this application?

You may use this application to apply for a Kaiser Permanente for Individuals and Families (KPIF) plan.

- If you want coverage for your family on the same KPIF plan, please fill out one application for the family. If a family member wants a different health plan, he or she must complete a separate application.
- To be eligible for KPIF coverage, you must live in our California service area.
- To be eligible for KPIF coverage, you and any dependent you're applying for can't be entitled to Medicare Part A or enrolled in Medicare Part B.
- If you qualify for and want to take advantage of federal financial assistance to help pay for copays, coinsurance, deductibles, or premiums, don't complete this application. You must apply for coverage through Covered California at CoveredCA.com.
- If you're already a KPIF member, don't use this form. To make changes to your account, call **1-800-464-4000.**

Things to remember

- You can apply faster online at **buykp.org/apply**. The date we receive your application may change your effective date. Please send this application back as quickly as you can.
- Please answer all questions, and type or print using ink only. Leave an empty box in between words, and put a hyphen in the box for hyphenated names.
- If you're applying during a special enrollment period, you can find instructions at **kp.org/specialenrollment** or call **1-800-494-5314.**
- Remember, this new enrollment will not end other coverage through Covered California or Kaiser Permanente. Don't want 2 plans? Be sure to end your other plan the day before your new plan starts to avoid paying 2 premiums or having a gap in your coverage.
- Please send back all pages of this application. **If your application is incomplete, not signed, doesn't include your first month's payment, or doesn't include required proof of your qualifying life event (if applicable), it may be canceled.** Send these by mail to:

  Kaiser Permanente for Individuals and Families
  P.O. Box 23219
  San Diego, CA 92193-9921

  Or send it by secure fax to: **1-866-816-5139**

  Note: Checks must be mailed and can't be faxed.

Need help?

- For help with completing this application, please call **1-800-670-5420.** For TTY, call **711.**
- **We'll provide language assistance at no cost to you.**
- If you're working with a broker, please call him or her for assistance.

In California, all plans are offered and underwritten by Kaiser Foundation Health Plan, Inc., One Kaiser Plaza, Oakland, CA 94612.

Primary applicant

STEP 1: Check your eligibility

Are you or any dependent you're applying for either entitled to Medicare Part A or enrolled in Medicare Part B? ☐ Yes ☐ No

If you selected "Yes," those of you who are entitled to Medicare Part A or enrolled in Medicare Part B can't enroll in a KPIF plan.

Please visit **kp.org/medicare** to learn more about your Medicare plan options or to apply for Medicare coverage.

STEP 2: Tell us when you're applying

Select one option: **A.** ☐ Open enrollment **B.** ☐ A special enrollment period

If **A.** Skip to Step 3.

If **B.** Choose the life event that made you eligible for a special enrollment period:

- ☐ Loss of health care coverage (write the last full day you had coverage)*
- ☐ Gaining or becoming a dependent through marriage or domestic partnership registration
- ☐ Gaining or becoming a dependent through the birth of a child, adoption, foster care, or placement for adoption or foster care (Please choose your effective date.)
  - ☐ The date of birth, adoption, foster care, or placement for adoption or foster care
  - ☐ The first day of the month after we receive the application
- ☐ Losing a dependent through divorce, dissolution of domestic partnership, or legal separation
- ☐ Death of the subscriber or a dependent
- ☐ Child support order or other court order to cover a dependent
- ☐ Permanent relocation
- ☐ Release from incarceration
- ☐ Change in eligibility for federal financial assistance through Covered California†
- ☐ Change in eligibility for employer health coverage
- ☐ Determination by Covered California
- ☐ Misinformation about coverage
- ☐ Provider network changes

Please write the date of your qualifying life event. ☐☐ / ☐☐ / ☐☐☐☐ (mm/dd/yyyy)

Proof of eligibility is required. Please visit **kp.org/specialenrollment** or call **1-800-494-5314** for more information.

*If your qualifying life event is loss of Kaiser Permanente coverage, we may review your prior membership records to verify loss of minimum essential coverage.
†If you'll be getting federal financial assistance, don't use this form. We can help you apply at CoveredCA.com.

STEP 3: Choose your health plan

Choose 1 health plan. If any family members are applying for different health plans, please submit a separate application for each plan.

Bronze	Silver	Gold	Platinum
☐ Kaiser Permanente - Bronze 60 HDHP HMO	☐ Kaiser Permanente - Silver 70 HMO Off Exchange	☐ Kaiser Permanente - Gold 80 HMO Coinsurance	☐ Kaiser Permanente - Platinum 90 HMO
☐ Kaiser Permanente - Bronze 60 HMO	☐ Kaiser Permanente - Silver 70 HMO 2150/45	☐ Kaiser Permanente - Gold 80 HMO	
☐ Kaiser Permanente - Bronze 60 HDHP HMO 5500/40%	☐ Kaiser Permanente - Silver 70 HDHP HMO 3000/15%		

Minimum coverage plan

To purchase a minimum coverage plan, applicants must be younger than 30 on the effective date, or provide a certificate of exemption from Covered California that shows hardship or lack of affordable coverage. We won't be able to process your application without the certificate of exemption if you are 30 and older. To see if you qualify, please go to **marketplace.cms.gov/applications-and-forms/hardship-exemption.pdf** and follow the instructions.

☐ Kaiser Permanente - Minimum Coverage HMO

For information about health and dental benefits and limitations, cost-sharing amounts, and premiums, please review the details in your enrollment materials. To request a copy of the *Evidence of Coverage* for a particular plan, please go to **kp.org/plandocuments**, call **1-800-464-4000,** or contact your broker.

STEP 4: Choose your optional adult dental plan

Dental coverage is included in your health plan for child members until the end of the month in which the member turns 19. Kaiser Permanente offers an optional dental insurance plan to adults, which includes those individuals whose eligibility for pediatric dental services has ended. This optional coverage is available for an additional charge. Our optional adult dental coverage is underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc. (KFHP), and administered by Delta Dental of California, one of the nation's largest and most experienced dental benefits providers. Please choose one option below.

- ☐ Yes. I am requesting enrollment in the KPIC dental insurance plan that is available to me as a supplemental option to my health plan coverage. Kaiser Permanente Insurance Company, a subsidiary of Kaiser Foundation Health Plan, Inc., underwrites the KPIC dental insurance plan. Once enrolled, I understand I can't cancel my dental coverage without also canceling my health plan coverage, except during open enrollment or a special enrollment period.
- ☐ No. I'm not interested in optional dental coverage.

STEP 5: Enter your information

Primary applicant

In an individual plan, the primary applicant is the person who will be covered by the health plan. In a family plan, the primary applicant is the family member on the health plan who is authorized to make changes to the account. If this application is only for a child under 18, the child is the primary applicant.

First name

Social Security number (if any) ___ - ___ - ____

Last name

Date of birth (mm/dd/yyyy) __ / __ / ____

MI

Former medical record number (if any) ____ — __

State (if any)

Gender: ☐ Male ☐ Female

Phone ___ - ___ - ____

Home address (no P.O. boxes, please)

City

State

ZIP code

County

Mailing address (if different than home address)

City

State

ZIP code

Preferred language spoken (if not English)

Preferred language read (if not English)

Email address (optional) *I understand that Kaiser Permanente may contact me via email.*

(continues)

STEP 5: Enter your information *(continued)*

Parent or legal guardian (if the primary applicant is a child under 18)

First name

MI

Last name

Social Security number (if any)

Gender:
☐ Male ☐ Female

Date of birth (mm/dd/yyyy)

Preferred language spoken (if not English)

Preferred language read (if not English)

Spouse/domestic partner to be covered

A domestic partner is a person registered and legally recognized as your domestic partner by California.

First name

MI

Choose one:
☐ Spouse ☐ Domestic partner

Last name

Social Security number (if any)

Former medical record number (if any)

State (if any)

Gender:
☐ Male ☐ Female

Date of birth (mm/dd/yyyy)

Dependents to be covered

If you have more than 2 dependents to be covered, please fill out an extra copy of this page and submit it with your application.

1 First name

MI

Last name

Social Security number (if any)

Former medical record number (if any)

State (if any)

Gender:
☐ Male ☐ Female

Date of birth (mm/dd/yyyy)

Relationship to primary applicant

2 First name

MI

Last name

Social Security number (if any)

Former medical record number (if any)

State (if any)

Gender:
☐ Male ☐ Female

Date of birth (mm/dd/yyyy)

Relationship to primary applicant

STEP 6: Choose an authorized representative (if you have one)

You can give a trusted friend or relative permission to talk about this application with us, see your information, or act for you on matters related to this application only. This person is called an authorized representative.

First name

MI

Last name

Phone

By signing, you've appointed this person as your legally authorized representative to get official information about this application, and to act for you on matters related to this application.

X

Primary applicant (parent or legal guardian for children under 18)

Date (mm/dd/yyyy)

STEP 7: Sign the application agreement

Important: All applicants and dependents 18 and older must read, sign, and date below. If the primary applicant is a child under 18, then his or her parent or legal guardian must sign. By signing, the parent or legal guardian agrees to be responsible for paying all premiums, copays, coinsurance, and deductibles for all the applicants listed on this application. A copy of your agreement with your signature is as valid as the original. If signatures are missing, we will cancel the application. If there are more than 2 dependents 18 and older signing, please attach a copy of this page with the additional signatures.

- I understand that Kaiser Foundation Health Plan, Inc., will rely on the information provided in this application. If any information is found to be fraudulent or intentionally misrepresented, then Kaiser Foundation Health Plan, Inc., may choose to terminate coverage back to the coverage effective date.

X

Primary applicant (parent or legal guardian for children under 18)

Date (mm/dd/yyyy)

X

Spouse/domestic partner

Date (mm/dd/yyyy)

X

Dependent (18 and older)

Date (mm/dd/yyyy)

X

Dependent (18 and older)

Date (mm/dd/yyyy)

STEP 8: Sign the Kaiser Foundation Health Plan, Inc., arbitration agreement

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Membership Agreement, Disclosure Form, and Evidence of Coverage*.

X _____ Date (mm/dd/yyyy) __/__/____

Primary applicant (parent or legal guardian for children under 18)

X _____ Date (mm/dd/yyyy) __/__/____

Spouse/domestic partner

X _____ Date (mm/dd/yyyy) __/__/____

Dependent (18 and older)

X _____ Date (mm/dd/yyyy) __/__/____

Dependent (18 and older)

A copy of your agreement with your signature is as valid as the original. If signatures are missing, we will cancel the application. If there are more than 2 dependents 18 and older signing, please attach a copy of this page with the additional signatures.

Primary applicant

STEP 9: Enter first month's payment details

Payment information

First name of person responsible for payment

MI

Last name of person responsible for payment

Address

City

State

ZIP code

Payment options

☐ **Credit card** ☐ **Debit card** ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder's first name as it appears on card

MI

Cardholder's last name as it appears on card

Card number

Expiration date (mm/yyyy)

X

Cardholder's signature

Date (mm/dd/yyyy)

☐ **Electronic payment** ☐ Checking account ☐ Savings account

I authorize Kaiser Foundation Health Plan, Inc. (KFHP), and the designated financial institution to accept this transfer of the first month's premium amount from my checking or savings account when my application is processed by KFHP.

Bank name

Routing number

Account number

Account holder's first name

MI

Account holder's last name

X

Account holder's signature

Date (mm/dd/yyyy)

☐ **Check** ☐ **Money order**

Write the name of the primary applicant on the check. Mail payment with your application to the address listed on page 1.

Primary applicant

Automatic monthly payments

This **optional** service allows you to automatically pay your monthly premiums electronically on the 1st of the month (unless it falls on a weekend or holiday). If you'd like to sign up, please fill out your information below. To cancel or update automatic payments, go to **kp.org/payonline** or call the Member Service Contact Center at **1-888-236-4490.**

Billing information

Is this information the same as your first month's payment details? ☐ Yes ☐ No **If no, please fill out this section.**

First name of person responsible for payment

MI

Last name of person responsible for payment

Billing address

City

State ZIP code

Payment options

Debit cards can't be used for automatic monthly payments.

☐ **Credit card** ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder's first name as it appears on card

MI

Cardholder's last name as it appears on card

Card number

Expiration date (mm/yyyy)

X

Cardholder's signature

Date (mm/dd/yyyy)

☐ **Electronic payment** ☐ Checking account ☐ Savings account

I authorize Kaiser Foundation Health Plan, Inc. (KFHP), and the designated financial institution to accept this transfer from my checking or savings account.

Bank name

Routing number

Account number

Account holder's first name

MI

Account holder's last name

X

Account holder's signature

Date (mm/dd/yyyy)

Primary applicant

For applicants using an agent/broker/KPIF representative

If you used an agent/broker/KPIF representative, please make sure he or she completes this page. A Kaiser Permanente representative includes any agent/broker/KPIF representative who has helped you decide which plan to enroll in or helped you fill out the application.

Agent/broker/KPIF representative first name

MI

Last name

The broker of record may receive monetary and/or nonmonetary payments from KPIF in connection with the purchase of this coverage.
Note: Premiums are the same whether or not you use an agent/broker/KPIF representative.

To be completed by your Kaiser Permanente–appointed agent/broker/KPIF representative after completion of this application:

Notice to agent, broker, KPIF representative: If you have assisted the applicant in submitting the application, the law requires that you attest to this assistance. If, in making this attestation, you state as true any material fact you know to be false, you will be subject to a civil penalty of up to ten thousand dollars ($10,000), as authorized under California Health and Safety Code section 1389.8(c) or Insurance Code section 10119.3, in addition to any other applicable penalties or remedies available under current law.

You must answer the following question by selecting Yes or No:

I assisted the applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information, and the applicant understood the explanation.

☐ Yes ☐ No

X

Agent/broker/KPIF representative

Date (mm/dd/yyyy)

Agent/broker/KPIF representative (first, middle, last) (please print)

Address

City

State

ZIP code

KPIF–appointed broker ID number

Agency name

Agency number

Phone

Fax

Email address

Nondiscrimination Notice

Kaiser Permanente does not discriminate on the basis of age, race, ethnicity, color, national origin, cultural background, ancestry, religion, sex, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, source of payment, genetic information, citizenship, primary language, or immigration status.

Language assistance services are available from our Member Services Contact Center 24 hours a day, seven days a week (except closed holidays). Interpreter services, including sign language, are available at no cost to you during all hours of operation. We can also provide you, your family, and friends with any special assistance needed to access our facilities and services. In addition, you may request health plan materials translated in your language, and may also request these materials in large text or in other formats to accommodate your needs. For more information, call **1-800-464-4000** (TTY users call **711**).

A grievance is any expression of dissatisfaction expressed by you or your authorized representative through the grievance process. For example, if you believe that we have discriminated against you, you can file a grievance. Please refer to your *Evidence of Coverage or Certificate of Insurance* or speak with a Member Services representative for the dispute-resolution options that apply to you. This is especially important if you are a Medicare, Medi-Cal, MRMIP, Medi-Cal Access, FEHBP, or CalPERS member because you have different dispute-resolution options available.

You may submit a grievance in the following ways:

- By completing a Complaint or Benefit Claim/Request form at a Member Services office located at a Plan Facility (please refer to *Your Guidebook* for addresses)
- By mailing your written grievance to a Member Services office at a Plan Facility (please refer to *Your Guidebook* for addresses)
- By calling our Member Service Contact Center toll free at **1-800-464-4000** (TTY users call **711**)
- By completing the grievance form on our website at **kp.org**

Please call our Member Service Contact Center if you need help submitting a grievance.

The Kaiser Permanente Civil Rights Coordinator will be notified of all grievances related to discrimination on the basis of race, color, national origin, sex, age, or disability. You may also contact the Kaiser Permanente Civil Rights Coordinator directly at One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612.

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, DC 20201, 1–800–368–1019, 800–537–7697 (TDD). Complaint forms are available at *hhs.gov/ocr/office/file/index.html***.**

Aviso de no discriminación

Kaiser Permanente no discrimina a ninguna persona por su edad, raza, etnia, color, país de origen, antecedentes culturales, ascendencia, religión, sexo, identidad de género, expresión de género, orientación sexual, estado civil, discapacidad física o mental, fuente de pago, información genética, ciudadanía, lengua materna o estado migratorio.

La Central de Llamadas de Servicio a los Miembros brinda servicios de asistencia con el idioma las 24 horas del día, los siete días de la semana (excepto los días festivos). Se ofrecen servicios de interpretación sin costo alguno para usted durante el horario de atención, incluido el lenguaje de señas. También podemos ofrecerle a usted, a sus familiares y amigos cualquier ayuda especial que necesiten para acceder a nuestros centros de atención y servicios. Además, puede solicitar los materiales del plan de salud traducidos a su idioma, y también los puede solicitar con letra grande o en otros formatos que se adapten a sus necesidades. Para obtener más información, llame al **1-800-788-0616** (los usuarios de la línea TTY deben llamar al **711**).

Una queja es una expresión de inconformidad que manifiesta usted o su representante autorizado a través del proceso de quejas. Por ejemplo, si usted cree que ha sufrido discriminación de nuestra parte, puede presentar una queja. Consulte su *Evidencia de Cobertura (Evidence of Coverage)* o *Certificado de Seguro (Certificate of Insurance)*, o comuníquese con un representante de Servicio a los Miembros para conocer las opciones de resolución de disputas que le corresponden. Esto tiene especial importancia si es miembro de Medicare, Medi-Cal, el Programa de Seguro Médico para Riesgos Mayores (Major Risk Medical Insurance Program MRMIP), Medi-Cal Access, el Programa de Beneficios Médicos para los Empleados Federales (Federal Employees Health Benefits Program, FEHBP) o CalPERS, ya que dispone de otras opciones para resolver disputas.

Puede presentar una queja de las siguientes maneras:

- completando un formulario de queja o de reclamación/solicitud de beneficios en una oficina de Servicio a los Miembros ubicada en un centro del plan (consulte las direcciones en *Su Guía*)
- enviando por correo su queja por escrito a una oficina de Servicio a los Miembros en un centro del plan (consulte las direcciones en *Su Guía*)
- llamando a la línea telefónica gratuita de la Central de Llamadas de Servicio a los Miembros al **1-800-788-0616** (los usuarios de la línea TTY deben llamar al **711**)
- completando el formulario de queja en nuestro sitio web en **kp.org**

Llame a nuestra Central de Llamadas de Servicio a los Miembros si necesita ayuda para presentar una queja.

Se le informará al coordinador de derechos civiles de Kaiser Permanente (Civil Rights Coordinator) de todas las quejas relacionadas con la discriminación por motivos de raza, color, país de origen, género, edad o discapacidad. También puede comunicarse directamente con el coordinador de derechos civiles de Kaiser Permanente en One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612.

También puede presentar una queja formal de derechos civiles de forma electrónica ante la Oficina de Derechos Civiles (Office for Civil Rights) en el Departamento de Salud y Servicios Humanos de los Estados Unidos (U.S. Department of Health and Human Services) mediante el portal de quejas formales de la Oficina de Derechos Civil es (Office for Civil Rights Complaint Portal), en *ocrportal.hhs.gov/ocr/portal/lobby.jfs (en inglés)* o por correo postal o por teléfono a: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (línea TDD). Los formularios de queja formal están disponibles en *hhs.gov/ocr/office/file/index.html (en inglés).*

無歧視公告

Kaiser Permanente禁止以年齡、人種、族裔、膚色、原國籍、文化背景、血統、宗教、性別、性別認同、性別表達、性取向、婚姻狀況、生理或心理殘障、付款來源、遺傳資訊、公民身份、主要語言或移民身份為由而歧視任何人。

會員服務聯絡中心每週七天24小時提供語言協助服務（節假日除外）。本機構在全部營業時間內免費為您提供口譯，包括手語服務。我們還可為您和您的親友提供使用本機構設施與服務所需要的任何特別協助。此外，您還可索取翻譯成您的語言的健康保險計劃資料，以及採用大號字體或其他格式的版本來滿足您的需求。若需更多資訊，請致電**1-800-757-7585**（TTY專線使用者請撥**711**）。

投訴指任何您或您的授權代表透過流程來表達不滿的做法。例如，如果您認為自己受到歧視，即可提出投訴。若需瞭解適用於自己的爭議解決選項，請參閱《承保範圍說明書》（*Evidence of Coverage*）或《保險證明書》（*Certificate of Insurance*），或咨詢會員服務代表。如果您是 Medicare、Medi-Cal、MRMIP（Major Risk Medical Insurance Program, 高風險醫療保險計劃）、Medi-Cal Access、FEHBP（Federal Employees Health Benefits Program, 聯邦僱員健康保險計劃）或CalPERS會員，向會員服務代表咨詢尤其重要，因為您可能會有不同的爭議解決方式選擇。

您可透過以下途徑投訴：

- 在健康保險計劃服務設施的會員服務處填寫《投訴或福利索賠/申請表》，地址見《健康服務指南》(Your Guidebook)。
- 將書面投訴信郵寄到健康保險計劃計劃服務設施的會員服務處（地址見《健康服務指南》(Your Guidebook)。
- 給我們的會員服務聯絡中心打免費電話，電話號碼是**1-800-757-7585**（TTY專線使用者請撥**711**）。
- 在我們的網站上填寫投訴表，網址是**kp.org**

如果您在投訴時需要協助，請致電我們的會員服務聯絡中心。

涉及人種、膚色、原國籍、性別、年齡或殘障歧視的一切申訴都將通知 Kaiser Permanente的民權事務協調員（Civil Rights Coordinator）。您也可與Kaiser Permanente的民權事務協調員直接聯絡，地址：One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612。

您還可以電子方式透過民權辦公室的投訴入口網站向美國健康與公共服務部民權辦公室（U.S. Department of Health and Human Services, Office for Civil Rights）提出民權投訴，網址是 *ocrportal.hhs.gov/ocr/portal/lobby.jsf* 或者按照如下資訊採用郵寄或電話方式聯絡：U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697（TDD 專線）。投訴表可從網站 *hhs.gov/ocr/office/file/index.html* 下載。

Language Assistance Services

English: Language assistance is available at no cost to you, 24 hours a day, 7 days a week. You can request interpreter services, materials translated into your language, or in alternative formats. Just call us at **1-800-464-4000**, 24 hours a day, 7 days a week (closed holidays). TTY users call **711**.

Arabic: خدمات الترجمة الفورية متوفرة لك مجانًا على مدار الساعة كافة أيام الأسبوع. بإمكانك طلب خدمة الترجمة الفورية أو ترجمة وثائق للغتك أو لصيغ أخرى. ما عليك سوى الاتصال بنا على الرقم **1-800-464-4000** على مدار الساعة كافة أيام الأسبوع (مغلق أيام العطلات). لمستخدمي خدمة الهاتف النصي يرجي الاتصال على الرقم (**711**).

Armenian: Ձեզ կարող է անվճար օգնություն տրամադրվել լեզվի հարցում՝ օրը 24 ժամ, շաբաթը 7 օր: Դուք կարող եք պահանջել բանավոր թարգմանչի ծառայություններ, Ձեր լեզվով թարգմանված կամ այլընտրանքային ձևաչափով պատրաստված նյութեր: Պարզապես զանգահարեք մեզ՝ **1-800-464-4000** հեռախոսահամարով՝ օրը 24 ժամ՝ շաբաթը 7 օր (տոն օրերին փակ է): TTY-ից օգտվողները պետք է զանգահարեն **711**:

Chinese: 您每週 7 天，每天 24 小時均可獲得免費語言協助。您可以申請口譯服務、要求將資料翻譯成您所用語言或轉換為其他格式。我們每週 7 天，每天 24 小時均歡迎您打電話 **1-800-757-7585** 前來聯絡（節假日 休息）。聽障及語障專線 (TTY) 使用者請撥 **711**。

Farsi: خدمات زبانی در 24 ساعت شبانروز و 7 روز هفته بدون اخذ هزینه در اختیار شما است. شما می توانید برای خدمات مترجم شفاهی، ترجمه جزوات به زبان شما و یا به صورتهای دیگر درخواست کنید. کافیست در 24 ساعت شبانروز و 7 روز هفته (به استثنای روزهای تعطیل) با ما به شماره **1-800-464-4000** تماس بگیرید. کاربران TTY با شماره **711** تماس بگیرند.

Hindi: बिना किसी लागत के दुभाषिया सेवाएँ, दिन के 24 घंटे, सप्ताह के सातों दिन उपलब्ध हैं। आप एक दुभाषिये की सेवाओं के लिए, बिना किसी लागत के सामग्रियों को अपनी भाषा में अनुवाद करवाने के लिए, या वैकल्पिक प्रारूपों के लिए अनुरोध कर सकते हैं। बस केवल हमें **1-800-464-4000** पर, दिन के 24 घंटे, सप्ताह के सातों दिन (छुट्टियों वाले दिन बंद रहता है) कॉल करें। TTY उपयोगकर्ता **711** पर कॉल करें।

Hmong: Muajkwc pab txhais lus pub dawb rau koj, 24 teev ib hnub twg, 7 hnub ib lim tiam twg. Koj thov tau cov kev pab txhais lus, muab cov ntaub ntawv txhais ua koj hom lus, los yog ua lwm hom.Tsuas hu rau **1-800-464-4000**, 24 teev ib hnub twg, 7 hnub ib lim tiam twg (cov hnub caiv kaw). Cov neeg siv TTY hu **711**.

Japanese: 当院では、言語支援を無料で、年中無休、終日ご利用いただけます。通訳サービス、日本語に翻訳された資料、あるいは資料を別の書式でも依頼できます。お気軽に **1-800-464-4000** までお電話ください（祭日を除き年中無休）。TTY ユーザーは **711** にお電話ください。

Khmer: ជំនួយភាសា គឺមានឥតអស់ថ្លៃដល់អ្នកឡើយ 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ។ អ្នកអាចស្នើសុំសេវាអ្នកបកប្រែ សំភារៈដែលបានបកប្រែទៅជាភាសាខ្មែរ ឬជាទំរង់ផ្សឹងទៀត។ គ្រាន់តែទូរស័ព្ទមកយើង តាមលេខ **1-800-464-4000** បាន 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ (បិទថ្ងៃបុណ្យ)។ អ្នកប្រើ TTY ហៅលេខ **711**។

Korean: 요일 및 시간에 관계없이 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하는 통역 서비스, 귀하의 언어로 번역된 자료 또는 대체 형식의 자료를 요청할 수 있습니다. 요일 및 시간에 관계없이 **1-800-464-4000** 번으로 전화하십시오 (공휴일 휴무). TTY 사용자 번호 **711**.

Laotian: ການຊ່ວຍເຫຼືອດ້ານພາສາມີໃຫ້ໂດຍບໍ່ເສັງຄ່າ ແກ່ທ່ານ, ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ. ທ່ານ ສາມາດຮ້ອງຂໍຮັບບໍລິການນາຍພາສາ, ໃຫ້ແປເອກະ ສານເປັນພາສາຂອງທ່ານ, ຫຼື ໃນຮູບແບບອື່ນ. ພຽງ ແຕ່ໂທຣຫາພວກເຮົາທີ່ **1-800-464-4000**, ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ (ປິດວັນພັກຕ່າງໆ). ຜູ້ໃຊ້ສາຍ TTY ໂທຣ **711**.

Navajo: Saad bee áká'a'ayeed náhóló t'áá jiik'é, naadiin doo bibąą' dįį' ahéé'iikeed tsosts'id yiskąąjį damoo ná'ádleehjį. Atah halne'é áká'adoolwołígíí jóki, t'áadoo le'é t'áá hóhazaadjį hadilyąą'go, éí doodaii' nááná lá ał'ąą ádaat'ehígíí bee hádadilyaa'go. Kojį hodiilnih **1-800-464-4000**, naadiin doo bibąą' dįį' ahéé'iikeed tsosts'id yiskąąjį damoo ná'ádleehjį (Dahodiyin biniiyé e'e'aahgo éí da'deelkaal). TTY chodeeyoolínígíí kojį hodiilnih **711**.

Punjabi: ਬਿਨਾਂ ਕਿਸੀ ਲਾਗਤ ਦੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫਤੇ ਦੇ 7 ਦਿਨ, ਦੁਭਾਸ਼ੀਆ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਉਪਲਬਧ ਹੈ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਦੀ ਮਦਦ ਲਈ, ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਅਨੁਵਾਦ ਕਰਵਾਉਣ ਲਈ, ਜਾਂ ਕਿਸੇ ਵੱਖ ਫਾਰਮੈਟ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਬਸ ਸਿਰਫ਼ ਸਾਨੂੰ **1-800-464-4000** ਤੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ (ਛੁੱਟੀਆਂ ਵਾਲੇ ਦਿਨ ਬੰਦ ਰਹਿੰਦਾ ਹੈ) ਫ਼ੋਨ ਕਰੋ। TTY ਦਾ ਉਪਯੋਗ ਕਰਨ ਵਾਲੇ **711** 'ਤੇ ਫ਼ੋਨ ਕਰਨ।

Russian: Мы бесплатно обеспечиваем Вас услугами перевода 24 часа в сутки, 7 дней в неделю. Вы можете воспользоваться помощью устного переводчика, запросить перевод материалов на свой язык или запросить их в одном из альтернативных форматов. Просто позвоните нам по телефону **1-800-464-4000**, который доступен 24 часа в сутки, 7 дней в неделю (кроме праздничных дней). Пользователи линии TTY могут звонить по номеру **711**.

Spanish: Contamos con asistencia de idiomas sin costo alguno para usted 24 horas al día, 7 días a la semana. Puede solicitar los servicios de un intérprete, que los materiales se traduzcan a su idioma o en formatos alternativos. Solo llame al **1-800-788-0616**, 24 horas al día, 7 días a la semana (cerrado los días festivos). Los usuarios de TTY, deben llamar al **711**.

Tagalog: May magagamit na tulong sa wika nang wala kang babayaran, 24 na oras bawat araw, 7 araw bawat linggo. Maaari kang humingi ng mga serbisyo ng tagasalin sa wika, mga babasahin na isinalin sa iyong wika o sa mga alternatibong format. Tawagan lamang kami sa **1-800-464-4000**, 24 na oras bawat araw, 7 araw bawat linggo (sarado sa mga pista opisyal). Ang mga gumagamit ng TTY ay maaaring tumawag sa **711**.

Thai: เรามีบริการล่ามฟรีสำหรับคุณตลอด 24 **ชั่วโมง ทุกวันตลอดชั่วโมงทำการของเราคุณสามารถขอให้ล่าม ช่วยตอบคำถามของคุณที่เกี่ยวกับความคุ้มครองการดูแล สุขภาพของเราและคุณยังสามารถขอให้มีการแปลเอกสา รเป็นภาษาที่คุณใช้ได้โดยไม่มีการคิดค่าบริการเพียงโทร หาเราที่หมายเลข 1-800-464-4000 ตลอด** 24 **ชั่วโมงทุกวัน (ปิดให้บริการในวันหยุดราชการ) ผู้ใช้** TTY **โปรดโทรไปที่ 711**

Vietnamese: Dịch vụ thông dịch được cung cấp miễn phí cho quý vị 24 giờ mỗi ngày, 7 ngày trong tuần. Quý vị có thể yêu cầu dịch vụ thông dịch, tài liệu phiên dịch ra ngôn ngữ của quý vị hoặc tài liệu bằng nhiều hình thức khác. Quý vị chỉ cần gọi cho chúng tôi tại số **1-800-464-4000**, 24 giờ mỗi ngày, 7 ngày trong tuần (trừ các ngày lễ). Người dùng TTY xin gọi **711**.