IMPORTANT:

This is a short-term, limited-duration policy, NOT comprehensive health coverage.

This is a temporary, limited policy that has fewer benefits and federal protections than other types of health insurance options, like those on HealthCare.gov.

THIS POLICY	INSURANCE ON HEALTHCARE.GOV
Might not cover you due to preexisting health conditions like diabetes, cancer, stroke, arthritis, heart disease, mental health & substance use disorders	Can't deny you coverage due to preexisting health conditions
Might not cover things like prescription drugs, preventive screenings, maternity care, emergency services, hospitalization, pediatric care, physical therapy & more	Covers all essential health benefits
Might have no limit on what you pay out-of-pocket for care	Protects you with limits on what you pay each year out-of-pocket for essential health benefits
You won't qualify for federal financial help to pay premiums & out-of-pocket costs	Many people qualify for federal financial help
Doesn't have to meet federal standards for comprehensive health coverage	All plans must meet federal standards

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.

LOOKING FOR COMPREHENSIVE HEALTH INSURANCE?

- Visit HealthCare.gov or call 1-800-318-2596 (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

QUESTIONS ABOUT THIS POLICY?

For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."

Form No. 20-3840 (11-25)

Blue Cross of Idaho

Access Individual Health Application

Please type or print legibly in black ink and complete all applicable sections.

Please send us the application in one of the following ways:

Mail to: Blue Cross of Idaho, PO Box 7408, Boise, ID 83707
Email to: ***iss@bcidaho.com***
Upload to: ***accessplansidaho.com***

SECTION 1 ENROLLMENT INFORMATION (check all that apply)

1. Are you: ☐ A new applicant ☐ Adding dependents
2. Are you a resident[1] of the state of Idaho? ☐ Yes ☐ No

   [1]*The primary applicant must be a resident of the state of Idaho on or before the effective date of and during the term of the policy to be eligible for coverage. Coverage under the policy will be terminated if the primary applicant was not a resident upon the effective date of this policy and/or failed to maintain residency in the state of Idaho.*
3. Do you have a current Idaho driver's license or Idaho identification card? ☐ Yes ☐ No

   Idaho driver's license or identification card number _____ Expiration date _____

   If you are unable to provide an Idaho driver's license or identification card number, to establish residency you must provide copies of two other forms of documentation that contain your name and residential address with this completed application. Examples include home mortgage statement; lease or loan agreement; homeowner's, renter's or car insurance policy (within the last 60 days). These documents must contain the applicant's name and residential address.
4. Requested effective date (subject to Blue Cross of Idaho approval): (MM/DD/YYYY) _____

SECTION 2 APPLICANT INFORMATION

First Name, Middle Name, Last Name							
Physical Address					City, County, State, Zip Code		
Mailing Address (if different than physical address)					City, County, State, Zip Code		
Billing Address (if different than mailing address)					City, County, State, Zip Code		
Preferred Phone Number		Cell Phone Number			Email Address		
Marital Status ☐ Single ☐ Married	Date of Birth (MM/DD/YYYY)	Age	☐ Male ☐ Female ☐ Prefer not to answer	Height	Weight	Tobacco Use* ☐ Yes ☐ No	Social Security Number

*For any person who has used a tobacco product on average four or more times a week within the last six months (anyone age 21 or older).

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SECTION 3

DEPENDENT INFORMATION

List all eligible dependents you want to enroll, including any child who is under the age of 26, or who is medically certified as disabled and dependent on parent for support (copy of certification required). Use extra paper if necessary.

Names of Dependents (first, middle, last)	Relationship to Applicant (spouse, child, etc.)	Date of Birth (MM/DD/YYYY))	Age	Gender	Height	Weight	Tobacco Use[2]	Social Security Number
				☐ Male ☐ Female ☐ Prefer not to answer			☐ Yes ☐ No	
				☐ Male ☐ Female ☐ Prefer not to answer			☐ Yes ☐ No	
				☐ Male ☐ Female ☐ Prefer not to answer			☐ Yes ☐ No	
				☐ Male ☐ Female ☐ Prefer not to answer			☐ Yes ☐ No	
				☐ Male ☐ Female ☐ Prefer not to answer			☐ Yes ☐ No	
				☐ Male ☐ Female ☐ Prefer not to answer			☐ Yes ☐ No	

[2]Has any person 21 years of age or older listed on this application used a tobacco product on average four or more times a week within the last six months?

SECTION 4

OTHER COVERAGE INFORMATION

For proper crediting of preexisting condition waiting periods AND coordination of benefits, please complete the section below. Use extra paper if necessary.

Please indicate for EACH person listed on this application any health insurance coverage (including Medicare, Medicaid, FEHBP, uniformed services, Indian Health Service, high risk pool or other creditable coverage) in effect within 12 months prior to the proposed effective date of this coverage. Each person applying for coverage must be listed below. If no health insurance coverage was in effect within the past 12 months, please indicate NONE.

Other Insurance Carrier Information: Insurance Carrier Name, Policy Number, Phone Number	Policyholder Name	Names of Covered Members: Self and Dependent(s)	Coverage Start Date (MM/DD/YYYY)	Coverage End Date (MM/DD/YYYY)	Type of Coverage	Will this Coverage Continue?
					☐ Group ☐ Individual ☐ Short Term ☐ COBRA	☐ Yes ☐ No
					☐ Group ☐ Individual ☐ Short Term ☐ COBRA	☐ Yes ☐ No
					☐ Group ☐ Individual ☐ Short Term ☐ COBRA	☐ Yes ☐ No
					☐ Group ☐ Individual ☐ Short Term ☐ COBRA	☐ Yes ☐ No
					☐ Group ☐ Individual ☐ Short Term ☐ COBRA	☐ Yes ☐ No

Are you or any dependent listed on this application receiving workers' compensation payments or currently eligible to receive such payments?

☐ Yes ☐ No If **YES**, give person's name, specific type and details: _____

MEDICARE COVERAGE INFORMATION **If any person listed on this application is covered by Medicare, please complete the following:**

Name (first, middle, last)	Medicare Beneficiary Number	Reason for Medicare Eligibility (age, disability or ESRD)

Date of Medicare Entitlement (MM/DD/YYYY): Part A _____ Part B _____

SECTION 5A — HEALTH STATEMENT

PLEASE ANSWER BELOW	Within the last 10 years, have you or any family member listed on this application ever seen a doctor, been diagnosed with, had treatment, hospitalization, medications, tests or been advised to have treatment or surgery for any of the following? If YES, please provide details on grid below.
A. Cancer/Tumor ☐ Yes ☐ No	☐ Brain ☐ Breast ☐ Cervical ☐ Colon ☐ Leukemia ☐ Liver ☐ Lung ☐ Lymphoma ☐ Melanoma ☐ Non-Malignant Tumor ☐ Ovarian ☐ Prostate ☐ Testicular ☐ Other Cancer
B. Heart/Circulatory ☐ Yes ☐ No	☐ Aneurysm ☐ Angina ☐ Angioplasty/Stent ☐ Blood Clots/Disorders ☐ Bypass ☐ Cholesterol/Triglycerides ☐ Congestive Heart Failure ☐ Hemophilia ☐ High Blood Pressure ☐ Pacemaker/ICD ☐ Stroke
C. Reproductive ☐ Yes ☐ No	☐ Breast Disorders ☐ Endometriosis ☐ Fibroids ☐ Infertility ☐ Menstrual Disorders
D. Intestinal/Endocrine/Liver ☐ Yes ☐ No	☐ Chronic Pancreatitis ☐ Cirrhosis ☐ Colon Disorder ☐ Crohn's ☐ Diabetes (I/II) ☐ Gall Bladder ☐ Gastric Bypass ☐ Hepatitis B/C ☐ Liver Disorder ☐ Pituitary Disorder ☐ Reflux ☐ Ulcer ☐ Ulcerative Colitis
E. Brain/Nervous ☐ Yes ☐ No	☐ ALS ☐ Alzheimer's ☐ Cerebral Palsy ☐ Cyst ☐ Head Injury ☐ Migraines ☐ Multiple Sclerosis ☐ Paralysis ☐ Parkinson's Disease ☐ Seizures/Epilepsy
F. Immune ☐ Yes ☐ No	☐ AIDS ☐ Arthritis (Rheumatoid/Psoriatic) ☐ HIV+ ☐ Immunodeficiency ☐ Lupus ☐ Psoriasis ☐ Scleroderma
G. Lung/Respiratory ☐ Yes ☐ No	☐ Allergies ☐ Asthma ☐ Chronic Bronchitis ☐ COPD ☐ Cystic Fibrosis ☐ Emphysema ☐ Lung Disorders ☐ Pneumonia ☐ Sarcoidosis ☐ Sleep Apnea ☐ Tuberculosis
H. Eyes/Ears/Nose/Throat ☐ Yes ☐ No	☐ Acoustic Neuroma ☐ Cataracts ☐ Chronic Ear Infections ☐ Chronic Sinusitis ☐ Cleft Lip/Palate ☐ Deviated Septum ☐ Glaucoma ☐ Retinopathy
I. Urinary/Kidney ☐ Yes ☐ No	☐ Bladder Disorders ☐ Kidney Disorders ☐ Kidney Stones ☐ Polycystic Kidney Disease ☐ Prostate Disorder ☐ Renal Failure
J. Bones/Muscles ☐ Yes ☐ No	☐ Back Disorder ☐ Bulging/Herniated Disc ☐ Chronic Pain Syndrome ☐ Fibromyalgia/Chronic Fatigue Syndrome ☐ Joint Injury ☐ Knee Disorder ☐ Neck Disorder ☐ Osteoarthritis ☐ Shoulder Disorder ☐ Spina Bifida
K. Behavioral Health ☐ Yes ☐ No	☐ ADHD ☐ Alcohol/Drug ☐ Anxiety/Depression ☐ Autism ☐ Bipolar Depression ☐ Eating Disorder ☐ Inpatient Mental Health ☐ Manic Depression ☐ Substance Abuse ☐ Suicide Attempt
L. Transplant ☐ Yes ☐ No	☐ Bone Marrow ☐ Discussed Possible Future Transplant ☐ Organ ☐ Stem Cell ☐ Transplant Complications
M. Pregnant ☐ Yes ☐ No	Are you or any family member listed on this application currently pregnant? If so, then on the grid below include due date, details about any complications, surrogacy information (if applicable), etc.
N. Hospital/Surgery ☐ Yes ☐ No	Have you or any family member listed on this application been hospitalized or had surgery during the last five years?
O. Future Treatment/Surgery ☐ Yes ☐ No	Within the past 10 years, have you or any family member listed on this application been advised by a medical provider to have any treatment and/or surgical operation(s) that you or any family member have not yet had?
P. Congenital Conditions ☐ Yes ☐ No	Do you or any family member listed on this application have any congenital conditions, diagnosed by a medical provider, that have not already been disclosed on the detail grid below for a previous questions?
Q. $5,000+ Claims ☐ Yes ☐ No	Have you or any family member listed on this application had claims in excess of $5,000 that have not already been disclosed on the detail grid below for a previous question?
R. Other ☐ Yes ☐ No	Within the past 10 years, have you or any family member listed on this application suffered from any chronic or recurring ailments, illnesses, or other departures from good health diagnosed by a medical provider that have not already been disclosed on the detail grid below for a previous question?
S. Prescriptions ☐ Yes ☐ No	During the past 12 months, have you or any family member listed on this application received a prescription for medication from a healthcare provider or taken any prescribed medication not already been disclosed on the detail grid below for a previous question?
T. Denied/Refused Coverage ☐ Yes ☐ No	Have you or any family member listed on this application ever been refused or issued restricted health insurance coverage?

SECTION 5B — HEALTH STATEMENT

If you answered yes to any question in Section 5A, please complete the information in this section. Use extra paper if necessary.

Item (A–T) from Section 5A	Person Affected	Name of Condition – Include Type of Treatment	Date Condition Began (MM/YY)	Date Last Treated (MM/YY)	Name of Healthcare Provider	Name of Hospital and Number of Days (if applicable)	Medications – Include type or name, dosage, length of time used and how often taken	Was Recovery Complete?

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SECTION 6 GUARANTEED ISSUE AND RENEWABILITY

Carriers must provide guaranteed availability and issuance of coverage in any Access plans offered. Dependents under the age of 26 must be eligible for coverage. No special enrollment period is needed to enroll in any Access plans. Such policies must be guaranteed renewable in accordance with Idaho code.

SECTION 7 REPLACEMENT OF EXISTING COVERAGE

Will this policy replace any other accident and sickness insurance presently in force? ☐ Yes ☐ No

Notice to Applicant Regarding Replacement of Accident and Sickness Insurance

According to this application, you intend to allow to lapse or otherwise terminate existing accident and sickness insurance and replace it with a program to be issued by Blue Cross of Idaho. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the healthcare coverage available to you under the new program.

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new program, or the new program may also require a waiting period for certain specified conditions. This could result in denial or delay of a claim for benefits under the new program, whereas a similar claim might have been payable under your present program.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present program. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present program and replace it with new coverage, please be certain to completely and accurately answer all questions on this application. Failure to include all information on an application may provide a basis for the company to deny any future claims and to refund your premiums as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

SECTION 8 ELECTRONIC COMMUNICATION DELIVERY AGREEMENT

To provide you with a convenient and mobile avenue to access all of your health insurance documents and to reduce the use of paper, Blue Cross of Idaho sends communications to members through a secured member account at ***members.bcidaho.com*** and provides notification by email to the email address you supply in your application when we post a new communication to your secure account. Registering for your member account is quick and easy at ***members.bcidaho.com***.

Unless I reject electronic distribution by checking the checkbox below, I consent by my signature on behalf of myself and any covered dependents to the electronic distribution of communications related to the coverage I have applied for, and agree that I consent to:

- Electronically receive any materials that are currently available electronically as well as those that become available in the future. Printed and mailed copies will be sent to my mailing address prior to the availability of electronic copies.
- Electronically receive the following materials: explanation of benefits statements (EOBs); enrollment or effective date notices; acknowledgements of claims receipts; requests for additional information; and determinations on submitted claims, including adverse benefit determinations; legally required information and notifications, including but not limited to notices about the Women's Health and Cancer Rights Act, any federal or state rules and regulations or privacy protection laws; information regarding complaints, appeals or grievances; summaries of benefits and coverage (SBCs) and uniform glossaries of terms; benefit change notices; policy changes or updates; renewal information; discontinuation or termination notices; continuation of coverage rights; certificates of creditable coverage; billing notices or statements; and any health and wellness information I have requested.

To receive a printed copy of any electronic notice, you can print a copy from your secure member account or call Customer Service at the number listed on the back of your member ID card.

To easily change your communication preferences, log into your member account and select ***My Account*** from the top menu. Or, visit your member preference center found at the footer of any email you receive.

☐ **NO**, I do not want electronic distribution of communications. Unless my consent is not required for an electronic distribution, I elect to receive communications related to my coverage in a paper format.

SECTION 9 AFFIRMATION

I affirm the answers given in this application are complete and correct. I am providing these answers as part of the application procedure required by Blue Cross of Idaho to enroll in its insurance coverage. I understand that the insurance carrier will rely on each answer in making its determination to extend coverage and to determine the type of coverage offered. I understand if this application contains any material misstatements or omissions, the insurance carrier may, within the first 24 months of coverage, take any legal action available by law.

I will promptly inform the insurance carrier in writing if anything happens before my coverage takes effect that makes any answer in this application incomplete or incorrect.

I understand that a 12-month waiting period for coverage of preexisting conditions may apply. I understand and agree no coverage shall be in force until approved by the insurance carrier.

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SECTION 10 STATEMENT OF UNDERSTANDING

By signing this application, I represent that all my answers are complete and accurate to the best of my knowledge and belief, and that I understand and agree to the following conditions:

a. No independent producer, agent or employee of the insurance carrier can change any part of this application or waive the requirement that I answer all questions completely and accurately.

b. The insurance carrier may terminate my coverage for any misrepresentation, omission of fact by, concerning, or on behalf of any insured that was or would have been material to the insurance carrier's acceptance of a risk, extension of coverage, provision of benefits or payment of any claim.

c. Coverage for me and any eligible persons named on this application will begin on the effective date assigned by the insurance carrier.

d. I understand that this application will become part of the contract between the insurance carrier and me.

e. I affirm that I have reviewed all answers given on this application and, regardless of whether an independent producer or other person has filled out the answers for me, I verify that the answers are true and complete.

f. This program does not cover services received for any Preexisting Conditions. A Preexisting Condition means any condition:

- that would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment within the six-month period preceding the effective date; or
- for which medical advice, diagnosis, care or treatment was recommended by or received from a health care provider within the six-month period preceding the effective date; or
- a pregnancy existing on the effective date of coverage, except for involuntary complications of pregnancy incurred after the effective date.

This exclusion may last up to 12 months from your first day of coverage; however, the exclusion period will be reduced by the number of days of your prior "creditable coverage." Most prior health coverage is considered creditable coverage and can be used to reduce the preexisting condition exclusion period if you have not experienced a break in coverage of 63 days or more.

This preexisting condition exclusion does not apply to a child who is enrolled in the plan within 60 days after birth, adoption or placement for adoption.

SECTION 11 ACKNOWLEDGEMENT AND AUTHORIZATION TO OBTAIN MEDICAL RECORDS

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are eligible for benefits coverage and are listed on the application) for the purpose of facilitating healthcare treatment, payment or for the purpose of business operations necessary to administer healthcare benefits, or as required by law.

Health information requested or disclosed may be related to treatment or services performed by:

- A physician, dentist, pharmacist or other physical or behavioral healthcare practitioner;
- A clinic, hospital, long-term care or other medical facility;
- Any other institution providing care, treatment, consultation, pharmaceuticals or supplies; or
- An insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records or hospital records (including nursing records and progress notes).

This acknowledgement does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

Authorization to Obtain Records: I authorize any physician, medical professional, hospital, clinic, pharmacy, pharmacy benefit manager or other pharmacy related services organization, health plan, insurance company, claims administrator, employer, governmental agency or other person or firm, to disclose to Blue Cross of Idaho or its authorized representative, my personal information, including copies of records concerning physical or mental illness, advice, diagnosis, prognosis, prescription information, care or treatment provided to me. I understand that such information will be used by Blue Cross of Idaho for the purpose of evaluating my application for insurance. Health information obtained will not be redisclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. This authorization shall be valid for six months from this date and may be revoked by sending written notice to Blue Cross of Idaho at 3000 E. Pine Ave, Meridian ID 83642. Failure to execute this authorization may result in Blue Cross of Idaho being unable to collect information relating to you and result in the inability obtain Access individual coverage.

Signature of Applicant _____ Signature Date (MM/DD/YYYY) _____

Signature of Spouse (if applying for coverage) _____ Signature Date (MM/DD/YYYY) _____

Signature of Adult Dependent _____ Signature Date (MM/DD/YYYY) _____

Signature of Adult Dependent _____ Signature Date (MM/DD/YYYY) _____

Signature of Adult Dependent _____ Signature Date (MM/DD/YYYY) _____

(An adult dependent is a dependent age 18 or older)

SECTION 12 PARENTAL OR GUARDIAN CONSENT TO APPLICATION

I, the undersigned, represent that the person listed as the applicant on this application is under 18 years of age and is making application for health coverage with my full knowledge and consent. I hereby accept full responsibility for the payment of premiums and the answers and information provided in this application.

Signature _____ Print Name _____ Date (MM/DD/YYYY) _____

SECTION 13 AGENT INFORMATION

Agent's Name _____ ID No. _____

Signature of Agent _____ Date _____

DISCRIMINATION IS AGAINST THE LAW

Blue Cross of Idaho complies with applicable Federal civil rights laws and does not discriminate, exclude or treat less favorably on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability or sex.

Blue Cross of Idaho:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - o Qualified sign language interpreters
  - o Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, which may include:
  - o Qualified interpreters
  - o Information written in other languages

If you need these services, contact Blue Cross of Idaho Civil Rights Coordinator at 1-800-627-1188 (TTY: 711).

If you believe that Blue Cross of Idaho has 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 at:

Civil Rights Coordinator
3000 E. Pine Ave., Meridian, ID 83642
Telephone: 1-800-274-4018
Fax: 208-331-7493
Email: ***grievancesandappeals@bcidaho.com***
TTY: 711

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator 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 ***https://ocrportal.hhs.gov/ocr/smartscreen/main.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 ***https://www.hhs.gov/ocr/complaints/index.html***.

ATTENTION: If you speak Arabic, Bantu, Chinese, Farsi, French, German, Japanese, Korean, Nepali, Romanian, Russian, Serbo-Croatian, Spanish, Tagalog, or Vietnamese, appropriate auxiliary aids and language assistance services are available free of charge. Call 1-800-627-1188 (TTY: 711).

Arabic انتبه: إذا كنت تتحدث اللغة العربية ، فإن خدمات المساعدة اللغوية متاحة لك مجانًا اتصل على 1188-627-800-1 (للصم والبكم: 711).

Bantu: ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-627-1188 (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 1-800-627-1188 (TTY：711)。

Farsi توجه: اگر به زبان فارسی صحبت می کنید، خدمات رایگان پشتیبانی زبان، در دسترس شما است. شماره تماس 1188-627-800-1 (TTY:711).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-627-1188 (ATS : 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-627-1188 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-627-1188 (TTY:711) まで、お電話にてご連絡ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-627-1188 (TTY: 711)번으로 전화해 주십시오.

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-627-1188 (टटिविइ: 711) ।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-627-1188 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-627-1188 (телетайп: 711).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-627-1188 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-627-1188 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-627-1188 (TTY: 711.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-627-1188 (TTY: 711).