Premera Medigap Application Packet

Thank you for your interest in the Premera BlueCross Medicare Supplement plan!

This application packet provides you with a link (below) to the electronic Enrollment Form and the Outline of Coverage in addition to a link to the Choosing a Medigap Policy Guide.

Should you decide to apply by secure upload/mail/fax/email, the printable application needs to be reviewed and signed by an Agent before it can be submitted to Premera BlueCross. You may email, fax or mail it in to CDA Insurance:

- Fax: 1.541.284.2994
- Email: cs@cda-insurance.com
- Secure File Upload: Click here
- Mail: CDA Insurance LLC
  PO Box 26540
  Eugene, Oregon 97402

Other Important Information
Download Medicare's Choosing a Medigap Policy Guide (.pdf) Download Application – Click here Download Policy Outline (.pdf)

Our website: https://www.medicare-washington.com

If you should have any questions on the application, please call us at 1.800.884.2343 or 1.541.434.9613.

Washington Medicare Supplement Enrollment Application for Plans A, C, G, High Deductible G, and N

PO Box 327, MS 295
Seattle, WA 98111
800-752-6663
Fax: 425-918-5278

PREMERA | BLUE CROSS
An Independent Licensee of the Blue Cross Blue Shield Association

You are eligible to apply for a Premera Blue Cross (Premera) Medicare Supplement Plan if you:

- Reside in Washington (excluding Clark County),
- Currently have both Medicare Part A and Part B, and
- Don't receive Medicaid assistance other than payment of your Medicare Part B Premium.

Please type your answers or print clearly in ink so we can process your application quickly. Be sure to return all pages to us. Omissions, incomplete answers, or the use of correction fluid or tape will result in the return of your application and may cause a delay in the effective date of your coverage.

A Personal Information

Last Name	Suffix	First Name	Middle Initial

Home Address (cannot be a PO Box or business address)	City	County	State	Zip
			WA	
Mailing Address (if different from above)	City	County	State	Zip
Billing Address (if different from both above)	City	County	State	Zip

Phone Number	Alternate Phone Number
( )	( )

Email Address*	Birthdate (Month/Day/Year)	Gender
		☐ Male ☐ Female

*Important Note: *We can send enrollment notifications, information about how to use your plan, your Welcome Kit, and a copy of this application to you by email instead of a paper copy.*
Do you want to receive enrollment notifications, information about how to use your plan, your Welcome Kit, and a copy of this application to you by email?

☐ Yes ☐ No

Race (Optional)

Premera is committed to serving the diverse needs of all our members. These fields are completely optional. If you'd like to self-identify, please do so. To change these selections at any time please call 800-722-1471. The collection of this information will not determine eligibility, rating, or claim payments.

(Check one)

- ☐ America Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Two or more races
- ☐ Other race

Ethnicity (Optional)

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Language (Optional)

Please select the language in which you're proficient. If your proficient in the English language, as well as others, please select English from the list. To change these selections at any time, please call 800-722-1471. The collection of this information will not determine eligibility, rating, or claim payments.

(Check one)

- ☐ Arabic
- ☐ Chinese
- ☐ English
- ☐ French/Haitian Creole French
- ☐ German
- ☐ Greek
- ☐ Italian
- ☐ Japanese
- ☐ Korean
- ☐ Polish
- ☐ Portuguese
- ☐ Russian
- ☐ Spanish
- ☐ Tagalog
- ☐ Vietnamese
- ☐ Other: _____

B Plan Selection

Which Medicare Supplement plan do you want to enroll in?

☐ Plan A ☐ Plan C ☐ Plan G ☐ Plan G High Deductible ☐ Plan N

Note: Only those applicants who are initially eligible for Medicare before January 1, 2020, may apply for Plans C, F, and High Deductible F, if offered.

Plan Start Date

You are eligible for coverage to start on the first of the month after the postmark date if all information is completed and accurate and we approve your application. Please indicate the month you want your coverage to start.

I want this plan to begin on the first of _____. (No more than 90 days after the application is signed.)
(enter month)

C Medicare Information

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application. **Please answer all questions:**

To the best of your knowledge:

☐ Y ☐ N 1. Did you turn 65 in the last 6 months?

☐ Y ☐ N 2. Will you turn 65 in the next 6 months?

☐ Y ☐ N 3. Did you enroll in Medicare Part B in the last 6 months?

Medicare Number (11 alphanumeric characters as seen in the image above)	
Hospital (Part A) Effective Date	Medicare (Part B) Effective Date

Please fill in your Medicare Number and effective dates in the box above using the information from your Medicare card or attach a copy of your Medicare Card. We need all characters to enroll you.

If you answered YES to 1 or 2, please skip the Health Statements (Section F). The law guarantees that for six months immediately following enrollment in Medicare medical coverage Part B, individuals cannot be denied insurance due to health conditions.

D Payment and Premium Discounts

DO NOT send payments with this application.

You will get monthly paper bills if you do not select automatic monthly withdrawals.

A government agency or any other third party may not sponsor or pay for your individual health plan, except as required by law.

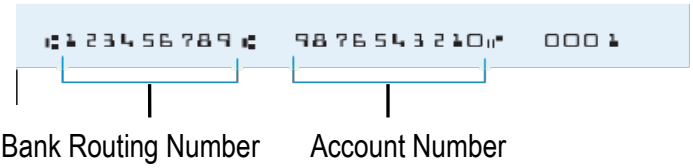
Tip – Save $60/year Sign up for automatic monthly withdrawals (AFT) and save $60 a year. Call us at 800-722-1471 for more information.

Please complete this section if you are selecting automatic monthly withdrawal

I have selected automatic monthly withdrawal and I hereby authorize Premera to initiate funds transfer from the bank or financial institution account indicated below. I authorize my financial institution to honor these transfers.

Account holder's name (print)			
Financial institution or bank name			
City	State	Zip	
Bank routing number (see below)	Account number (see below)	☐ Checking	☐ Savings

Fill out the information above. To ensure accuracy of your automatic withdrawal, we recommend that you send us a photocopy of your voided check.



Additional terms and conditions:

- Funds are transferred on the fifth business day of each month to pay for that month's coverage. For example, the deduction on February 5th pays for coverage in February.
- I understand that my monthly subscription charges will be automatically withdrawn from my bank account each month until I notify Premera that it should be cancelled. To ensure cancellation, I must notify Premera no later than the twentieth of the month to be effective for the following month's automatic withdrawal. I have the right to stop payment on a specific bank transfer at least 3 days prior to the next scheduled withdrawal date.
- It may take as long as 45 days to set up the funds transfer. I may receive a paper bill to cover the initial month(s) while the transfer is being set up.

Bank account holder Signature X	Today's date

E Other Healthcare Information

Please review the statements below, then answer all questions to the best of your knowledge.

- You do not need more than one Medicare Supplement insurance policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage but will otherwise be substantially equivalent to your coverage before the date of suspension.
- If you are eligible for and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health benefit plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

1. Tell us about any help you receive from your state's Medicare program (required):

☐ Y ☐ N a. Are you covered for any medical assistance through the state Medicaid program?

Note to applicant: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.

☐ Y ☐ N b. If yes, will Medicaid pay your premiums for this Medicare Supplement plan?

☐ Y ☐ N c. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B Premium?

☐ Y ☐ N d. Have you recently lost coverage for medical assistance through the state Medicaid program?

If yes, when did it end? _____ / _____ / _____

2. Tell us about your Medicare Supplement coverage (required):

☐ Y ☐ N a. Do you have another Medicare Supplement policy in force?

If so, with what company, and what plan do you have?

Company & plan name: _____

Member ID: _____

Start date: _____ / _____ / _____ End date: _____ / _____ / _____

Customer Service Phone Number: _____

☐ Y ☐ N b. If so, do you intend to replace your current Medicare Supplement policy with this plan?

3. Tell us about your Medicare Advantage coverage (required):

☐ Y ☐ N a. If you had coverage from any Medicare plan other than original Medicare within the last 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave End blank.

Company & plan name: _____

Start: _____ / _____ / _____ End: _____ / _____ / _____

☐ Y ☐ N b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?

☐ Y ☐ N c. Was this your first time in this type of Medicare plan?

☐ Y ☐ N d. Did you drop a Medicare Supplement policy to enroll in the Medicare plan?

4. Tell us about any other group or individual health insurance coverage (required):

☐ Y ☐ N a. Have you had coverage under any other health insurance within the past 63 days? For example, an employer, union, or individual plan.

If so, with what company, and what kind of policy?

Company & plan name: _____

Member ID: _____

Start date: _____ / _____ / _____ End date: _____ / _____ / _____

Customer Service Phone Number: _____

F Do I need to complete health questions?

When applying for Plan A, C, G, High Deductible G, or N, you do not need to complete Section G if any of the following is true.

1. Your Medicare managed care plan or PACE program coverage ends because the plan is leaving the Medicare program, stops giving care in your area, or you move out of the plan's service area, and you apply for Medicare Supplement (Medigap) coverage after you receive notice that your coverage is terminating or ceasing, and no later than 63 days after your coverage terminates or ceases.
2. Your employer group health plan coverage that supplements the benefits under Medicare ends or ceases to provide all such supplemental benefits to you, and you apply for Medicare Supplement (Medigap) coverage after (a) your coverage is met or ceases, or (b) you receive notice that your coverage is terminating or ceasing, whichever is later, and no later than 63 days after your coverage terminates.
3. Your Medicare Supplement (Medigap) insurance company goes bankrupt, and you lose your coverage, or your Medicare Supplement (Medigap) policy coverage ends through no fault of your own, and you apply for Medicare Supplement (Medigap) coverage beginning on the earlier of your coverage terminating or you are receiving notice of termination or bankruptcy, and no later than 63 days after your coverage terminates.
4. You enrolled in a Medicare Part D plan during your initial enrollment period and were enrolled under a Medicare Supplement (Medigap) policy that covers outpatient prescription medications, and you apply for Medicare Supplement (Medigap) coverage up to 60 days before the initial Medicare Part D enrollment period and no later than 63 days after the effective date of your Medicare Part D coverage. Please enclose proof of enrollment in Medicare Part D.
5. You joined a Medicare Advantage or PACE program when you were first eligible for Medicare Part A (and you're enrolled in Medicare Part B). Within the first year of joining, you want to switch to Original Medicare, and you apply for a Medicare Supplement (Medigap) coverage up to 60 days before and no later than 63 days after your Medicare Advantage or PACE program coverage terminates.
6. You dropped a Medicare Supplement (Medigap) policy to join a Medicare Advantage or PACE program for the first time and now you want to leave. You have been in the plan for no more than a year and you apply for a Medicare Supplement (Medigap) policy up to 60 days before and no later than 63 days after your plan terminates. A health statement is not required if you enroll in the same Medicare Supplement (Medigap) policy (with the same company) that you had previously, if available.
7. You leave a Medicare Advantage plan or drop a Medicare Supplement (Medigap) plan because the company or its representatives haven't followed the rules or misled you, and you apply for a Medicare Supplement (Medigap) policy up to 60 days before and no later than 63 days after your plan terminates.
8. You currently are enrolled in a standardized Medicare Supplement (Medigap) plan issued in 1990 or later, and you wish to switch to a plan with either greater, equal, or lesser benefits. (For example, from a 1990 standard Plan F to a 2010 standard Plan F.) Exception: if you have Plan A, you can only switch to Plan A without requiring underwriting.

G Your Health Conditions

Answer these health questions to determine if you are eligible for this coverage.

If any statements in Section F apply to you, skip this section, and move on to Section H.
If no statements in Section F apply to you, fill out this section.

1. **Do any of these conditions apply to you?** ☐ Y ☐ N

- End stage renal (kidney) disease
- Currently receiving dialysis
- Diagnosed with kidney disease that may require dialysis
- Cirrhosis/liver failure
- Chronic obstructive pulmonary disorder (COPD)
- Have a bleeding (coagulation defect), blood disorder, or leukemia
- Rheumatoid arthritis, joint replacement
- Schizophrenia, bipolar mood, attempted suicide, or eating disorder
- Transplant (excludes corneal)
- Insulin dependent diabetes

2. **Within the past 5 years, has a medical professional diagnosed, discussed, or recommended treatment options for any of the following conditions?** ☐ Y ☐ N

- Alcohol, or chemical/drug abuse or dependence
- DVT (clots) or PVD (peripheral vascular disease)
- Stroke/TIA or paralysis
- Prostatitis
- Heart attack, congestive heart failure, coronary artery disease, pacemaker, stenosis, or heart valve prolapse or transplant
- Ulcerative colitis or Crohn's disease
- Chronic bronchitis or tuberculosis
- Chronic back/neck/disc problems

If you answered YES under questions 1 or 2 in this section, you are NOT eligible for these plans at this time.

If your health status changes in the future, allowing you to answer NO to all of the questions in this section, please submit an application at that time.

For information regarding plans that may be available, contact your local state department on aging.

If you answered NO to both questions 1 and 2, your answer to questions 3 and 4 will be used to determine if your application will be accepted.

3. **Height and weight:**

Height	Weight / lbs.
Feet Inches	

4. Have you taken medications within the past year?

☐ **Yes.** Please enter your medication information in the table provided below.

☐ **No.** Please move to Section H.

Medication Name	How long have you been taking this medication?	What does this medication treat?

H Authorization and Verification of Information

I, the undersigned, apply for enrollment with Premera Blue Cross (Premera). I represent that all statements and answers on this application are complete and true. I understand coverage is available to me due to: (1) my residing in Washington (excluding Clark County). (2) my enrollment in Medicare Parts A and B, (3) my eligibility for Medicare due to age (65 or over), and (4) I don't receive Medicaid assistance other than payment of my Medicare Part B premium. I understand and agree that coverage does not begin until Premera accepts this application and assigns an effective date of coverage and that receipt of my money (cash, check or money order) does not constitute enrollment under any Medicare Supplement program. I authorize Premera, at its option, to pay providers directly for services rendered. I also understand and agree that Premera may:

1. Accept this application; or
2. Deny this application, in which case any subscription charges submitted will be refunded to, and accepted by me; or
3. Within the first two years of my coverage, void my contract (in other words, cancel my coverage back to its effective date, as if never existed at all) if I have made any intentionally false or misleading statements on this application or enrollment form that are material enough to affect my acceptability for coverage.

I understand that Premera may collect, use, and disclose personal information about me as required or permitted by law or to perform routine business functions, such as determining my eligibility for enrollment, credit for waiting periods, and benefits; paying claims; and fulfilling other obligations stated in its contract with me. If Premera discloses my personal information for any other reason, Premera will first remove any data that can be used to easily identify me or will get my signed authorization.

I further understand that any physician, health care provider, hospital, insurance or reinsurance company, pharmacy benefits manager or third party benefits administrator may disclose my personal health information, including any and all diagnostic, procedural, treatment, claim, prescription or other health related information including records concerning alcohol and/or chemical dependency, reproductive health (including abortion), sexually transmitted diseases, HIV, AIDS, psychiatric disorders and mental illness to Premera or its representatives as allowed by law.

I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

I understand that the Medicare Supplement contract will not pay benefits during the first three months after the effective date for any condition for which I have had treatment, medicine, or diagnostic testing within the three months prior to my effective date. I understand that, under certain conditions, this limitation may be shortened or waived. **The waiting period may be waived if I apply for this contract within 63 days of leaving other healthcare coverage and I provide proof with this application.**

I understand I am responsible for canceling any prior coverage.

If you answered yes to questions 2 or 3 in Section E, you must complete and sign the attached replacement notice.

☐ I acknowledge receipt of the Guide to Health Insurance for People with Medicare and the Outline of Coverage.

I have read all information and have answered all questions to the best of my ability.

Signature of applicant X	Today's date

Note: if you are signing as the legal representative for the applicant, please enclose a copy of the appropriate legal documentation.

! ! ! IMPORTANT: Be Sure to Return the Entire Application ! ! !

Continue to the next page for the Replacement Notice

For producer use only

Be sure to return this page to us even if you do not have a producer.

If this application is being submitted through a producer, they must complete the information below and the attached Notice of Replacement, if appropriate. If all questions are not answered completely, the application will be returned.

Completion of this section by a producer is required.

1. List any other medical or health insurance policies sold to the applicant. _____

   _____

2. List policies sold which are still in force. _____

   _____

3. List policies sold in the past five years which are no longer in force. _____

   _____

Producer name (please print) TIFFANY JACKSON	Premera producer number (5 digits) V0698
Producer email address TIFFANY@LOWINSURE.COM	Producer contact number (541) 434-9613
Producer signature X	Date

PREMERA | BLUE CROSS

Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with: Civil Rights Coordinator ─ Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the 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/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-722-1471 (TTY: 711).

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 800-722-1471（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-722-1471 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-722-1471 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-722-1471 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-722-1471 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 800-722-1471 (телетайп: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-722-1471 (TTY: 711)។

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。800-722-1471（TTY:711）まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 800-722-1471 (መስማት ለተሳናቸው: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-722-1471 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-722-1471 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-722-1471 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-722-1471 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-722-1471 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-722-1471 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-722-1471 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-722-1471 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-722-1471 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-722-1471 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-722-1471 (TTY: 711) تماس بگیرید.