Application for Individual Dental/Vision Insurance

BlueCross BlueShield Minnesota

Please complete steps 1 – 8.

Step 1) Tell us about yourself.
Step 2) Tell us about your household.
Step 3) Choose a plan and payment.
Step 4) Tell us if you have other dental and/or vision insurance.
Step 5) Review notification and authorization information.
Step 6) Review payment and billing information.
Step 7) Sign the Application.
Step 8) Send your completed Application (all pages) to Blue Cross and Blue Shield of Minnesota (Blue Cross).

If this Application is being completed by an agent/producer, please complete and return the Producer Attestation with the rest of the completed Application.

Need help?

- **This information is available in other ways for people with disabilities or who need it translated into another language by calling 1-800-531-6685 (toll free). For TTY, call 711.**
- **Need help choosing a plan or completing this Application?**
  For in-person help or over the phone: Visit bluecrossmn.com/advisors to connect with a Blue Cross Advisor.
  If you work with an insurance agent/producer: Please contact your agent/producer for assistance or call 1-800-531-6685 and one of our Blue Cross representatives will be happy to assist you. **Hours: 8 a.m. to 6 p.m. Central Time, Monday through Friday.**

Who can enroll in the products on this Application?

- You must be a resident of Minnesota. You must obtain our Residency Policy at bluecrossmn.com/residencypolicy or call 1-800-531-6685 and one of our Blue Cross representatives will be happy to assist you.
- If you are applying for new coverage as a contractholder, you must be over the age of 18. If you are under the age of 18, you must have a parent or guardian listed as the contractholder.
- If eligible, coverage will be provided under an individual contract. Blue Cross does not issue individual coverage through any arrangement with an employer.
- These plans do *not* meet the minimum essential health benefit requirements for pediatric oral health and pediatric vision coverage as required under the Affordable Care Act.

Who can pay my Premium?

- Generally, you pay your own premium.
- Blue Cross may, in its sole discretion and in accordance with applicable law and regulatory guidance, *decline to accept* premium and cost-sharing payments made directly or indirectly by ineligible third parties. "Ineligible third parties" include any person or entity from which Blue Cross is not required by law to accept such third-party payments. This may include, for example, commercial entities, health care providers and suppliers, and other persons or entities with direct or indirect financial interests. "Payments" include those made by any means, (e.g., cash, check, money order, credit card payment, electronic funds transfer), etc. If you have questions about this third-party payment policy or whether Blue Cross will accept premium and/or cost-sharing payments made by a specific person or entity, please contact customer service at 1-800-531-6685 before you complete this Application.

How do I submit this Application?

- Complete this entire Application including all explanations as requested and all required documents. Print clearly using black or blue ink. Incomplete Applications will be returned to you to be completed. This may affect the date your coverage starts. All pages within this form must be returned to be considered a completed application.
- Sign and date this Application. This Application must be received at the home office of Blue Cross within 15 days of your signature. Incomplete Applications are null and void after 30 days.
- To submit your Application faster, please use one of these options to enroll:
  – Email: enrollment.forms@bluecrossmn.com – Phone: 1-877-293-7040 – Online: bluecrossmn.com

STEP 1 - Tell us about yourself

I have an existing Blue Cross/Blue Plus® member ID number: _____

I am a new applicant:

☐ Applying for coverage for myself only ☐ Applying for coverage for myself and my dependents

I am currently enrolled in a Blue Cross Dental or Vision individual plan:

☐ Adding a dependent ☐ Making a plan change

Please note: Processing of your Application may be delayed if this form is NOT completed in its entirety. PLEASE PRINT CLEARLY.

When you include Social Security numbers (SSNs), we can process your Application more efficiently, but you are not required to include them for your dependents or yourself.

First Name	Last Name and Suffix	
Social Security Number (optional)	Gender ☐ Male ☐ Female	Date of Birth (mm/dd/yyyy)

Permanent Home Address (No P.O. Box #)			
City	State	ZIP	County

☐ Correspondence Address (If different from home address)			
City	State	ZIP	County

☐ Billing Address (If different from permanent home and correspondence address)			
City	State	ZIP	County

Email Address		
Home Telephone Number (Non-mobile)	Work Telephone Number	Mobile Telephone Number

1. I have been a permanent resident of Minnesota for a minimum of 183 days: ☐ Yes ☐ No
   Important: We can only offer coverage to permanent Minnesota residents.
2. Will you or any other enrollee receive any premium or cost-sharing payments made by a specific person or entity, directly or indirectly, by an **ineligible** third party described on page 1? ☐ Yes ☐ No
3. Ethnic Background*: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Choose not to answer
4. Race (Select one or more)*: ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Asian ☐ American Indian or Alaskan Native ☐ Other, please specify_____ ☐ Choose not to answer
5. Spoken Language*: ☐ English ☐ Spanish ☐ Other, please specify_____ ☐ Choose not to answer
6. Written Language*: ☐ English ☐ Spanish ☐ Braille ☐ Other, please specify_____ ☐ Choose not to answer

☐ Ethnic background and race is the same for all dependents. If checked, ethnic background and race do not need to be selected for dependent(s) within the following section.

GO TO STEP 2

STEP 2 - Who will be on the Plan?

Tell us about everyone who is applying for coverage.

Dependent 1	Relationship to You	Date of Birth (mm/dd/yyyy)	Social Security Number (optional)	Gender
First Name				☐ Male ☐ Female
Last Name				

1. Does this dependent live at the same address as you? ☐Yes ☐ No **If No,** list address:_____
2. Ethnic Background*: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Choose not to answer
3. Race (Select one or more)*: ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Asian ☐ American Indian or Alaskan Native ☐ Other, please specify_____ ☐ Choose not to answer

Dependent 2	Relationship to You	Date of Birth (mm/dd/yyyy)	Social Security Number (optional)	Gender
First Name				☐ Male ☐ Female
Last Name				

1. Does this dependent live at the same address as you? ☐Yes ☐ No **If No,** list address:_____
2. Ethnic Background*: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Choose not to answer
3. Race (Select one or more)*: ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Asian ☐ American Indian or Alaskan Native ☐ Other, please specify_____ ☐ Choose not to answer

Dependent 3	Relationship to You	Date of Birth (mm/dd/yyyy)	Social Security Number (optional)	Gender
First Name				☐ Male ☐ Female
Last Name				

1. Does this dependent live at the same address as you? ☐Yes ☐ No **If No,** list address:_____
2. Ethnic Background*: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Choose not to answer
3. Race (Select one or more)*: ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Asian ☐ American Indian or Alaskan Native ☐ Other, please specify_____ ☐ Choose not to answer

Dependent 4	Relationship to You	Date of Birth (mm/dd/yyyy)	Social Security Number (optional)	Gender
First Name				☐ Male ☐ Female
Last Name				

1. Does this dependent live at the same address as you? ☐Yes ☐ No **If No,** list address:_____
2. Ethnic Background*: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Choose not to answer
3. Race (Select one or more)*: ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Asian ☐ American Indian or Alaskan Native ☐ Other, please specify_____ ☐ Choose not to answer

Dependent 5	Relationship to you	Date of Birth (mm/dd/yyyy)	Social Security Number (optional)	Gender
First Name				☐ Male ☐ Female
Last Name				

1. Does this dependent live at the same address as you? ☐Yes ☐ No **If No,** list address:_____
2. Ethnic Background*: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Choose not to answer
3. Race (Select one or more)*: ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Asian ☐ American Indian or Alaskan Native ☐ Other, please specify_____ ☐ Choose not to answer

☐ Additional dependent(s) on attached page.

*We may use this information to address differences in health care and improve communication with our members. Providing information is voluntary and will not affect your benefits and coverage, how much you pay, or how we pay your claims.

GO TO STEP 3

STEP 3 - Coverage and payment selection

Your coverage will begin on the first day of the month following receipt of your completed Application unless you indicate a different requested effective date below – whichever is later. Requested effective dates must be within 90 days following receipt of your completed Application.

Dental Coverage Option: Freedom ☐ $1,500 ☐ $2,000 ☐ Value Standard ☐ Value Enhanced ☐ Value Premium ☐ Preferred Bill Frequency Options: ☐ Monthly ☐ Quarterly ☐ Semiannual ☐ Annual Premium Payment ($): _____	My coverage will be for: ☐ Contractholder only ☐ Contractholder and one dependent _____ (name of dependent) ☐ Family	Requested Effective Date: _____ (mm/yyyy) If adding a child dependent outside of renewal, check the reason for the add: ☐ Newborn ☐ Newborn grandchild ☐ Adoption/placement for adoption ☐ Court ordered
Vision Coverage Option: ☐ Value Standard – with Exam ☐ Value – Eyewear Only Plan Annual Premium Payment (Annual Billing Only) ($): _____	My coverage will be for: ☐ Contractholder only ☐ Contractholder and one dependent _____ (name of dependent) ☐ Family	Requested Effective Date: _____ (mm/yyyy) If adding a child dependent outside of renewal, check the reason for the add: ☐ Newborn ☐ Newborn grandchild ☐ Adoption/placement for adoption ☐ Court ordered

STEP 4 Dental and/or Vision insurance information

If you have a current Blue Cross Individual/Family dental and/or vision policy, your current plan will be replaced as of the effective date of your new plan. If your current coverage is through an employer or another insurance carrier, Blue Cross cannot cancel that coverage for you.

1.	Have you or any family members applying for a dental plan under this Application had continuous comparable coverage immediately prior to the effective date of the dental plan selected in STEP 3? If you answered Yes, please provide the supporting documents listed below and complete question 2. **NOTE:** Previous dental coverage will be reviewed and may impact your eligibility or benefits. Supporting document(s) must be provided to prove eligibility. Discount dental coverage does not qualify as comparable coverage.		☐ Yes ☐ No
	Supporting Documentation:	• Letter for previous dental carrier showing comparable coverage - Must be on the official carrier letterhead - Must list all persons covered under the plan and their coverage dates • Summary of plan benefits	

2.	**Carrier:**	**Effective Date:**	**Cancel Date:**	**Contractholder:**

☐ Additional coverage information on attached page.

GO TO STEP 5

STEP 5 - Notification and authorization information

By completing this enrollment Application, I understand that I will be submitting an actual request for enrollment and I agree to the following:

- My signature on this Application indicates that I have read and fully understand the following statements when applying for dental/vision coverage through Blue Cross and Blue Shield of Minnesota (Blue Cross).
- I understand and agree that coverage, if approved, will begin as specified on page 4. I authorize Blue Cross either to use information from my check to make a one-time electronic funds transfer from my account or to process the payment as a check transaction. When Blue Cross uses information from my check to make an electronic funds transfer, funds may be withdrawn from my account as soon as the same day Blue Cross receives my check and I will not receive my check back from my financial institution.
- I understand that coverage will be provided under an individual contract. I understand that Blue Cross does not issue individual coverage through an employer. Blue Cross is not responsible for any action taken by an employer that results in this coverage being considered group coverage under state or federal law. The employer is solely responsible for any such finding.
- For purposes of obtaining information in connection with this Application, reinstatement, or change in coverage benefits, this release is valid as long as I am continually covered with Blue Cross. I am entitled to receive a copy of any release I sign.
- Blue Cross primarily relies upon the information provided and full disclosure of the information listed on this Application in the decision whether to accept the applicant and/or dependent(s) listed on this Application for coverage. I acknowledge the importance of providing accurate and complete information. I acknowledge I must answer all questions in the Application, even if I and/or dependent(s) listed on this Application currently have coverage or had prior coverage with Blue Cross. I understand I must be a permanent resident of Minnesota to be eligible for this coverage and I hereby attest that as of the effective date of my contract I am a permanent resident of Minnesota and am eligible for this coverage. I also understand that if this attestation is determined not to be true, Blue Cross will rescind my contract and coverage, and no claims will be paid.
- I attest that I was not encouraged or advised to apply for this coverage in connection with any offer by an ineligible third party (described on page 1) to directly or indirectly pay all or some of my premiums or cost sharing.
- I agree to notify Blue Cross immediately of any change in my or my dependents enrollment information between the date of this Application and the effective date of coverage. Failure to notify Blue Cross of any change in the information contained on this Application may result in the denial of claims, the issuance of a contract amendment, or a premium adjustment or we may void the contract.
- By providing an email address, I agree to receive communications and marketing materials related to the plan I selected and products offered by or made available from Blue Cross and its affiliates. I may unsubscribe or change my email address at any time by following the instructions included in each email communication.
- By providing a telephone number, I expressly consent to accept and receive communications and marketing materials related to the plan I selected and products offered by or made available from Blue Cross and its affiliates, via text message or voice call to my mobile device and to the cellular/mobile telephone number(s) that I provided.

  NOTE: Email and text messaging transmission cannot be guaranteed to be secure or error-free as information could be intercepted, corrupted, lost, destroyed, arrive late or incomplete, or contain viruses. As the recipient of an email or text message from an unsecured email or device, Blue Plus does not accept liability for any errors or omissions in the contents of the email or text message, which arise as a result of email or text message transmission.
- Upon request, I agree to furnish additional information needed concerning eligibility of any dependent(s) enrolling for coverage. I have read the preceding instructions, statements and answers and represent them to be true and complete to the best of my knowledge and belief. I understand that my or my dependents enrollment eligibility and coverage of benefits under this dental or vision coverage may be subject to a lock-out period. Dental coverage may also be subject to a waiting period. I understand and agree Blue Cross will act in reliance upon the information I have provided on this Application, which materially affects enrollment eligibility and may result in the denial of claims, rescission of the contract, the issuance of a contract amendment, or a premium adjustment.
- I understand and agree that payment of a claim does not preclude the right of Blue Cross to deny future claims or take any action it determines appropriate, including seeking repayment of claims already paid. I understand Blue Cross may also seek rescission of the contract in instances of fraud and intentional misrepresentation.
- I understand that this Agreement renews on an annual basis. I acknowledge that my first premium payment is due by the due date printed on my first invoice. I understand that failing to pay before this due date will result in my Application being voided. I understand that payments in advance of the amount will be credited to my future payments. I understand my payment must be received and processed in full before claims can be paid for any eligible services received. I acknowledge that if my ongoing premium payments are not received within the plan grace period, my plan will be terminated.

Attention: This page must be included when returning your completed Application.

GO TO STEP 6

STEP 6 - Payment and billing information

- For dental coverage, you can pay your dental plan premium monthly in advance to Blue Cross. If it is convenient, you may pay more than your monthly amount. We will apply excess amounts on a monthly basis during the calendar year.
- For vision coverage, you must pay your vision plan premium annually.
- We must receive and process your full premium payment before we can pay claims for any eligible services you receive. If your premium payment is not received within the plan grace period, your plan will be terminated. The termination date will be the last month in which we received your required payment. Claims for eligible services will not be processed unless your current premium has been paid in full.

STEP 7 - Sign Application

If this Application is completed as an electronic or online application, both parties agree to conduct this transaction electronically.

Applicant's Signature _____ Date _____

STEP 8 - Send your completed Application

Send in your completed Application to Blue Cross by one of the following methods.

U.S. Mail:

Include your completed, signed Application and any applicable supporting documentation to:

Blue Cross and Blue Shield of Minnesota
P.O. Box 982806
El Paso, TX 79998

Fax or email:

Fax your completed, signed Application to (651) 662-6439 or email to enrollment.forms@bluecrossmn.com.

Important: Your enrollment may be delayed if this Application is not completed in its entirety.
Please fill out and return all pages of this Application.

For Producer Use Only

PRODUCER ATTESTATION

ATTENTION PRODUCER: If you have questions about completing this Application, please call the Producer Line at 1-888-878-0138.

If this section is not fully completed, you will not be assigned as the AOR.

Blue Cross Agency Code (10-digit code)

Producer Code (10-digit code)

A PRODUCER must complete this section to act on the Applicant's behalf.

I attest I have reviewed the completed Application with the Applicant(s) and:

- I certify that I have met the requirements listed in Minnesota Statute 60K.46 subdivision 4 regarding suitability, as well as those requirements set forth in the Agent Code of Conduct and within the Blue Cross and Blue Shield of Minnesota and Blue Plus contract. Note: Visit Agent Central and search for "Agent Code of Conduct."
- I am not aware, based on the Applicant's responses to my inquiries, of any factors impacting the eligibility of the Applicant and each of his or her dependents applying for coverage
- I further understand that no producer may accept risk or pass on any eligibility requirements, make or alter the terms of the Application or policy, or waive any contractual rights or requirements
- I attest the Applicant was present and signed this Application in my presence
- I provided a copy of the submitted Application to the Applicant(s), in its entirety, immediately in a secure manner pursuant to all applicable laws
- I agree to retain a copy of the submitted Application for my records and to provide a copy of the submitted Application to Blue Plus upon request.

Agency Name _____

Producer Name _____
First MI Last

Producer Signature _____ Date _____

Business Telephone _____

Producer Email _____

BlueCross BlueShield Minnesota

Blue Cross® and Blue Shield® of MInnesota and Blue Plus® are nonprofit Independent licensees of the Blue Cross and Blue Shield Association

Blue Cross and Blue Shield of Minnesota
3400 Yankee Drive
Eagan, MN 55121

INTERNAL USE ONLY

Blue Cross Agency Code (10-digit code)

Producer Code (10-digit code)

Notice of Nondiscrimination and Accessibility

At Blue Cross and Blue Shield of Minnesota and Blue Plus, we treat everyone fairly. We don't exclude you, or treat you less favorably, because of your race, skin color, national origin, age, disability status, or sex (including sexual orientation; sex characteristics including intersex traits; pregnancy or related conditions; gender identity; and sex stereotypes). We follow federal civil rights laws and don't discriminate against anyone based on these traits.

If you communicate best in a language other than English, you can request free language assistance services.

If you have a vision, hearing, or speech impairment, we can communicate in a way that works best for you. This may include using sign language interpreters, providing documents in large print or Braille, audio recordings, or other aids at no charge.

Need these services? Call **1-855-903-2583**, TTY **711** or call the number on the back of your member identification card.

Discrimination is against the law.

If we failed to provide services or discriminated in another way based on your race, skin color, national origin, age, disability status, or sex, (including sexual orientation; sex characteristics including intersex traits; pregnancy or related conditions; gender identity; and sex stereotypes), you can file a complaint by contacting our Nondiscrimination Civil Rights Coordinator:

Email: Civil.Rights.Coord@bluecrossmn.com
Telephone: 1-800-509-5312
Mail: Blue Cross and Blue Shield of Minnesota
ATTN: Civil Rights Coordinator P3-2
PO Box 64560, Eagan, MN 55164-0560

Nondiscrimination complaint forms are available on our website at bluecrossmn.com/NDL, or from the Nondiscrimination Civil Rights Coordinator.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services

- electronically through the Office for Civil Rights complaint portal: ocrportal.hhs.gov/ocr/portal/lobby.jsf
- by mail at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201
- or by phone at: 1-800-368-1019, 1-800-537-7697 (TDD)

Civil rights complaint forms are available at hhs.gov/ocr/office/file/index.html.

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ENGLISH
ATTENTION: If you speak a language other than English, language services are available free of charge. If you have a vision, hearing, or speech impairment, we can communicate in a way that works best for you. This may include using sign language interpreters, providing documents in large print or Braille, audio recordings, or other aids at no charge. Call 1-855-903-2583 (TTY 711).

廣東話 (Cantonese – Traditional Chinese)
請注意：如果您說 廣東話 您可要求免費語言協助服務。
如果您有視力、聽力或言語障礙，
我們會以最適合您的方式與您溝通
這可能包括使用手語傳譯員、免費提供大字體或點字文件、錄音或其他輔助工具。請致電 1-855-903-2583 聽障熱線 (TTY 711)。

ESPAÑOL (Spanish)
ATENCIÓN: Si habla Español, puede solicitar servicios gratuitos de asistencia lingüística. Si tiene una deficiencia visual, auditiva o del habla, podemos comunicarnos de la manera que le resulte mejor a usted. Esto puede incluir el uso de intérpretes de lengua de señas, el suministro de documentos en letra grande o braille, grabaciones de audio u otras ayudas sin cargo. Llame al 1-855-903-2583 (TTY 711).

العربية (Arabic)
تنبيه: إذا كنت تتحدث العربية، يمكنك طلب خدمات المساعدة اللغوية المجانية. إذا كنت تعاني من إعاقة بصرية أو سمعية أو نطقية، يمكننا التواصل معك بالطريقة التي تناسبك. وقد يشمل ذلك استخدام مترجمين للغة الإشارة، أو توفير المستندات بحروف كبيرة أو بطريقة برايل، أو تسجيلات صوتية، أو غيرها من الوسائل المساعدة من دون مقابل. اتصل على الرقم 1-855-903-2583 (الهاتف النصي 711).

አማርኛ (Amharic)
ትኩረት ይሰጥ፦ አማርኛ ቋንቋ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ እገዛ አገልግሎቶችን መጠየቅ ይችላሉ። የማየት፣ የመስማት ወይም የመናገር ችግር ካለብዎት ለእርስዎ በተሻለ በሚሠራው መንገድ መግባባት እንችላለን። ይህ ደግሞ የምልክት ቋንቋ አስተርጓሚዎችን መጠቀምን፣ በትላልቅ ህትመቶች ወይም በብሬይል የተጻፉ ሰነዶችን፣ የድምፅ ቅጂዎችን ወይም ሌሎች መርጃዎችን ያለ ክፍያ ማቅረብን ይጨምራል።
1-855-903-2583 (TTY 711) ላይ ይደውሉ።

FRANÇAIS (French)
ATTENTION : Si vous parlez Français, vous pouvez demander des services d'assistance linguistique gratuits. Si vous avez une déficience visuelle, auditive ou vocale, nous pouvons communiquer de la manière qui vous convient le mieux. Il peut s'agir d'interprètes en langue des signes, de documents en gros caractères ou en braille, d'enregistrements audio ou d'autres aides gratuites. Composez le 1-855-903-2583 (ATS 711).

LUS HMOOB (Hmong)
LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob, koj tuaj yeem thov cov kev pab cuam uas pab hom lus tau dawb. Yog hais tias koj qhov muag tsis pom kev zoo, tsis hnov lus, los sis hais tsis tau lus, peb tuaj yeem sib txuas lus hauv ib txoj hau kev uas ua hauj lwm tau zoo tshaj plaws rau koj. Qhov no tej zaum yuav muaj xam nrog kev siv cov neeg txhais lus piav tes, kev muab cov ntaub ntawv luam tawm ua tus ntawv loj los sis Ua Ntawv Su Rau Cov Neeg Tsis Pom Kev Siv Tau (Braille), kev kaw ua suab lus, los sis lwm yam kev pab yam tsis tau them nqi. Hu rau 1-855-903-2583 (TTY 711).

SOOMALI (Somali)
XASUUSIN: Haddii aad ku hadasho Soomali, waxaad codsan kartaa adeegyada caawimaadda luqada oo bilaash ah. Haddii aad laxaad la'aan kataahy aragga, maqalka, ama hadalka, waxaanu kugula xidhiidhi karnaa habka adiga kuugu habboon. Tan waxaa ka mid ah in aan isticmaalno turjumaanada luuqada dhegoolaha, in la bixiyo waraaqo ku qoran xarfaha waaweyn ama qoraalka indhoolayaasha, in la sameeyo cajalado la duubay, ama in la helo waxyaabo kale oo caawimaad ah oo bilaash ah. Wac 1-855-903-2583 (TTY 711).

ខ្មែរ (Khmer)
ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ អ្នកអាចស្នើសុំសេវាជំនួយបកប្រែភាសាដោយឥតគិតថ្លៃ។ ប្រសិនបើអ្នកមើលមិនឃើញ ស្តាប់មិនឮ ឬនិយាយមិនបាន យើងអាចប្រាស្រ័យទាក់ទងជាមួយអ្នកតាមរបៀបផ្សេងដែលមានប្រសិទ្ធភាពល្អបំផុតសម្រាប់អ្នក។ ការប្រាស្រ័យទាក់ទងនេះអាចមានដូចជាអ្នកបកប្រែភាសាសញ្ញា ការផ្តល់ឯកសារដែលបោះពុម្ពអក្សរធំៗ ឬអក្សរស្ទាប ឬការថតទុកជាសំឡេង ឬជំនួយផ្សេងទៀត ដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-855-903-2583 (TTY 711)។

한국어 (Korean)
주의: 한국어를 사용하시는 경우 귀하는 무료 언어 지원 서비스를 요청하실 수 있습니다. 시각 장애, 청각 장애 또는 언어 장애가 있는 경우 저희는 귀하에게 가장 적합한 방법으로 연락을 드릴 수 있습니다. 여기에는 수화통역사 이용, 대형 활자 또는 점자로 작성된 문서 제공, 음성 녹음 또는 기타 무료 지원이 포함될 수 있습니다.
1-855-903-2583 (TTY 711)번으로 전화하십시오.

M09164 (8/24)

ကညီကျိာ် (Karen) ဟ်သူဉ်ဟ်သး- နမ့်၊ကတိၤ ကညီကျိာ် နှဉ်, နယ့ကျိာ်ဂ့်၊ဝီတ၊်တိစၢၤမၤစၢၤလၢတလၫ်ဘူးလဲ သ့နှဉ်လီၤ. နမ့်၊အိဉ်ဒီးတ၊်တလၢတပှဲၤလၢ မဲာ်တ၊်ထံဉ်, တ၊်နှ၊်ဟူ, မ့တမ့်၊ တ၊်စံးကတိၤတ၊်နှဉ် ပဆဲးကျၢဆဲးကျိးတ၊်လၢ ကျဲကဲထီဉ်လိာ်ထီဉ်အဂ့ၤကတ၊်၊်လၢနဂီၤသ့နှဉ်လီၤ. တ၊်အံၤ ပဉ်ဃုာ်ဒီး တ၊်စူးကါ နီ၊်ခိက့၊်ဂီၤကျိာ်အပှၤကျိာ်ထံတ၊်တဖဉ်, တ၊်ဟ့ဉ်လံာ်လ၊်တဖဉ်လၢ အလံာ်ဖျၫဉ်ဖးဒိဉ်, မ့တမ့်၊ ပှၤမဲာ်ဘျိဉ်အလံာ်, တ၊်ကလုာ်, မ့တမ့်၊ တ၊်မၤစၢၤဂုၤဂၤတဖဉ် လၢတလၫ်အဘူးလဲနှဉ်လီၤ. ကိးလီတဲစိဆူ 1-855-903-2583 (TTY 711) တက့၊်ၤ	**မြန်မာဘာသာ (Burmese)** သတိပြုရန်- သင်သည် မြန်မာဘာသာ စကားကို ပြောပါက၊ အခမဲ့ ဘာသာစကား အကူအညီ ဝန်ဆောင်မှုများကို တောင်းဆိုနိုင်ပါသည်။ သင့်တွင် အမြင်အာရုံ၊ အကြားအာရုံ သို့မဟုတ် စကားပြောခြင်း ချို့ယွင်းမှုရှိနေပါက သင့်အတွက် အသင့်လျော်ဆုံးဖြစ်မည့်နည်းလမ်းဖြင့် ကျွန်ုပ်တို့ထံသို့ ဆက်သွယ်နိုင်ပါသည်။ ၎င်းတွင် လက်ဟန်ပြဘာသာစကား စကားပြန်များကို အသုံးပြုခြင်း၊ စာရွက်စာတမ်းများကို ပုံနှိပ်စာလုံးကြီးများ သို့မဟုတ် မျက်မြင်စာဖြင့် ပံ့ပိုးပေးခြင်း၊ အသံဖမ်းယူခြင်းများ သို့မဟုတ် အခြားအထောက်အကူများဖြင့် အခမဲ့ပံ့ပိုးပေးခြင်းတို့ ပါဝင်ပါသည်။ 1-855-903-2583 (TTY 711) သို့ ဖုန်းခေါ်ဆိုပါ။
OROMOO (Oromo) Xiyyeeffannoon haa kennamu:- Oromo Afaan kan dubbatan yoo ta'e, tajaajiloota gargaarsa afaanii bilisaa gaafachuu ni dandeessu. Rakkoo ilaaluu, dhaga'u ykn dubbachuu yoo qabaattan, karaa isiniif mijatuun haala isiniif galuun mari'achuu ni dandeenya. Kunis of keessatti kan qabatu, hiiktota afaan mallattoo fayyadamuun maxxansa gurguddaa ykn bireeylii, waraabbiiwwan sagalee ykn gargaarsota biroo kaffaltii tokkoo malee gaafachuu dha. 1-855-903-2583 (TTY 711) irratti bilbilaa.	**РУССКИЙ (Russian)** ВНИМАНИЕ: Если ваш язык — РУССКИЙ, вы можете запросить бесплатные услуги языковой поддержки. Если у вас есть нарушение зрения, слуха или речи, мы можем общаться таким образом, который лучше всего подходит вам. Это может включать бесплатное использование переводчиков на языке жестов, предоставление документов крупным шрифтом или шрифтом Брайля, использование аудиозаписей или других вспомогательных средств. Звоните по телефону 1-855-903-2583 (TTY 711).
ພາສາລາວ (Lao) ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າ ພາສາລາວ, ທ່ານສາມາດຂໍບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໄດ້ໂດຍບໍ່ເສຍຄ່າ. ຖ້າທ່ານມີຄວາມບົກຜ່ອງດ້ານສາຍຕາ, ການໄດ້ຍິນ ຫຼື ການປາກເວົ້າ, ພວກເຮົາສາມາດສື່ສານດ້ວຍວິທີທີ່ເໝາະສົມກັບທ່ານທີ່ສຸດ. ອັນນີ້ອາດຈະລວມເຖິງການໃຊ້ນາຍພາສາມື, ການຈັດກຽມເອກະສານເປັນໂຕພິມໃຫຍ່ ຫຼື ອັກສອນນູນ, ການບັນທຶກສຽງ ຫຼື ການຊ່ວຍເຫຼືອດ້ານສື່ອື່ນໆໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍໃດໆ. ໂທ 1-855-903-2583 (TTY 711).	**Tagalog (Tagalog)** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang humingi ng mga libreng serbisyo na tulong sa wika. Kung may kapansanan ka sa paningin, pandinig, o pananalita, maaari tayong mag-usap sa paraan na pinakamabuti para sa iyo. Maaaring kabilang dito ang paggamit ng mga interpreter ng sign language, pagbibigay ng mga dokumento na malalaki ang pagkaprinta o Braille, mga audio recording, o iba pang mga tulong nang walang bayad. Tumawag sa 1-855-903-2583 (TTY 711).
VIETNAMESE (Vietnamese) LƯU Ý: Nếu quý vị nói Vietnamese, quý vị có thể yêu cầu dịch vụ hỗ trợ ngôn ngữ miễn phí. Nếu quý vị bị khiếm thị, khiếm thính hoặc khuyết tật về âm ngữ, chúng tôi có thể giao tiếp theo cách phù hợp nhất với quý vị. Điều này có thể bao gồm việc sử dụng thông dịch viên ngôn ngữ ký hiệu, cung cấp tài liệu dạng bản in cỡ chữ lớn hoặc chữ nổi, bản ghi âm hoặc các phương tiện hỗ trợ khác miễn phí. Xin gọi số 1-855-903-2583 (TTY 711).	简体中文 **(Chinese Simplified)** 注意：如果您说普通话，则可以免费申请语言协助服务。如果您有视力、听力或语言障碍，我们可以用最适合您的方式与您交流。这可能包括免费提供手语翻译、大字体或盲文文件、录音或其 他辅助工具。 请致电 1-855-903-2583（文字电话 711）。