KAISER PERMANENTE®

Individual and Family Plans

2017 Kaiser Foundation Health Plan of Washington enrollment application

For coverage effective on or after Jan. 1, 2017

Thank you for considering us for your individual and family coverage. To apply for enrollment:

- Complete this application in black or blue ink only.
- Read the application carefully and answer all applicable sections completely. **All pages must be returned and your signature is required.**
- Confirm that you meet all the eligibility requirements called out throughout this application.
- Send the application and supporting documents to:
  Kaiser Permanente Individual and Family Sales
  GNW-C1W-02
  P.O. Box 35002
  Seattle, WA 98124-3402

  For application deadlines, see page 6, "Coverage effective date."
- Call us at **1-800-358-8815** or **206-448-4141** if you have any questions about this application or the process.

FOR INTERNAL USE ONLY

Date application was received:

Effective date: _____

1. APPLICATION TYPE

Check the boxes below that apply to you. Please note: Coverage usually begins on the first of the month (see "Coverage effective date" on page 6 for details). If you are applying outside of open enrollment, you must have a qualifying event.

☐ **I am/we are new applicants.**

☐ **I am/we are current members and wish to:**

- ☐ Add dependent(s)
- ☐ Change plans
- ☐ Change from dependent to subscriber
  (Please complete subscriber information in Section 3 on page 3.)

☐ **I am applying for coverage for a child or children only.** (In Section 3 on page 3, please include parent/guardian information under "Applicant/subscriber" and include child information under "Dependent child.")

All medical plans offered and underwritten by Kaiser Foundation Health Plan of Washington, 601 Union St., Suite 3100, Seattle, WA 98101.

2. QUALIFYING EVENTS

Complete if you're applying outside of open enrollment and submit your documentation along with your application. You must enroll no more than 60 days from the date of the qualifying event. **Date of event:** _____

Individuals already enrolled on an Individual and Family Plan cannot change metal levels in conjunction with one of the qualifying events below.

CHECK ONE	QUALIFYING EVENTS	DOCUMENTATION
☐	Loss of your health coverage, including an employer plan, unless the loss is based on misrepresentation of a material fact affecting coverage or fraud related to the health coverage. Note: Voluntarily terminating other health coverage or being terminated for not paying premiums will not be considered loss of coverage. Losing coverage that is not minimum essential coverage is also not considered loss of coverage.	For loss of employer group coverage, a copy of the COBRA offer letter or a letter from your employer listing each applicant that experienced a loss in coverage, the reason for the termination, and when the termination occurred. For loss of individual coverage, a copy of the carrier termination letter or Certificate of Creditable Coverage listing each applicant that experienced a loss in coverage and when the termination occurred.
☐	No longer eligible for Medicaid or a public program providing health benefits.	Copy of the termination letter from Medicaid or other program indicating loss of eligibility and the date of loss.
☐	A permanent change in residence, work, or living situation, whether or not within the choice of the individual, where the health plan under which they were covered does not provide coverage in that person's new service area. If move is within the United States, individuals must have had minimum essential coverage for one or more days during the previous 60 days. This does not apply to those who moved from a foreign country or from a U.S. Territory; however documentation showing move is required.	Copy of termination letter from prior health plan—must include covered individuals and date coverage was lost, if applicable. Documentation from the previous and new addresses (i.e. utility bill, Washington driver's license, rental agreement, etc.) dated within the previous 60 days.
☐	The birth, adoption, or placement for adoption, of the applicant for whom coverage is sought.	Copy of the official birth certificate, adoption papers, medical support order, or the court order appointing a guardian.
☐	The Health Benefit Exchange discontinues your coverage and the three-month grace period (delinquency period) for continuation of coverage has expired.	Letter from the Exchange or health plan indicating coverage was discontinued by the Exchange and the three-month grace period for continuation of coverage has expired.
☐	Your employer doesn't pay your COBRA premiums on time. Note: Voluntary termination of COBRA is not a qualifying event. If you terminate or stop paying your COBRA, you must wait for the next Open Enrollment Period.	Copy of the letter from employer or COBRA administrator indicating loss was due to failure of the employer to remit premium.
☐	Your COBRA coverage has been exhausted or you reach the lifetime limit on your COBRA plan. Note: Voluntary termination of COBRA is not a qualifying event. If you terminate or stop paying your COBRA, you must wait for the next Open Enrollment Period.	Copy of the letter from employer or COBRA administrator indicating loss of COBRA due to exhausting the benefits or exceeding lifetime limit in the plan and no other COBRA coverage is available.
☐	Loss of coverage on a group plan due to age.	Copy of letter from employer of prior health plan indicating loss of coverage due to age.
☐	Marriage or entering into a domestic partnership (dependents also qualify). At least 1 partner must have minimum essential coverage at the time of the event or have lived in a foreign country for 1 or more days during the 60 days prior to event.	Copy of marriage certificate or domestic partnership registration; documentation showing 1 partner has minimum essential coverage, or documentation showing residence outside the country within 60 days of the event.

Continued on next page

☐	Loss of coverage as the result of dissolution of marriage or termination of a domestic partnership.	Copy of divorce decree, annulment papers, or affidavit of termination of domestic partnership, and copy of termination letter from prior health plan.
☐	Discontinuance of Washington State Health Insurance Pool (WSHIP) coverage.	Copy of the termination letter from WSHIP.
☐	Other circumstances where your health plan is no longer available to a subset of people that includes you.	Copy of the termination letter from the prior health plan indicating loss of coverage due to special circumstances.

3. SUBSCRIBER, DEPENDENT, AND ADDRESS INFORMATION

Applicant/subscriber name Last, first, middle initial	Member ID number, if current or former Kaiser Permanente member	
Date of birth	Sex M/F	Social Security number
If age 21 or older, has individual used tobacco products regularly within the last 6 months?* ☐ Yes ☐ No		

Spouse/domestic partner name Last, first, middle initial	Member ID number, if current or former Kaiser Permanente member	
Date of birth	Sex M/F	Social Security number
If age 21 or older, has individual used tobacco products regularly within the last 6 months?* ☐ Yes ☐ No		

Dependent child name (under age 26) Last, first, middle initial	Member ID number, if current or former Kaiser Permanente member	
Date of birth	Sex M/F	Social Security number
If age 21 or older, has individual used tobacco products regularly within the last 6 months?* ☐ Yes ☐ No		

Dependent child name (under age 26) Last, first, middle initial	Member ID number, if current or former Kaiser Permanente member	
Date of birth	Sex M/F	Social Security number
If age 21 or older, has individual used tobacco products regularly within the last 6 months?* ☐ Yes ☐ No		

*Regular tobacco use is defined as 4 or more times per week, excluding religious or ceremonial use and the use of e-cigarettes.

Dependent child name (under age 26) Last, first, middle initial		Member ID number, if current or former Kaiser Permanente member
Date of birth	Sex M/F	Social Security number
If age 21 or older, has individual used tobacco products regularly within the last 6 months?*		☐ Yes ☐ No

Dependent child name (under age 26) Last, first, middle initial		Member ID number, if current or former Kaiser Permanente member
Date of birth	Sex M/F	Social Security number
If age 21 or older, has individual used tobacco products regularly within the last 6 months?*		☐ Yes ☐ No

Dependent child name (under age 26) Last, first, middle initial		Member ID number, if current or former Kaiser Permanente member
Date of birth	Sex M/F	Social Security number
If age 21 or older, has individual used tobacco products regularly within the last 6 months?*		☐ Yes ☐ No

Dependent child name (under age 26) Last, first, middle initial		Member ID number, if current or former Kaiser Permanente member
Date of birth	Sex M/F	Social Security number
If age 21 or older, has individual used tobacco products regularly within the last 6 months?*		☐ Yes ☐ No

REQUIRED—Residential street address (no P.O. Box)			
City	State	ZIP	County

Mailing address	City	State	ZIP
Email address**			Contact phone number

*Regular tobacco use is defined as 4 or more times per week, excluding religious or ceremonial use and the use of e-cigarettes.

**By providing your email address, you are agreeing to receive email communications from Kaiser Permanente.

4. BILLING INFORMATION

No payment is required at this time. You will be mailed a bill once you are approved for coverage. Information about paying online or setting up recurring electronic payments will be included with your welcome letter once you are enrolled.

Check one of the following three billing options and fill in the billing information (if applicable).

☐ **1. Send bill to:** subscriber mailing address.*

OR

☐ **2. Send bill to:** address other than subscriber mailing address.*	☐ **3. Send bill to:** guarantor at the address below.*
Billing name	Guarantor name
Address	Address
City	City
State/ZIP	State/ZIP
Billing phone number	Guarantor phone number
Billing email	Guarantor email

*The applicant, or financial guarantor for children under the age of 18 and/or dependents who are totally incapable of self-sustaining employment, is responsible for premium payments. To the extent permissible by law, a third-party paying premiums on behalf of an applicant is required to either (1) set up an individual online account for payment at kp.org/wa/pay or (2) submit one check per subscriber policy if receiving a paper bill.

5. PLAN CHOICES

Check one box to indicate your health plan selection.

Kaiser Foundation Health Plan of Washington
Core provider network

These plans are only available in these counties: Benton, Columbia, Franklin, Island, King, Kitsap, Kittitas, Lewis, Mason, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, Walla Walla, Whatcom, Whitman, and Yakima.

- ☐ Bronze
- ☐ Core Bronze HSA (see notes below)
- ☐ Flex Bronze
- ☐ Core Silver HSA (see notes below)
- ☐ VisitsPlus Silver HD
- ☐ Flex Silver
- ☐ Flex Gold

HSA notes:

- Kaiser Permanente has partnered with HealthEquity to administer a Health Savings Account (HSA) that is integrated with your HSA plan. **Do you want to choose HealthEquity for your HSA?** ☐ **Yes** ☐ **No**
- Federal law places some limitations on HSA eligibility. Consult your tax advisor or materials available through the U.S. Treasury Dept. for this important information to make sure you're selecting the right HSA plan for your family.
- Subscribers under age 18 can enroll in the health plan but are not eligible for an HSA.

6. DENTAL COVERAGE

Pediatric dental coverage is mandatory for anyone under the age of 19.

You may elect to cover those 19 and older on your plan as well.

I am electing:

☐ Pediatric coverage: for enrollees up to age 19.

☐ Family coverage: for all enrollees including spouse/domestic partner and dependent children up to age 26.

Coverage provided by Delta Dental of Washington, 400 Fairview Ave N., Suite 800, Seattle WA 98109-5371.

OR

☐ I do not want to enroll in dental coverage at this time. I certify that I have, or will have, other pediatric dental coverage for anyone under age 19 covered by my medical plan. I understand that a suspension of my medical plan benefits may occur if I do not supply proof of applicable other pediatric dental coverage to Kaiser Permanente within 60 days of my medical plan enrollment.

Submit proof of other dental coverage to Kaiser Permanente via mail or fax to Kaiser Permanente Individual and Family Sales, GNW-C1W-02, P.O. Box 35002, Seattle, WA 98124-3402 or fax **206-877-0655**.

7. TERMS AND CONDITIONS

1. **Residency eligibility.** You must reside in one of the following counties when purchasing a medical plan in the **Kaiser Foundation Health Plan of Washington Core Network:** Benton, Columbia, Franklin, Island, King, Kitsap, Kittitas, Lewis, Mason, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, Walla Walla, Whatcom, Whitman, or Yakima. Kaiser Permanente, at any time, may request proof of residency to ensure you reside within the service area.
2. **Medicare eligibility.** You or your dependent(s) who are applying are not entitled to Medicare; if you are unsure of your Medicare eligibility please visit medicare.gov. If you or your dependent is age 65 or older but not eligible for Medicare, please submit a "Not Eligible for Medicare" document from the Social Security Administration. If it is discovered that you or your dependent(s) were entitled to Medicare prior to enrolling in a Kaiser Permanente Individual and Family plan, Kaiser Permanente reserves the right to terminate coverage.
3. **Dependent children.** First 3 children ages 0–20 each will be charged the age 0–20 rate. There's no charge for additional children ages 0–20. Each child older than age 20 will be charged the rate applicable to his or her individual age.
4. **Adults applying as a guarantor (dependent-only coverage).** A guarantor may enroll only dependent children who are under the age of 18 and dependents who are totally incapable of self-sustaining employment. Financial guarantors are required for children under the age of 18. A guarantor will be enrolled as a subscriber without medical benefits. As a guarantor, you hereby agree to accept the financial and contractual responsibilities for the dependent listed on the application.
5. **Coverage effective date.** The effective date of your application is based upon Kaiser Permanente's receipt of your completed application. All application documents must be received in the Individual and Family Sales Department at Kaiser Permanente.
   - If you are requesting to enroll during the open enrollment period, and wish to enroll for a Jan. 1 effective date, your application must be received by Dec. 31, 2016.
   - If you are requesting to enroll outside of the open enrollment period due to a qualifying event:
     - For application documents received on or before the last day of the month, coverage will begin on the first day of the following month.
     - For coverage due to a birth, effective as of date of birth.
     - For those adopted or placed for adoption, coverage is effective the date of adoption or placement, whichever occurs first.
     - For special enrollment based on marriage or domestic partnership, or loss of minimum essential coverage, coverage will be effective on the first date of the next month.

6. **Premium payments.** Premium payments are due on a calendar-month basis on or before the first day of each month, subject to a grace period of 10 days. Payment can be made online at kp.org/wa/pay, pay by mail with payment coupon, pay by phone by calling 1-888-901-4636, or you can pay using your bank's online bill pay service.
7. **Revoking coverage.** Intentionally providing false or misleading information on your application documents or failing to pay monthly premiums may result in Kaiser Permanente's refusal to extend coverage, cancellation of coverage, or rescission of coverage for you or your family members.
8. **Applicant's financial liability.** a) Pre-enrollment services: If any hospital or medical service is rendered to you or your dependent(s) prior to your effective date of coverage, you will be responsible for paying for those services. These non-covered services will be billed to you at the full cost. Regardless of whether you or your dependents become a member, you will be responsible for payment of such charges; b) Prior authorizations: Upon termination from any Kaiser Permanente Individual and Family plan, all prior authorizations for health care coverage for the terminated individual(s) will no longer be valid, and you will be financially liable for any additional services you receive.
9. **Dental coverage.** When the family dental coverage is purchased, all individuals on the medical plan will be enrolled with dental. When medical coverage is terminated, dental coverage will also be terminated.

8. PRODUCER INFORMATION (SECTION REQUIRED IF APPLICABLE)

Kaiser Permanente sales representative or producer name

Kaiser Permanente producer ID number

Company/house name (if applicable)

Kaiser Permanente house ID number

Phone number

9. ACKNOWLEDGEMENTS AND SIGNATURES

☐ **I acknowledge that:**

- I have read and agree to the Terms and Conditions (Section 7) included with this application.
- This application becomes part of my Medical Coverage Agreement.
- I have the right to examine and return the Medical Coverage Agreement within 10 days of receipt.
- My age-band rate is based on my age when my coverage becomes effective or my age as of Jan. 1 when the plan renews; premium amount is subject to change upon 30 days' written notice, which will be sent to the subscriber's mailing address.
- If my/our physical residential address changes to a different county in the Kaiser Permanente service area, my premium rates may be subject to change.
- The signatures shown below allow me, my spouse/domestic partner, or my producer (Section 8) to release to Kaiser Permanente information about any person listed on my Individual and Family plan application documents.

- Under the Health Insurance Portability and Accountability Act (HIPAA), Kaiser Permanente, without my authorization, may only release limited information about my selection of a plan to my spouse/domestic partner, adult/minor children, producer, or anyone else.
- Kaiser Permanente may collect, use, or disclose the nonpublic personal information of persons listed on this application as required or permitted by law and to conduct routine business functions such as determining eligibility for enrollment, reviewing prior coverage for waiting periods, paying claims, and, if appropriate, coordinating benefits, and fulfilling other legal obligations specified in my Kaiser Permanente Medical Coverage Agreement.
- I authorize Kaiser Permanente to disclose information about the selection of a plan to the Producer of Record (Section 8) for the duration of coverage and final reconciliation of the Kaiser Permanente account. A signed Authorization to Disclose Health Plan Information form is required for all other disclosures to the Producer of Record.

I declare that, to the best of my knowledge, all information I have provided with this application is true and complete, and that all of the persons for whom I am requesting enrollment are eligible for coverage. I understand that if I have made intentionally false or misleading statements on behalf of myself or any family members, the Medical Coverage Agreement may be cancelled retroactively to its effective date. I further understand that it is a crime to knowingly provide false, incomplete, or misleading information for the purpose of fraudulently obtaining health coverage. Penalties may include imprisonment, fines, and denial of benefits.

☐ **Documentation:** I am enclosing all documentation as required, including, if applicable, documentation to enroll due to a special qualifying event. Any missing information may delay processing of my application.

☐ **Signature:** This application has been signed by me and my spouse/domestic partner, if applicable.

☐ **If not the primary applicant, I am the:**

☐ Parent ☐ Holder of Power of Attorney (attach legal documentation)

☐ Legal Guardian (attach legal documentation)

Primary applicant/(parent/legal guardian) signature Date

Spouse/domestic partner signature Date

Kaiser Permanente Nondiscrimination Notice and Language Access Services

KAISER PERMANENTE®

KAISER PERMANENTE NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. ("Kaiser Permanente") comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Kaiser Permanente does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

Kaiser Permanente:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:
- Qualified interpreters
- Information written in other languages

If you need these services, contact Kaiser Permanente Member Services.

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance by phone, mail, fax, or email. If you need help filing a grievance, a Kaiser Permanente Member Services Representative is available to help you. Language assistance is provided free of charge.

Kaiser Permanente Member Services

Phone: 206-630-4636
Toll-free: 1-888-901-4636
TTY Washington Relay Service: 1-800-833-6388 or 711
TTY Idaho Relay Service: 1-800-377-3529 or 711
Fax: 206-901-6205 or toll-free 1-888-874-1765
Address: PO Box 34593, Seattle, WA 98124-1593
Email: csforms@ghc.org

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 Avenue SW., Room 509F
HHH Building
Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

For Medicare Advantage Plans Only: Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

H5050_XB0001444_54_17 accepted
2017-XB-5_ACA_Notice_Taglines

LANGUAGE ACCESS SERVICES

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-888-901-4636 (TTY: 1-800-833-6388 or 711).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

中文 **(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 1-888-901-4636 (TTY: 1-800-833-6388 / 711)。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

한국어(Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-901-4636 (TTY: 1-800-833-6388 / 711) 번으로 전화해 주십시오.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-901-4636 (телетайп: 1-800-833-6388 / 711).

Filipino (Tagalog): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Українська (Ukrainian): УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-901-4636 (телетайп: 1-800-833-6388 / 711).

ភាសាខ្មែរ (Khmer)**៖ បរយ័ត៖** បើសិនអកនិយាខែរ, សេជំនួយែជក យេមិនគិតល គឺចនសំប់បំរេអក។ ចូរទូរស័ព 1-888-901-4636 (TTY: 1-800-833-6388 / 711)។

日本語 (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。1-888-901-4636 (TTY: 1-800-833-6388 / 711) まで、お電話にてご連絡ください。

አማርኛ (Amharic)፥ ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-901-4636 (መስማት ለተሳናቸው: 1-800-833-6388 / 711).

Oromiffa (Oromo): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

العربية (Arabic): لديكم حق الحصول على مساعدة ومعلومات في ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-901-4636 (رقم هاتف الصم والبكم: 1-800-833-6388 / 711).

ਪੰਜਾਬੀ (Punjabi): ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-901-4636 (TTY: 1-800-833-6388 / 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

ພາສາລາວ (Lao): ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Srpsko-hrvatski (Serbo-Croatian): OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-901-4636 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-833-6388 / 711).

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-901-4636 (ATS: 1-800-833-6388 / 711).

Română (Romanian): ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Adamawa (Fulfulde): MAANDO: To a waawi Adamawa, e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

فارسی (Farsi): توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-901-4636 (TTY: 1-800-833-6388 / 711) تماس بگیرید.