BlueCross BlueShield of Illinois

Dearborn National

Group Enrollment Application | Change Form

Please read the instructions on the inside thoroughly before completing this enrollment application/change form.

232320.0817

ENROLLMENT APPLICATION/CHANGE FORM INSTRUCTIONS

PLEASE READ THOROUGHLY BEFORE COMPLETING ENROLLMENT APPLICATION/CHANGE FORM

Use a black or blue ballpoint pen only. Print neatly. Do not abbreviate.

SECTION 1 **ENROLLMENT EVENTS**	Check all the boxes that apply to indicate if you are a new enrollee or if you are requesting a change to your coverage. Indicate the event and date, if applicable. Complete the additional sections that correspond to your selection. **New Enrollee:** Complete all sections where applicable. **Add Dependent:** Complete all sections where applicable. • If you are applying for coverage for a disabled dependent over the age limit of your employer's plan, please provide the additional information requested in Section 5. Additional documentation may be required as addressed in that section. • If your employer offers coverage for children and your children are eligible, your children are eligible for health and/or dental coverage up to the dependent limiting age and may not be denied coverage due to marital, student or employment status before age 26 (check with your employer for additional details regarding eligibility requirements). In addition, eligible military personnel may not be denied coverage before age 30 under Illinois law. If you are adding an eligible military personnel dependent who is over the age limit of the employer's plan, completion of a Defense Department Form (DD 214) is required in addition to this application. **Open Enrollment:** The period of time offered on a regular basis during which you can elect to enroll in a specific group health insurance plan or make changes to your current membership. **Special Enrollment Event:** If you qualify, special enrollment is any change to your current membership such as marriage*, divorce**, adoption, suit for adoption or placement for adoption, leave/layoff, moving out of the service area, etc. This change may occur outside of open enrollment. **Effective Date of Benefits:** Field is mandatory and should reflect your requested date. **Completion of Other Eligibility Requirements:** Check this box only if your employer has eligibility requirements that you have met/completed prior to enrollment, such as measurement period or orientation period. **Cancel Enrollee/Cancel Dependent/Cancel Coverage:** Complete Sections 1, 2, 4 (skip Section 4 if declining coverage), 8 and 9. In Section 4 include name, social security number and date of birth of individual(s) canceling.
SECTION 2 **YOUR INFORMATION**	Complete this section with details about yourself even if you are declining coverage.
SECTION 3 **YOUR COVERAGE**	Complete all portions related to the coverages for which you are applying. Please list the seven character plan ID for your selected benefit design (example: S533PPO) in the plan # field. If you are unsure of your group size or do not know your plan ID, please ask for guidance from your employer. If you are enrolling with Dearborn National®, enter the information requested. When listing the beneficiary, provide both the first and last name and the relationship to you. List all beneficiaries that apply.
SECTION 4 **COVERAGE OPTIONS**	Complete all areas that apply to you and each dependent. **For HMO Plans Only:** • Those applying for HMO coverage are required to select a primary care physician/practitioner (PCP) for each covered individual. List the name of the physician/practitioner and the provider number from the provider directory or Provider Finder® at **bcbsil.com**. Be sure to check the appropriate box for a new patient. • If you selected HMO coverage, you must select a medical group/individual practice associations (IPAs) and a primary care physician (PCP) for each person to be covered. You must also select a PCP within the selected medical group/IPA for each person to be covered. You may choose a different medical group/IPA for each person. Care received from a woman's principal health care provider (WPHCP) may be eligible for coverage without referrals from your PCP. However, your PCP and your WPHCP must be affiliated with or employed by your medical group/IPA in order for each person to be eligible for coverage. Until we receive your selected medical group/IPA, you may not be eligible and your claims may be denied. Be sure to enter the medical group/IPA number, name, PCP number and name. • If you are adding an eligible military personnel dependent who is over the age limit of your employer's plan, completion of a Defense Department Form 214 (DD 214) is required in addition to this application. **Change Primary Care Physician/Practitioner:** Complete Section 1 and check the "Other Change(s)" box; then, complete Sections 2, 3, 4 and 9. In Section 4, please include enrollee's or dependent's name, social security number, date of birth, name and number of the new PCP and the name and number of the new IPA. **Change Address/Name:** Complete Section 1 and check the "Other Change(s)" box; then, complete Sections 2 and 9.
SECTION 5 **DISABLED DEPENDENT**	A disabled dependent must be medically certified as disabled and dependent upon you or your spouse***/domestic partner in order to be considered for coverage if dependent coverage is part of your employer's plan. The disabled dependent is required to be covered prior to age 26 to be eligible for coverage over the dependent child age limit of your employer's plan. A Disabled Dependent Certification and Disabled Dependent Physician Certification document must be completed and submitted with this enrollment application, if applicable.
SECTION 6 **OTHER COVERAGE**	Complete this section if you or any dependent have other group or individual health and/or dental coverage (if applicable) that will not be canceled when the coverage under this application becomes effective.
SECTION 7 **MEDICARE COVERAGE**	Complete this section if you or any of your dependents are covered by Medicare. Enter the start and end dates for the coverage that applies. Your Medicare HIC number must be listed (it can be found on your Medicare ID card). Check the reason for your Medicare coverage.
SECTION 8 **DECLINATION OF COVERAGE**	Complete this section if you are declining health coverage for yourself and your dependents. **Anyone** declining coverage for any reason should complete Section 8, not just those declining because of other coverage. **IMPORTANT NOTICE:** If you are declining enrollment for yourself or your dependents (including your spouse) because of other health care coverage, you may, in the future, be able to enroll yourself or your dependents in the plan if you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of a marriage, party to a civil union, birth, adoption, becoming a party in a suit for adoption, or placement of a foster child in your home, you may be able to enroll yourself and your dependents if you request enrollment within 31 days after the marriage, birth, adoption, suit for adoption or placement for adoption, or placement of an eligible foster child in your home.
SECTION 9 **COVERAGE CONDITIONS**	Sign your name and date the enrollment application if you agree to the conditions set forth in this section. Your enrollment application should be submitted to your employer's **Enrollment Department**, which will then submit your form to BCBSIL**.**
	As used on the application (unless indicated otherwise): These terms may be used in a different way in other documents. * *The term "marriage" includes legal marriage and the establishment of a civil union or domestic partnership (coverage subject to your employer's plan).* ** *The term "divorce" includes legal divorce and the comparable termination of a civil union or domestic partnership (coverage subject to your employer's plan).* *** *The term "spouse" includes a legal spouse and a party to a civil union or domestic partnership (coverage subject to your employer's plan).*

Changes in state or federal law or regulations, or interpretations thereof, may change the terms and conditions of coverage.

If you are a current member and have questions, you may call the Customer Service number on the back of your member ID card.

ENROLLMENT APPLICATION/CHANGE FORM

Group # | Section # | Social Security #

Account # | Category

BlueCross BlueShield of Illinois   Dearborn National®

SECTION 1 — ENROLLMENT EVENTS

PLEASE CHECK ALL THAT APPLY – IF YOU ARE DECLINING COVERAGE, COMPLETE SECTIONS 2, 8 AND 9 ONLY

☐ **New Enrollee** ☐ **Add Dependent** ☐ **Open Enrollment** ☐ **Other Changes**

Are you applying as a result of a Special Enrollment Event?

☐ **No** ☐ **Yes, Event Date:** ____ / ____ / ____

Event: ☐ New Hire ☐ Marriage* ☐ Birth

☐ Adoption, Placement for Adoption or Suit for Adoption (provide legal documents)

☐ Court Order (provide court order or decree)

☐ Loss of Other Coverage

☐ Other (explain): ______________________________

Effective Date of Benefits: ____ / ____ / ____ ☐ **Completion of Other Eligibility Requirements**

☐ **Cancel Enrollee** ☐ **Cancel Dependent**

Cancel Coverage: ☐ Health ☐ Dental

☐ Term Life ☐ Dependent Life

☐ Short-Term Disability ☐ Long-Term Disability

List names of those canceling in Section 4 below

Event: ☐ Divorce** ☐ Death

☐ Terminated Employment ☐ Other

Indicate Event Date: ____ / ____ / ____

SECTION 2 — PLEASE TELL US ABOUT YOURSELF

COMPLETE EVEN IF DECLINING COVERAGE

Last Name	First Name	MI (opt)	Suffix	Birth Date (MM/DD/YYYY)	Social Security # – –
Mailing Address - Street - Apt #	City			State	ZIP code
Email Address	☐ Male ☐ Female	Home/Cell Phone #			
Name of Employer	Job Title	Business Phone #	Employment Date (MM/DD/YYYY)	On average, how many hours a week do you work? (required)	

Eligibility Status: ☐ Active Employee ☐ Retired Employee - Date of Retirement: __________ ☐ COBRA Coverage Start Date__________ Projected End Date __________

☐ Illinois Continuation (insured plans only) Start Date__________ Projected End Date__________

SECTION 3 — SELECT YOUR COVERAGE

PLEASE CHECK ALL THAT APPLY

Small Group Plans (1-50 Employees)

Affordable Care Act Plans

☐ PPO ☐ Other __________

☐ Blue Choice Preferred PPO℠

☐ Blue Options℠

☐ Blue Precision HMO℠

☐ BlueCare Direct℠

Plan # (required) ______________________

Grandfathered and Grandmothered/Transitional Plans

☐ Blue Advantage Entrepreneur PPO℠

☐ Blue Choice Select PPO℠

☐ BlueEdge Select HSA℠

☐ BlueEdge HSA℠

☐ BlueEdge HCA Direct℠

☐ PPO Value Choice

☐ Blue Advantage HMO℠

☐ Blue Advantage HMO Value Choice℠

☐ Community Participation Organization (CPO)

☐ CPO Value Choice

☐ Other ______________________

Plan # (required) ______________________

Mid-Market and Large Group Standard Plans (51+ Employees)

Mid-Market & Large Group Standard Plans 51+

☐ PPO

☐ Blue Advantage HMO℠

☐ Blue Advantage HMO Value Choice℠

☐ Blue Choice Options℠

☐ Blue Choice Select PPO℠

☐ BlueEdge HSA℠

☐ BlueEdge Select HSA℠

☐ Plan # (required)______________

☐ Other ______________

Previous BCBSIL or HMO Membership

Group #: ______________

Section #: ______________

Identification #: ______________

Large Group Custom Plans (151+ Employees)

☐ Traditional

☐ PPO

☐ CPO

☐ CPO Value Choice HMO Illinois®

☐ HMO Illinois® w/HCA

☐ Blue Advantage **HIGH** - HMO

☐

☐ Blue Advantage **LOW** - HMO

☐ Blue Choice Options℠ Blue

☐ Choice Select PPO℠

☐ BlueEdge HCA℠

☐ BlueEdge HSA℠

☐ BlueEdge HCA Direct℠

☐ BlueEdge Select HCA℠

☐ BlueEdge Select HSA℠

☐ BlueEdge Select HCA Direct℠

☐ Vision

☐ Hearing

☐ Medicare Supplement

☐ Other ______________

☐ BlueCare Dental PPO℠

☐ BlueCare Dental HMO℠

☐ Dental Group # (if different than Medical Group policy #)

____

☐ Employee and Party to a Civil Union or Domestic Partner

Gender: ☐ Male ☐ Female

☐ Individual/Employee

☐ Employee/Children

☐ Employee/Spouse

☐ Family

Primary Language: ______________________

^

☐ I am not applying for Group Term Life, AD&D or Disability Insurance coverage

Employee Occupation/Job Title: ______________ Wage Rate $__________ per ☐ hour ☐ week ☐ month ☐ year

Group Basic Term Life and AD&D	☐ I do not apply	☐ I do apply	Amount $______________
Group Dependents' Life	☐ I do not apply	☐ I do apply	
Group Supplemental Life	☐ I do not apply	☐ I do apply	
Employee Election: $__________	Spouse Election: $__________		Child Election: $__________
Short-Term Disability	☐ I do not apply	☐ I do apply	
Long-Term Disability	☐ I do not apply	☐ I do apply	

	First Name	Initial	Last Name	Relationship	Birth Date (MM/DD/YYYY)	Social Security #
Primary Beneficiary						– –
Contingent Beneficiary						– –

As used on the application (unless indicated otherwise): These terms may be used in a different way in other documents.

* *The term "marriage" includes legal marriage and the establishment of a civil union or domestic partnership (coverage subject to your employer's plan).*

** *The term "divorce" includes legal divorce and the comparable termination of a civil union or domestic partnership (coverage subject to your employer's plan).*

*** *The term "spouse" includes a legal spouse and party to a civil union or domestic partnership (coverage subject to your employer's plan).*

^ *Products and services marketed under the Dearborn National™ brand and the star logo are underwritten and/or provided by Dearborn National® Life Insurance Company (Downers Grove, Illinois) in all states (excluding New York), the District of Columbia, the United States Virgin Islands, the British Virgin Islands, Guam and Puerto Rico. Dearborn National® Life Insurance Company does not provide Blue Cross and Blue Shield of Illinois products and services, and is a separate company.*

Last Name: Social Security #: — — Group #

SECTION 4 — COVERAGE OPTIONS

PLEASE COMPLETE ALL AREAS THAT APPLY
(If you are adding an eligible military personnel dependent who is over the age limit of your employer's plan, completion of a Defense Department Form 214 (DD 214) is required in addition to this application.)

Employee/Enrollee's Name		PCP Name PCP #	IPA Name IPA #
WPHCP Name WPHCP #	New Patient? ☐ Y ☐ N	HMO OB/GYN Name (optional)	HMO OB/GYN #

Dependent's Name ☐ Husband ☐ Wife ☐ Domestic Partner ☐ Party to a Civil Union		Dependent's PCP Name	PCP #	New Patient? ☐ Y ☐ N
IPA Name IPA #		WPHCP Name WPHCP #	HMO OB/GYN Name (optional) HMO OB/GYN #	
Dependent's Social Security # – –	Birth Date (MM/DD/YYYY)	Home Address (if different) Street/City/State/ZIP code		

Dependent's Name ☐ Son ☐ Daughter ☐ Other Eligible Dependent		Dependent's PCP Name	PCP #	New Patient? ☐ Y ☐ N
Birth Date (MM/DD/YYYY)	Home Address (if different) Street/City/State/ZIP code	Is this dependent a natural child, stepchild, foster child, adopted child or a child in suit for adoption? ☐ Y ☐ N	If not your eligible natural child, stepchild, foster child, adopted child or child in suit for adoption, are you (or your spouse) responsible for this dependent? ☐ Y ☐ N	
Dependent's Social Security # – –		IPA Name IPA #	HMO OB/GYN Name (optional) HMO OB/GYN #	

Dependent's Name ☐ Son ☐ Daughter ☐ Other Eligible Dependent		Dependent's PCP Name	PCP #	New Patient? ☐ Y ☐ N
Birth Date (MM/DD/YYYY)	Home Address (if different) Street/City/State/ZIP code	Is this dependent a natural child, stepchild, foster child, adopted child or a child in suit for adoption? ☐ Y ☐ N	If not your eligible natural child, stepchild, foster child, adopted child or child in suit for adoption, are you (or your spouse) responsible for this dependent? ☐ Y ☐ N	
Dependent's Social Security # – –		IPA Name IPA #	HMO OB/GYN Name (optional) HMO OB/GYN #	

Dependent's Name ☐ Son ☐ Daughter ☐ Other Eligible Dependent		Dependent's PCP Name	PCP #	New Patient? ☐ Y ☐ N
Birth Date (MM/DD/YYYY)	Home Address (if different) Street/City/State/ZIP code	Is this dependent a natural child, stepchild, foster child, adopted child or a child in suit for adoption? ☐ Y ☐ N	If not your eligible natural child, stepchild, foster child, adopted child or child in suit for adoption, are you (or your spouse) responsible for this dependent? ☐ Y ☐ N	
Dependent's Social Security # – –		IPA Name IPA #	HMO OB/GYN Name (optional) HMO OB/GYN #	

SECTION 5 — DISABLED DEPENDENT

PLEASE COMPLETE IF APPLICABLE

Name of Disabled Dependent	Nature of Disability
Name of Disabled Dependent	Nature of Disability

If disabled child is over the dependent age limit of your employer's plan, please attach a completed Disabled Dependent Certification and the Disabled Dependent Physician Certification document.

SECTION 6 — OTHER COVERAGE INFORMATION

PLEASE COMPLETE ALL AREAS THAT APPLY

Complete this section only if you or any of your dependents have other health and/or dental coverage **that will not be canceled** when the coverage under this application becomes effective. **List names of each individual covered**:

Group Coverage ☐ Yes ☐ No	Individual Coverage ☐ Yes ☐ No	Name and Address of Other Insurance Carrier	Effective Date (MM/DD/YYYY)	Type of Policy ☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family

Name of Policyholder	Birth Date (MM/DD/YYYY)	☐ Male ☐ Female	Relationship to Applicant ☐ Self ☐ Spouse ☐ Dependent

Employer's Name	Employment Date (MM/DD/YYYY)	Health Group #	Health ID #	Dental Group #	Dental ID #

SECTION 7 — MEDICARE COVERAGE INFORMATION

PLEASE COMPLETE IF APPLICABLE

Name of person covered:	Medicare A (Hospital) Effective Date: ______ End Date: ______ Medicare B (Medical) Effective Date: ______ End Date: ______ Medicare D (Drug) Effective Date: ______ End Date: ______ Medicare D (Drug) Carrier: ______	Medicare HIC # (From Medicare Card)
Please indicate reason for Medicare Eligibility:	☐ Entitled Age ☐ Entitled Disability ☐ End-Stage Renal Disease ☐ Disability and Current Renal Disease	
Name of person covered:	Medicare A (Hospital) Effective Date: ______ End Date: ______ Medicare B (Medical) Effective Date: ______ End Date: ______ Medicare D (Drug) Effective Date: ______ End Date: ______ Medicare D (Drug) Carrier: ______	Medicare HIC # (From Medicare Card)
Please indicate reason for Medicare Eligibility:	☐ Entitled Age ☐ Entitled Disability ☐ End-Stage Renal Disease ☐ Disability and Current Renal Disease	

BlueCross BlueShield of Illinois

SECTION 8 — DECLINATION OF COVERAGE

PLEASE COMPLETE IF YOU ARE DECLINING COVERAGE

This is to certify the available coverage has been explained to me. I have been given the opportunity to apply for the coverage offered to me and my eligible dependents and have voluntarily elected to decline the coverage as indicated below. If I desire to apply for coverage at a later date, I understand there may be a delay in the effective date of the coverage.

Name ☐ Employee	Reason for declining **Health**: ☐ Other Group Health Coverage – Carrier: ____ ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage – Carrier: ____ ☐ Other (explain) ____ ☐ I am not enrolled in any health insurance plan, but do not want this coverage
Name ☐ Employee	Reason for declining **Dental**: ☐ Other Group Dental Coverage ☐ Medicaid ☐ Individual Dental Coverage ☐ Other (explain)____ ☐ I am not enrolled in any dental insurance plan, but do not want this coverage
Name ☐ Spouse	Reason for declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage ☐ Other (explain)____ ☐ I am not enrolled in any health insurance plan, but do not want this coverage
Name ☐ Dependent	Reason for declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage ☐ Other (explain)____ ☐ I am not enrolled in any health insurance plan, but do not want this coverage
Name ☐ Dependent	Reason for declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage ☐ Other (explain)____ ☐ I am not enrolled in any health insurance plan, but do not want this coverage

SECTION 9 — COVERAGE CONDITIONS

- I am an employee or a retiree of the employer named in this enrollment application. I am eligible to participate in the coverage(s) afforded by my employer's plan, which is either underwritten or administered by Blue Cross and Blue Shield of Illinois or Dearborn National® Life Insurance Company. On behalf of myself and any dependents listed on this enrollment application, I apply for those coverage(s) for which I am eligible. I state that the information given on this enrollment application is true and correct. I understand and agree that any intentional misrepresentation of a material fact made by me will invalidate my coverage(s).
- Only those coverage(s) and amounts for which I am eligible will be available to me. I understand that if this enrollment application is accepted, the coverage(s) will become effective in accordance with the provisions of the Contract(s)/Plan(s).
- I agree that my employer acts as my agent. I authorize necessary payroll deduction by my employer, if any, to cover the cost of my coverage(s).
- I understand that my participation in the coverage(s) is subject to any future amendment. I also understand that all notices given to my employer are applicable to me.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Applicant's Signature ____________________ Date ____________

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator	Phone: 855-664-7270 (voicemail)
300 E. Randolph St.	TTY/TDD: 855-661-6965
35th Floor	Fax: 855-661-6960
Chicago, Illinois 60601	Email: CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services	Phone: 800-368-1019
200 Independence Avenue SW	TTY/TDD: 800-537-7697
Room 509F, HHH Building 1019	Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Washington, DC 20201	Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

BlueCross BlueShield of Illinois

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
Ελληνικά Greek	Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να μιλήσετε σε έναν διερμηνέα, καλέστε 855-710-6984.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें।
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił h odoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.