

Enrollment / Change Application

☐ **NEW ENROLLEE**

(Please complete A, C, D, E, F and G)

☐ **CHANGE REQUEST**

(For changes, complete Sections A, B and all other applicable sections)

Please type or print in black or blue, NOT RED ink

Completed By Group Administrator Only

Group Number (if applicable):

Blue Cross NC Subscriber ID Number (if applicable):

A. Employee Information:

Social Security Number:		Date of Birth:		Gender: ☐ Male ☐ Female	
Last Name:		First Name:		MI:	
Mailing Address:		City:	State:	Zip Code:	County:
P.O. Box (For Blue Options HSA / HSA eligible plans you must also provide a street address.)		City:	State:	Zip Code:	
Company Name:		Occupation:	Date of Full Time Employment: mm dd yyyy		
Work Address (For BlueHPN eligible plans you may also provide your work address.)		City:	State:	Zip Code:	County:
Language Preference: ☐ Spanish ☐ English ☐ Other: _____					
Home Phone Number: ()		Work Phone Number: ()		E-Mail Address:	
By sharing your phone number, you agree to calls or text from Blue Cross NC or its partners. Calls could include prerecorded, or robot voiced calls.					
Ethnicity: (This information is optional and will not be used in a discriminatory manner. Responses or nonresponses to this question will not affect eligibility for coverage.)					
☐ African American / Black ☐ Asian / Asian American ☐ American Indian / Alaska Native ☐ White / Caucasian ☐ Hispanic / Latino ☐ Choose not to report ☐ Other (specify): _____					
☐ Active Employee ☐ COBRA / State Continuation ☐ Retiree (51+)			Date of Retirement: mm dd yyyy		

B. If Enrolling in COBRA / State Continuation Qualifying Life Event (QLE):

☐ Termination of Employment ☐ Divorce ☐ Death of Subscriber ☐ Medicare Eligible ☐ Reduction in Hours ☐ Over Age Dependent					
What was the date of the Qualifying Life Event?		Date Continuation Started:		Date Continuation Ends:	
mm	dd yyyy	mm	dd yyyy	mm	dd yyyy

Employee Name:

C. If Enrolling Due to a Qualifying Life Event:

You may apply for coverage for yourself or a dependent outside of open enrollment due to a qualifying life event within 30 days of the date of the event (unless 60 days is required by law). (Legal documentation may be required.) Please fill out this section unless otherwise instructed by your Group Administrator.

Adding a Dependent due to:

☐ Marriage

mm	dd	yyyy
----	----	------

☐ Foster Placement

mm	dd	yyyy
----	----	------

☐ Birth

mm	dd	yyyy
----	----	------

☐ Court Order

mm	dd	yyyy
----	----	------

☐ Adoption

mm	dd	yyyy
----	----	------

☐ Other: _____

mm	dd	yyyy
----	----	------

Date of Occurrence

Date of Occurrence

Enrolling and/or adding a dependent due to loss of other coverage as a result of:

☐ Exhaustion of
COBRA
Continuation

mm	dd	yyyy
----	----	------

☐ Termination of employment

mm	dd	yyyy
----	----	------

☐ Divorce

mm	dd	yyyy
----	----	------

☐ Offered plan is no longer in
your service area

mm	dd	yyyy
----	----	------

☐ Loss of
dependent
status

mm	dd	yyyy
----	----	------

☐ Discontinuance of
other coverage

mm	dd	yyyy
----	----	------

☐ Death

mm	dd	yyyy
----	----	------

☐ Termination of employer
contributions toward coverage

mm	dd	yyyy
----	----	------

☐ Reduction
in hours

mm	dd	yyyy
----	----	------

☐ Meeting or exceeding the
lifetime benefit maximum
of other plan

mm	dd	yyyy
----	----	------

☐ Termination
of other
coverage

mm	dd	yyyy
----	----	------

Date of Occurrence

Date of Occurrence

If either of the following events occurred, you or your dependent(s) may apply within 60 days of the date of the event. Please indicate the event that applies to you and/or your dependent(s):

☐ Loss of eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP)

mm	dd	yyyy
----	----	------

☐ Gain eligibility for premium payment assistance from Medicaid or the Children's Health Insurance Program (CHIP)

What was the date of the
Qualifying Life Event?

D. If Making a Change from Previous Enrollment

Check All That Apply:

☐ Name
(Legal documentation
is required.)

☐ Other Insurance
Information

☐ Date of Birth Correction
(Legal documentation
may be required.)

☐ E-Mail Address

☐ Address

☐ Phone Number

☐ Replace ID Card

☐ Other: _____

Remove Dependent(s):

☐ Divorce

mm	dd	yyyy
----	----	------

☐ Death

mm	dd	yyyy
----	----	------

☐ Dependent
Age

mm	dd	yyyy
----	----	------

☐ Other: _____

mm	dd	yyyy
----	----	------

Date of Occurrence

Date of Occurrence

Reason: _____

Employee Name:

Cancel Coverage:

☐ Not Eligible

mm	dd	yyyy
----	----	------

☐ Subscriber Request
(Open Enrollment Only)

mm	dd	yyyy
----	----	------

☐ Left
Employment

mm	dd	yyyy
----	----	------

Date of Occurrence

☐ Other: _____

mm	dd	yyyy
----	----	------

Date of Occurrence

Reason: _____

Reinstate Coverage:

Reason: _____

Blue High Performance Network® Attestation

Members enrolling in a Blue High Performance Network® (BlueHPN®) plan: please review the following information.

Small Group 1-50 Fully-Insured

I understand that the plan selected has a national provider network limited to BlueHPN®. I certify that I live or work in one of the BlueHPN® Markets / Product Areas. I acknowledge that not all Blue Cross NC contracted providers may be in this plan's network and I will receive out-of-network coverage for urgent, emergent care or ambulance services, and for medically necessary covered services when an in-network provider is not reasonably available per Blue Cross NC's access to care standards. Non-participating urgent care services inside the BlueHPN® product area are not covered.

12+ Balanced Funding / 100+ Self Funded / 51+ Fully-Insured

I understand that the plan selected has a national provider network limited to BlueHPN®. I certify that I live or work in one of the BlueHPN® Markets / Product Areas. I acknowledge that not all Blue Cross NC contracted providers may be in this plan's network and I will receive out-of-network coverage for urgent, emergent care or ambulance services, and for medically necessary covered services when an in-network provider is not reasonably available per Blue Cross NC's access to care standards. Non-participating urgent care services inside the BlueHPN® product area are not covered.

I can search for a provider in the online "Find Care" tool to determine if my provider is in my plan's network. I acknowledge that I have the right to decline my employer's coverage and enroll in different coverage outside of the coverage offered by my employer.

HEALTH COVERAGE (if applicable):

☐ Employee Only ☐ Employee / Spouse / Domestic Partner ☐ Employee / Child(ren) ☐ Employee / Family

If your group is offering multiple plans,
please enter plan name selected: _____

DENTAL PLAN:

☐ Dental ☐ No Dental Coverage If your group is offering multiple plans,
please enter plan name selected: _____

DENTAL COVERAGE (if applicable):

☐ Employee Only ☐ Employee and Spouse and Child ☐ Employee / Spouse / Domestic Partner
☐ Employee and Dependent ☐ Employee and Child ☐ Employee / Children ☐ Employee / Family

BLUE 20/20SM VISION COVERAGE (if applicable):

☐ Employee Only ☐ Employee and Spouse and Child ☐ Employee / Spouse / Domestic Partner
☐ Employee and Dependent ☐ Employee and Child ☐ Employee / Children ☐ Employee / Family

If your group is offering multiple plans,
please enter plan name selected: _____

Employee Name:

DECLINE MEDICAL COVERAGE:

Check one only: ☐ I am rejecting Employee Coverage ☐ I am rejecting Dependent / Spouse Coverage

Declining coverage for the following reason (check one):

☐ Another plan offered by my employer

☐ COBRA or State Continuation

☐ A government plan (type): _____

☐ An individual plan

☐ My spouse's group coverage

☐ Other (explain): _____

☐ I and/or my dependents are not covered by any other health benefit plan

☐ Names of any dependents rejecting coverage: _____

I understand that if I elect to apply for coverage for myself, my spouse / domestic partner, and/or my dependent child(ren) through this employer health plan at a later time, I may be delayed until the employer's open enrollment period.

Important Notice of Special Enrollment:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance (including Medicaid or Children's Health Insurance Program (CHIP)) or group health plan coverage, you may be able to enroll yourself and the dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (other than Medicaid or CHIP) or if the employer stops contributing towards your or your dependents' other coverage and within 60 days after the loss of Medicaid or CHIP eligibility.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption or foster care, except when adding a dependent child will not change your coverage type or premiums that are owed.

☐ Signature of Primary Applicant: **X** _____ Date

F. Family Information – Legal Documentation May be Required

Health	Dental	Blue 20/20 Vision	Name (First, Middle Initial, Last, Suffix)	Social Security Number (Required for Spouse / Domestic Partner)	Birthdate (mm/dd/yyyy)	Gender	Child Status (please check if applicable)
☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Spouse ☐ Domestic Partner			☐ M ☐ F	N/A
☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	Child 1			☐ M ☐ F	☐ Intellectually or physically disabled
☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	Child 2			☐ M ☐ F	☐ Intellectually or physically disabled
☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	Child 3			☐ M ☐ F	☐ Intellectually or physically disabled

* Application does not guarantee enrollment.

** If you have more than three children, complete an Additional Dependent form.

☐ Additional Dependent form attached.

Dependent children include foster, adopted or a child placed by court or administrative order.

Application Continued on Next Page

Employee Name:

G. Other Health Insurance Information

Additional Health Coverage that will be in-force when this policy becomes active:

Insurance Carrier:			Policy Holder Name:			Policy Number:		
Date of Birth:			Effective Date:			Termination Date or Expected Termination Date:		
mm	dd	yyyy	mm	dd	yyyy	mm	dd	yyyy
						(If remaining active leave blank)		
What kind of coverage? ☐ Individual ☐ Group								
Persons covered:								
☐ Employee ☐ Spouse ☐ Domestic Partner ☐ Child 1 ☐ Child 2 ☐ Child 3 ☐ Additional Dependents								

Additional Health Coverage that will be in-force when this policy becomes active:

Insurance Carrier:			Policy Holder Name:			Policy Number:		
Date of Birth:			Effective Date:			Termination Date or Expected Termination Date:		
mm	dd	yyyy	mm	dd	yyyy	mm	dd	yyyy
						(If remaining active leave blank)		
What kind of coverage? ☐ Individual ☐ Group								
Persons covered:								
☐ Employee ☐ Spouse ☐ Domestic Partner ☐ Child 1 ☐ Child 2 ☐ Child 3 ☐ Additional Dependents								

If anyone covered has Medicare Coverage please complete below:

Persons covered:								
☐ Employee ☐ Spouse ☐ Domestic Partner ☐ Child 1 ☐ Child 2 ☐ Child 3 ☐ Additional Dependents								
Medicare Claim Number:			Medicare C ☐ Yes ☐ No					
			If yes, Carrier's Name: _____					

Eligible Due To:

☐ Renal Disease; First Day of Dialysis:				Where does dialysis take place?	☐ Home	☐ Center;	
	mm	dd	yyyy				
☐ Kidney Transplant?	☐ Yes	☐ No					
☐ Disability; Is the member actively working?	☐ Yes	☐ No					
☐ Age				Part B Effective Date:			
Part A Effective Date:					mm	dd	yyyy
	mm	dd	yyyy				

H. Other Dental Insurance Information

Have you or your dependents had any other dental coverage within the last 12 months (other than Blue Cross NC coverage that you are applying for today)? ☐ Yes ☐ No

See important notices regarding special enrollment information attached. Please list any dental coverage the employee and/or dependents has/had within the last 12 months (including Blue Cross NC coverage): (To receive prior dental credit against this group benefit plan, please list prior dental coverage within the last 12 months.) Blue Cross NC may request a certificate of creditable coverage for verification purposes.

Employee Name:

Insurance Carrier:			Policy Holder Name:			Policy Number:		
Date of Birth:			Effective Date:			Termination Date or Expected Termination Date:		
mm	dd	yyyy	mm	dd	yyyy	mm	dd	yyyy
						(If remaining active leave blank)		

What kind of coverage? ☐ Individual ☐ Group

Persons covered:

☐ Employee ☐ Spouse ☐ Domestic Partner ☐ Child 1 ☐ Child 2 ☐ Child 3 ☐ Additional Dependents**Additional Dental Coverage that will be in-force when this policy becomes active.**

Insurance Carrier:			Policy Holder Name:			Policy Number:		
Date of Birth:			Effective Date:			Termination Date or Expected Termination Date:		
mm	dd	yyyy	mm	dd	yyyy	mm	dd	yyyy
						(If remaining active leave blank)		

What kind of coverage? ☐ Individual ☐ Group

Persons covered:

☐ Employee ☐ Spouse ☐ Domestic Partner ☐ Child 1 ☐ Child 2 ☐ Child 3 ☐ Additional Dependents**I. Statement of Understanding / Legal Notices – Your Signature is Required**

I understand the benefits for which I (we) will be eligible are those described in the Blue Cross NC (including the benefit booklet) and changes provided for therein. I certify that all statements made herein and on all sections of this application are complete and true to the best of my knowledge. I understand that Blue Cross NC may, within two years of the date of this application, rescind my policy for any of my acts or practices that constitute fraud or if I make an intentional misrepresentation of material fact. If fraudulent misstatements were made, Blue Cross NC may take legal action at any time.

I understand that if I am applying for Blue Options HSA or an HSA eligible plan and my employer has established an HSA, the HSA will be provided to me directly by a separate administrator, unaffiliated with Blue Cross NC. Blue Cross NC is not responsible or liable for administration of the HSA.

I understand that if I am applying for a medical plan paired with an HRA and my employer has established an HRA, the HRA may be administered by Blue Cross NC separately from my health insurance plan, or by a separate administrator. Detailed information regarding my HSA/HRA will be provided by the designated administrator.

I also understand that due to bank regulations, if I provide a P.O. Box as my address I will receive a request for additional information regarding my mailing address. Failure to respond to requests for additional information will result in account closure and return of any funds posted to my account.

I understand that if my employer establishes an HSA/HRA, my employer or their designees will share certain personal information about me with these administrators to facilitate the administrator's establishment of the HSA/HRA account. By signing this application, I authorize my employer or their designees to share pertinent information with these selected administrators as applicable, which may include my name, address, social security number and my employer's name.

I understand that if issued a debit card in connection with my HSA/HRA, I agree that although Blue Cross NC's name and marks may be included on the face of the debit card for convenience, Blue Cross NC is not responsible or liable for administration of my debit card. The terms and conditions associated with my debit card are governed by my agreement with the bank issuing the card.

HSA Only:

If I am applying for Blue Options HSA or an HSA eligible plan, I understand that Blue Cross NC takes no responsibility for determining eligibility to contribute to an HSA and that I should consult a tax advisor if I have questions.

Employee Name:

By signing this application, I understand that I am authorizing the administrator to establish an HSA on my behalf, as of the date corresponding with the effective date of my Blue Cross NC plan with my employer. In order to activate the account, I will need to provide additional authorization through documents that will be provided to me by the fund administrator.

Notice of Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

For questions or to obtain more information, contact a Blue Cross NC Customer Service Representative at: **Blue Cross NC Customer Service, Blue Cross and Blue Shield of North Carolina, PO Box 2291, Durham, NC 27702, 1-877-258-3334** (toll-free).

By signing below, I agree to the above Statement of Understanding and have read all of the Legal Notices.

☐ Signature of Primary Applicant: **X**

mm	dd	yyyy
----	----	------

Date

J. Statement of Authorization for Release of Protected Health Information – Your Signature is Required

I understand that if I refuse to sign this authorization that Blue Cross NC may refuse to enroll me or determine that I am not eligible for benefits in Blue Cross NC.

I understand that my protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, or a health care clearinghouse and that relates to:

- (i) my past, present, or future physical or mental health or condition;
- (ii) the provision of health care to me; or
- (iii) the past, present, or future payment for the provision of health care to me.

I authorize any current or past medical professional, medical care institution, pharmacy benefit manager or other medical care giver that has treated me or provided medical services or supplies to me to disclose my protected health information to Blue Cross and Blue Shield of North Carolina ("Blue Cross NC").

I further authorize Blue Cross NC to review any applications for health care coverage that I may have submitted to Blue Cross NC in the past.

I authorize Blue Cross NC to receive, use and disclose as necessary my protected health information in connection with any underwriting or eligibility determination purposes in connection with the coverage for which I have applied.

The protected health information (excluding psychotherapy notes) that may be used and disclosed is as follows:

Medical records or any information concerning my current or past health status or treatment received from my medical care providers or previous applications for health care coverage.

I understand that Blue Cross NC will use my protected health information for the following purposes:

To determine my eligibility for enrollment and my premium rate.

I understand that Blue Cross NC will make every effort to safeguard my protected health information. I further understand that Blue Cross NC will not disclose my protected health information unless I request it or when state or federal privacy laws permit or require Blue Cross NC to disclose my protected health information. I understand that Blue Cross NC may disclose my protected health information to individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by the federal privacy regulations. I understand that if my protected health information is received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by the federal privacy regulations, my protected health information described above may be re-disclosed and no longer protected by federal privacy regulations.

Employee Name:

I understand that I may revoke this authorization at any time by sending a written notification addressed to:

**Commercial Operations / IDC
Blue Cross and Blue Shield of North Carolina
PO Box 2291
Durham, NC 27702-2291**

and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective:

- (i) for information that Blue Cross NC already used or disclosed, relying on this authorization or
- (ii) if the authorization was obtained as a condition of coverage in Blue Cross NC and, by law, Blue Cross NC has a right to contest the coverage.

This authorization expires 120 days from the date this authorization is signed by the applicable person listed below.

Signature of Primary Applicant
or Legal Personal Representative: **X**

mm	dd	yyyy
----	----	------

Date

Name of Legal Personal
Representative and Relationship
to Primary Applicant (please print):

mm	dd	yyyy
----	----	------

Date

A photographic copy of this authorization shall be as valid as the original.

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) provides free aids to service people with disabilities as well as free language services for people whose primary language is not English. Please contact the Customer Service number on the back of your ID card for assistance.

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) proporciona asistencia gratuita a las personas con discapacidades, así como servicios lingüísticos gratuitos para las personas cuyo idioma principal no es el inglés. Comuníquese con el número para servicio al cliente que aparece en el verso de su tarjeta del seguro para obtener ayuda.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English

ATTENTION: If you speak any of the following languages, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-888-206-4697 (TTY: 711) or speak to your provider.

Spanish / Español

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayudas y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-888-206-4697 (TTY: 711) o hable con su proveedor.

Chinese / 中文

注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-888-206-4697（文本电话：711）或咨询您的服务提供商。

Vietnamese / Việt

LƯU Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ được cấp miễn phí. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-888-206-4697 (Người khuyết tật: 711) hoặc trao đổi với nhà cung cấp dịch vụ của quý vị.

Korean / 한국어

알림: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-888-206-4697 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

French / Français

ATTENTION: Si vous parlez français, vous pouvez bénéficier de services d'assistance gratuits. Vous avez également à votre disposition des outils et services supplémentaires vous permettant de fournir des informations dans un format accessible, sans frais. Appelez le 1-888-206-4697 (TTY : 711) ou parlez à votre fournisseur.

Arabic / العربية

، تتوفر لك خدمات مساعدة لغوية مجانية. كما تتوفر مساعدة وخدمات إضافية مناسبة لتقديم تنبيه: إذا كنت تتحدث اللغة العربية المعلومات بتنسيقات يمكن الوصول إليها مجاناً. يُرجى الاتصال على الرقم 1-888-206-4697 (TTY: 711) أو تحدث مع مزود الخدمة الخاص بك

Hmong / Lus Hmoob

LUG CEEV TSHWJ XEEB: yog has tas koj has lug Hmoob muaj cov kev paab cuam txhais lug pub dlawb rua koj. Cov kev paab hab cov kev paab cuam ntxiv kws tsim nyog txhawm rua muab lug qha paub ua cov hom ntaub ntawv kws tuaj yeem nkaag cuag tau rua los kuj yeej tseem muaj paab dlawb tsis xaam tug nqe dlaab tsi tuab yaam nkaus. Hu rua 1-888-206-4697 (TTY: 711) los yog thaam nrug koj tug kws muab kev saib xyuas khu mob.

Russian / РУССКИЙ

ВНИМАНИЕ: Если Вы говорите на русском, то Вам доступны бесплатные услуги языковой поддержки. Соответствующие инструменты и информационные сервисы также предоставляются бесплатно. Позвоните по телефону 1-888-206-4697 (TTY: 711) или обратитесь к своему поставщику услуг.

Tagalog

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyon tulon sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulon at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-888-206-4697 (TTY: 711) o makipag-usap sa iyong provider.

Gujarati / ગુજરાતી

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હોવ તો, મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઓફિસલરી સહાય અને એક્સેસિબલ ફોર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-888-206-4697 (TTY: 711) પર કોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

Mon-Khmer, Cambodian / ភាសាខ្មែរ

កំណត់ចំណាំ: ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ សេវាកម្មជំនួយភាសាភាគតិចតម្លៃគឺមានផ្តល់ជូនសម្រាប់អ្នក។ ជំនួយ និងសេវាកម្មសមរម្យក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ដែលអាចចូលប្រើប្រាស់បានក៏មានផ្តល់ជូនដោយឥតគិតថ្លៃផងដែរ។ សូមទូរស័ព្ទទាក់ទង 1-888-206-4697 (TTY: 711) ឬនិយាយជាមួយផ្តល់សេវារបស់អ្នក។

German / Deutsch

WICHTIGER HINWEIS: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-888-206-4697 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

Hindi/ हिंदी

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएं भी निःशुल्क उपलब्ध हैं। 1-888-206-4697 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

Laotian / ລາວ

ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-888-206-4697 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

Japanese / 日本語

お知らせ: 日本語をお話しの場合、無料の言語支援サービスをご利用いただけます。アクセス可能な形式で情報を提供するための適切な補助的なサポートやサービスも無料でご利用いただけます。1-888-206-4697 (TTY: 711) にお電話いただくか、プロバイダーにお問い合わせください。