ROCKY MOUNTAIN HEALTH PLANS®
A UnitedHealthcare Company

1A

Individual Health Coverage Application

Please select <u>one plan</u> from the health plan options below.

Rocky Mountain Sky Offered to Residents in the following Counties: Eagle (80423, 80426, 80463, 81620, 81631, 81632, 81637, 81645, 81649, 81655, 81657, 81658), Grand, Lake, Summit	☐ HMO Gold 2500
	☐ HMO Silver HSA 4950 RX90 ☐ HMO Silver 5500
	☐ HMO Bronze HSA 6750 RX90 ☐ HMO Bronze HSA 7000/100 ☐ HMO Bronze 7200

REPLACEMENT OF COVERAGE INFORMATION

You normally do not require more than one of the same type of policy.
If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
You may be eligible for benefits under Medicaid or Medicare and may not need an accident and sickness policy. If you are eligible for Medicare, you may want to purchase a Medicare Supplemental policy.
If you are eligible for Medicare due to age or disability, counseling services are available in Colorado to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program.

REPLACEMENT COVERAGE QUESTIONS

To the best of your knowledge:	
Do you have another policy or contract in force?	☐ Yes ☐ No
If YES, with which company?_____	
If YES, do you intend to replace your current accident and sickness insurance with this contract?	☐ Yes ☐ No
If YES, for what reason are you purchasing this replacement policy? ☐ Additional Benefits ☐ No change in benefits, but lower premiums ☐ Fewer benefits and lower premiums ☐ Other (please specify) _____	
Do you have any other accident and sickness insurance that provides benefits similar to this accident and sickness policy?	☐ Yes ☐ No
If YES, with which company? _____ What kind of policy?_____	
Are you covered for medical assistance through the State Medicaid Program?	☐ Yes ☐ No
If YES, are you covered as a: ☐ Specified low income Medicare Beneficiary (SLMB)? ☐ Qualified Medicare Beneficiary (QMB)?	

To receive a personalized quote, get help completing your application, or for questions about our plans, please contact our Individual Sales Team at:
Phone: 800-453-2981, option 4 Email: individualsales@rmhp.org Fax: 970-244-7992

ROCKY MOUNTAIN HEALTH PLANS®
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6K

Individual Health Plan - Billing Form

Please print. Be sure to complete all information. Unanswered questions may result in a delay in processing.

Last Name:	First Name:	MI:	Social Security Number:
Member ID Number:	Date of Birth: / /	Business Phone: ( )	Home Phone: ( )
Address:	City:		State:
County:	Zip Code:	Effective Date of Change: / / *(if making a change to your current payment method)*	

1. Initial Payment:
☐ **Bank Draft** (complete Account Deduction authorization below) *First month premium only, unless you also choose this as your Ongoing Payment method.*

2. Ongoing Payment:
☐ **Monthly Bank Draft** (complete Account Deduction authorization below or set up recurring payments through your RMHP Member Portal)
☐ **Monthly Invoice** – RMHP will mail you a monthly invoice and bank draft will be cancelled.

Note: If this is your first payment, you must choose both an Initial and an Ongoing Payment method. If you are making a change to your current payment method, you only need to choose an Ongoing Payment method.

Account Deduction Authorization ☐ Checking ☐ Savings

Bank Name
Account Number
Routing Number

Authorization for Automatic Withdrawal

I hereby authorize Rocky Mountain Health Plans (RMHP) to initiate debit entries to the account indicated above, and I hereby authorize the depository (DEPOSITORY) named above to debit the same account.

RMHP has the authority to draft funds from my bank account. This authority will remain in effect until I change or cancel it in writing and will comply with all U.S. laws that apply. If I decide to terminate RMHP's authority to draft my premium, I understand I must send written notice to RMHP at least 10 days before the date of termination. Written notice can be an e-mail to billingreps@rmhp.org or mailed to RMHP, PO Box 10600, Grand Junction, CO 81502. I understand my monthly premium may be deducted from my designated payment account if 10 days prior notice is not given. RMHP is not responsible for bank fees that occur due to late notification. I understand this statement will become part of my policy if I am issued one.

Premiums are due on the 1st day of the month. Premiums received after the 1st shall be considered delinquent. Drafts on payer account will be made on approximately the 1st day of the month in which coverage will be in effect. RMHP's receipt of a nonpayment notice from the depository shall be considered a failure to pay premium, subject to delinquent status which could result in termination of coverage. Any changes to your account must be received in writing no later than the 20th day of the month prior to the change.

I, _____, authorize the monthly deduction of Rocky Mountain Health Plans premiums from my account
(Print Name)
for _____ (Subscriber Name, if Different)

Subscriber Signature: _____ Account Holder Signature: _____ Date: _____

Fax: 970-244-7769 **Email: billingreps@rmhp.org**

Colorado law requires carriers to make available a Colorado Health Benefit Plan Description Form, which is intended to facilitate comparison of health plans. The form must be provided automatically within seven (7) business days to a potential policyholder who has expressed interest in a particular plan or who has selected the plan as a finalist from which the ultimate selection will be made. The carrier also must provide the form, upon oral or written request, within seven (7) business days to any person who is interested in coverage under or who is covered by a health benefit plan of the carrier.

An access plan is available for each managed care network offered by Rocky Mountain Health Plans to any interested party upon request. Such access plans contain information on providers, hospitals, referral and grievance procedures, quality assurance, access for members with special needs, emergency coverage provisions, and other information on how to access services.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

ROCKY MOUNTAIN HEALTH PLANS®
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COLORADO UNIFORM INDIVIDUAL APPLICATION FOR MAJOR MEDICAL HEALTH BENEFIT PLANS

This form is designed for an individual's application for coverage. Please contact your carrier with questions regarding this form.

Federal financial assistance may be available for coverage purchased through Connect for Health Colorado. If purchasing coverage through Connect for Health Colorado, you will need to provide additional information for determination of eligibility for federal financial assistance. Further information may be found at www.connectforhealthco.com.

COVERAGE INFORMATION

Application Type: (check all that apply)	☐ New Coverage ☐ Change/Modification to Existing Coverage ☐ Open Enrollment ☐ Special Enrollment*				
Is the applicant purchasing this plan using a reimbursement arrangement (if applicable):	☐ Yes ☐ No	If so, what type:	☐ HRA	☐ ICHRA	☐ QSEHRA
Special Enrollment Period Qualifying event: ☐ Loss of Coverage ☐ Birth/Adoption/Placement for Adoption ☐ Marriage ☐ Other:_____ Date of Event:_____					
Requested Effective Date:	_____/_____/_____ (MM/DD/YYYY)				

* Proof of eligibility for special enrollment will be required – information available on the DOI website at: https://www.colorado.gov/pacific/dora/division-insurance

PRIMARY APPLICANT/INSURED INFORMATION

Instructions: Please type or print using black or blue ink. Please fill out the entire application for each person for whom coverage is being sought. If a person is currently enrolled in Medicare, this application should not be completed for that enrolled individual. If additional pages are needed to fully complete this application please attach, sign, and date each page.

First Name:		Middle Initial:		Last Name:	
SSN/TIN/ALT ID #: (Optional)		Date of Birth:	/ /	Current Age:	Gender: ☐ M ☐ F ☐ X

SSN is only necessary to determine eligibility for federal Advance Premium Tax Credit and Cost Sharing Reductions. Not filling out this field shall not be a reason to deny an application for coverage

Physical Address:				City:	
County:		State:		Zip:	
Mailing Address (If different, can be P.O. Box):				City:	
County:		State:		Zip:	
Home Phone:		Alternate Phone:		Email:	

Are you (check one): ☐ Single ☐ Married ☐ Common Law ☐ Civil Union ☐ Legally Separated ☐ Divorced ☐ Under 21

Are you or is anyone in your family American Indian or Alaskan Native? ☐ Yes ☐ No

This question is being asked as American Indians and Alaskan Natives have an enhanced ability to enroll in health benefit plans

ADDITIONAL APPLICANTS

Complete ONLY if your spouse/partner, and/or child(ren) under the age of 26 (older if medically disabled) are applying for coverage. If a dependent child is applying as an individual rather than as part of a family list the child as the primary applicant. If there is not enough space provided, please attach additional family information. Please sign and date the additional sheet. SSN is only necessary to determine eligibility for federal Advance Premium Tax Credit and Cost Sharing Reductions. Not filling out that field shall not be a reason to deny an application for coverage

Name First, MI, Last)	SSN/TIN/ALT ID #:	Gender	Relationship	Disability Y/N	Birth Date (MM/DD/YY)
		☐ M ☐ F ☐ X	SPOUSE/PARTNER	☐ Yes ☐ No	
		☐ M ☐ F ☐ X	☐ Child ☐ Dependent	☐ Yes ☐ No	
		☐ M ☐ F ☐ X	☐ Child ☐ Dependent	☐ Yes ☐ No	
		☐ M ☐ F ☐ X	☐ Child ☐ Dependent	☐ Yes ☐ No	
		☐ M ☐ F ☐ X	☐ Child ☐ Dependent	☐ Yes ☐ No	

Do(es) the child(ren) named within the application live with you at the same physical address shown above? ☐ Yes ☐ No (if no, complete below)

Child(ren)'s Name:		Mailing Address (If different):			
City:		County:		State:	Zip:
Home Phone:		Alternate Phone:		Email:	

Name of the Legal Guardian or Parent responsible for carrying health insurance for the child:							
If the primary applicant is under the age of 21 and different from above, provide the name and mailing address of the legal guardian or custodial parent:							
Legal Guardian or Custodial Parent's Name:		Mailing Address (If different):					
City:		County:		State:		Zip:	
Home Phone:		Alternate Phone:		Email:			

Please answer the following questions to the best of your knowledge. 45 CFR 147.102(a)(1)(iv) "For purposes of this section, tobacco use means use of tobacco on average four or more times per week within no longer than the past 6 months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco. Further, tobacco use must be defined in terms of when a tobacco product was last used."
Has anyone named in this application used tobacco or smokeless tobacco during the past 6 months? If yes, provide the information requested below.

Name of Person	Used Tobacco Products	
	☐ Yes	☐ No
	☐ Yes	☐ No
	☐ Yes	☐ No
	☐ Yes	☐ No

MEDICARE/MEDICAID INFORMATION

Is any applicant enrolled in Medicare?	☐ Yes	☐ No

Name of person covered by Medicare: _____.

For this applicant, please stop here, this insurance may duplicate existing Medicare coverage.

Is any applicant enrolled in Medicaid, CHIP+, or other governmental health program?	☐ Yes	☐ No

Name of person covered by Medicaid or other governmental health program: _____. For this applicant, please be aware that obtaining individual health insurance may affect which coverage is primary and/or applicant's eligibility for APTC.

CURRENT MEDICAL COVERAGE

Do you, your spouse/partner, or your dependent child(ren) listed in this application currently have health insurance? ☐ Yes ☐ No
(Dental Coverage in next Section)

Name	Carrier Name	Effective Date of Coverage (MM/DD/YY)	Termination Date of Coverage (MM/DD/YY)	Coverage Type

If any applicant has current health coverage, will that applicant cancel current coverage if this application is accepted? ☐ Yes ☐ No

Type of Coverage Key: G = Group Comprehensive Major Medical; I = Individual Comprehensive Major Medical; MS = Medicare Supplement; H = Hospital Coverage Only; V = Vision Coverage Only O=Other, please explain: _____

CERTIFICATION OF DENTAL INSURANCE COVERAGE (Certification of dental insurance coverage is not required when purchasing coverage through Connect for Health Colorado)	
Pediatric dental coverage is a required essential health benefit. The plan you select may not include pediatric dental coverage. Do you have pediatric dental coverage under another plan?	☐ Yes ☐ No Note: you may be required to provide proof that you have obtained coverage before this policy will be approved

TERMS AND CONDITIONS

I acknowledge that I have read all sections of this Application, and I certify on behalf of my eligible family dependents and myself that the answers contained in this Application are complete and accurate to the best of my knowledge.

I understand that my answers, together with any supplements or additional pages, are the basis for the certificate or policy that is issued. I agree that no insurance will be effective until the date specified by the carrier on the certificate or policy.

I understand that my signature constitutes an attestation that I have obtained the required pediatric dental coverage under a separate policy, and may be required to provide proof of this pediatric dental policy prior to this policy being issued and approved. (Certification of dental insurance coverage is not required when purchasing coverage through Connect for Health Colorado)

I understand that any intentional misrepresentation relied upon by the carrier may be used to deny a claim. I further understand that this contract can be voided if, within the first 24 months from the date of the policy or certificate, it is determined that I or a family member made an intentional misrepresentation in this application.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance carrier for the purpose of defrauding or attempting to defraud the carrier. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance carrier or agent of an insurance carrier who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

I understand that I may request a copy of this Application. I agree that a photographic copy of this Application shall be as valid as the original. A legible facsimile signature shall have the same force and effectiveness as the original. This document, or the information contained herein, will become a part of the contract when coverage is approved and issued.

I would like to receive all policy notices, premium notices, and other notices relating to this policy through the supplied email address above. ☐ Yes ☐ No

I understand I can change this designation at a later date by contacting my carrier directly, and understand it is my responsibility to notify my carrier of any changes to my email address.

Signature of Primary Applicant/Parent or Legal Guardian for Child-Only Plans	Date Signed:
Complete this section if someone assisted you in the completion of this Application	
The following person assisted me in completing the Application:	Please explain the assistant's relationship to you and your family:

AGENT/PRODUCER INFORMATION	
This section is to be completed by Agent or Producer.	
Agent / Agency of Record: (for commissions and correspondence)	Writing Agent / Producer:
Name (print):	Name (print):
Agent ID # (NPN):	Agent ID #(NPN):
Agent replacement questions: Will this policy replace any existing accident and sickness insurance policy(s)? ☐ Yes ☐ No	
As the Writing Agent/Producer, I acknowledge that I am responsible to personally interact with the primary applicant submitting this application in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the primary applicant in the benefits summary document or other plan literature.	
Writing Agent Signature	Date

DISCLOSURES

This document is a publication of the Colorado Division of Insurance. If you have questions about the content of this document please contact our offices at 303-894-7499 or visit our website at http://www.dora.colorado.gov/insurance. For questions regarding coverage or enrollment please see your carrier.

This section may be used to provide additional information that was required in the sections above and did not fit in the space provided.

Signature of Primary Applicant: _____ Date Signed: _____

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Affidavit of Employee's Permissible Employer Reimbursement through Wage Adjustment, HRA or QSEHRA

1. Will an employer of one hundred (100) or fewer eligible employees be paying for or reimbursing you through wage adjustment or a health reimbursement arrangement for any portion of the premium on the policy being applied for? _____Yes ____No **If you answered "yes", please continue. If you answered "no", you may stop.**

2. If the employer will be reimbursing an employee through a health reimbursement arrangement, does it qualify as a "qualified small employer health reimbursement arrangement" or QSEHRA*? ____Yes ____No

3. Did the employer have a small group health benefit plan providing coverage to any employee in the twelve (12) months prior to the date of this application? ____Yes ____No

If the answer to both questions 1 and 3 is "yes" and the answer to question 2 is "no", you may not be issued an individual policy with the premiums, or portion thereof, paid or reimbursed by the employer.

You will need to submit a signed affidavit from the employer, IF:

The answer to questions 1 and 2 is "yes" and the answer to question 3 is "no", or
The answer to question 1 is "yes" and the answer to questions 2 and 3 is "no".

The affidavit form to be executed by the employer is below. The submission of this affidavit does not guarantee that the individual policy you are applying for will be issued by the carrier.

Employers Name	
Employer's Address	
The undersigned officer or principal of the employer identified above certifies that: 1. The employer is a small employer as defined in § 10-16-102(61), C.R.S., with one hundred (100) or fewer eligible employees; 2. The employer has either not had in place a small group health benefit plan for the twelve (12) months prior to the execution of this affidavit or that is it using a qualified small employer health reimbursement arrangement (QDEHRA) to reimburse its employees' individual health insurance premiums.	
Signature	Date
Printed Name	Date
Position	Date

* Employers are required by federal law to provide employees written notice regarding QSEHRAs.

Individual Coverage Health Reimbursement Arrangement (ICHRA)

Will your employer be paying for or reimbursing you through an Individual Coverage Health Reimbursement Arrangement for any portion of the premium on this policy?	**YES**	**NO**

If yes, provide the Name of Employer , Employer Contact and Contact Information

Employer _____

Employer Contact Name _____

Contact Information Phone: E Mail Address

ROCKY MOUNTAIN HEALTH PLANS®
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Notice to Applicant Regarding Replacement of a Health Benefit Plan

UnitedHealthcare administered by Rocky Mountain Health Plans
2775 Crossroads Blvd, Grand Junction, CO 81506

According to your application, you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by Rocky Mountain Health Plans. Your new policy will provide zero days within which you may decide without cost whether you want to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find the purchase of this accident and sickness coverage is a wise decision you should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement to Applicant by Issuer or Producer:

I have reviewed your current accident and sickness insurance coverage. To the best of my knowledge, this accident and sickness policy will not duplicate your existing coverage because you intend to terminate your existing coverage. The replacement policy is being purchased for the following reason(s)(check one):

☐ **Additional benefits**

☐ **No change in benefits, but lower premiums**

☐ **Fewer benefits and lower premiums**

☐ **Other** (please specify) _____

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Signature of Producer or Other Representative* _____ Date

Applicant's Signature _____ Date

*Signature not required for direct response sales.

Notice and Consent of Electronic Submissions
Important information about completing your application on-line

Your application cannot be accepted unless you agree you have read and understand this information by signing below.

I confirm and agree that:

RMHP may use this electronic record of my application for:

- health care coverage from RMHP,
- providing me any and all legally required disclosures, and
- using my electronic signature to this application, on my own behalf and on behalf of all my dependents applying for healthcare coverage from RMHP.

RMHP may use the email address I give in this application to send me electronic notices and records about:

- this application;
- RMHP's decision to approve or reject this application, and
- other documents listed below.

If my application is accepted, and I have chosen to receive my RMHP health plan documents electronically, these will include:

- Evidence of Coverage;
- Summary of Benefits and Coverage (SBC);
- Member Handbook;
- Coverage Schedule;
- Benefit modification letters;
- Required annual notices;
- Other information about health care or my health plan; or
- News about RMHP.

I can ask RMHP, free of charge, for a hard copy of:

- a blank application,
- my completed application, or
- any of the documents listed above.

I may ask for these hard copies:

- By writing to
  RMHP Customer Service, 2775 Crossroad Blvd., Grand Junction, CO 81506
- By calling 800-346-4643
- In Person
- By email at customer_service@rmhp.org

More information to make such a request may be found at www.rmhp.org.

I may cancel my consent to receive electronic documents and notices from RMHP at any time, free of charge. I must send a written notice or email to the address above. The written cancellation will only be effective once RMHP receives it. After I give RMHP this written notice, no electronic communication to me, and no electronic communication from me to RMHP, will be effective.

Completing this electronic application and accessing my account information requires me to have access to the Internet and have a valid email account. Internet browsers supported are: • Internet Explorer, Firefox, Chrome, or Safari

To view my electronic documents and notices, I must have Adobe Reader version 5.0 or newer. By completing this electronic application, I confirm my system meets these minimum technical requirements. I have the ability to access, view and retain electronic records. I will also need a printer if I wish to print any copies of my application process. RMHP will give me notice in writing if

- these technical requirements change and,
- any changes may affect my access to my electronic records related to this application.

I authorize the plan selection in this application, accuracy of Replacement Coverage Information, and agree to notice and consent of electronic documentation.

Signature_____ Date_____

Notice of Nondiscrimination

Rocky Mountain Health Plans (RMHP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. RMHP does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

RMHP takes reasonable steps to ensure meaningful access and effective communication is provided timely and free of charge:

- Provides free auxiliary aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters (remote interpreting service or on-site appearance)
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, such as:
  - Qualified interpreters (remote or on-site)
  - Information written in other languages

If you need these services, contact the RMHP Member Concerns Coordinator at 800-346-4643, 970-243-7050, or TTY 970-248-5019, 800-704-6370, Relay 711; para asistencia en español llame al 800-346-4643.

If you believe that RMHP 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 with: the RMHP EEO Officer. You can file a grievance in person or by phone, mail, fax, or email.

- Phone: 800-346-4643, 970-244-7760, ext. 7883, or TTY 970-248-5019, 800-704-6370, Relay 711; para asistencia en español llame al 800-346-4643
- Mail: ATTN: EEO Officer, Rocky Mountain Health Plans, PO Box 10600, Grand Junction, CO 81502-5600
- Fax: ATTN: EEO Officer, 970-244-7909
- Email: eeoofficer@rmhp.org

If you need help filing a grievance, the RMHP EEO Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence 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*.

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Multi-Language Insert

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en la portada de esta guía.

請注意：如果您說中文(Chinese)，我們免費為您提供語言協助服務。請撥打本手冊封面所列的免付 費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Xin vui lòng gọi số điện thoại miễn phí dành cho hội viên trên trang bìa của tập sách này.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 이 책자 앞 페이지에 기재된 무료 회원 전화번호로 문의하십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ngtulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nakalista sa harapan ng booklet na ito.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русским (Russian). Позвоните по бесплатному номеру телефона, указанному на лицевой стороне данной брошюры.

تنبيه: إذا كنت تتحدث العربية ، فهناك خدمات مساعدة لغوية مجانية متاحة. اتصل بالرقم المجاني على غلاف هذا الدليل.

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo telefòn gratis pou manm yo ki sou kouvèti ti liv sa a.

ATTENTION : Si vous parlez français (French), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone sans frais pour les affiliés figurant au début de ce guide.

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny członkowski numer telefonu podany na okładce tej broszury.

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número do membro encontrado na frente deste folheto.

ATTENZIONE: in caso la lingua parlata sia l'italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero verde per i membri indicato all'inizio di questo libretto.

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer für Mitglieder auf der Vorderseite dieser Broschüre an.

注意事項：日本語(Japanese) を話される場合、無料の言語支援サービスをご利用いただけます。本冊子の表紙に記載されているメンバー用フリーダイヤルにお電話ください。

توجه: اگر به فارسی صحبت می کنید ، خدمات کمک به زبان رایگان در دسترس است. با شماره تلفن رایگان روی جلد این راهنما تماس بگیرید.

ध्यानदें:ल्यदि पहिंदी ल हैं,ल निःल ल्क ।। हाय । ।उपलब्धहैं। । कल्क रपर ल-लेनं रपरक लकरें।

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu tus tswv cuab xov tooj hu dawb teev nyob ntawm sab xub ntiag ntawm phau ntawv no.

ចំណាប់អារម្មណ៍:ចេះបើសិនអ្នកនិយាយភាសាខែឧរម្ង(Khmer)ដាចេសវាជំនួយភាសាចេដាយឥតគិតៃថ្លគឺមានសំរាប់អ្នកៗដា
សូមទូរស័ព្ទទៅចេលខសមាជិកឥតគេចែញថ្លជាឧកតាចេនៅខាងមុខនកូរនេសៀរេកាចេន:។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Pakitawagan iti miyembro toll-free nga number nga nakasurat iti sango ti libro.

DÍÍ BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí díí naaltsoos bidáahgi t'áá jiik'eh naaltsoos báha'dít'éhígíí béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka xubinta ee telefonka bilaashka ah ee ku qoran xagga hore ee buugyaraha.