☐ $1,500 Deductible
☐ $3,400 Deductible
☐ $4,500 Deductible
☐ $6,500Deductible

HSA Contribution: _____

Network: _____

☐ **Enrolling**
(Complete sections I, II, IV, and V.)
☐ **Waiving**
(Complete sections I and III.)
☐ **Information Changes**
(Complete sections I and II.)

For cancellations, use form F8708.

BlueCross BlueShield Minnesota

2025 Enrollment/Waiver Form

I Employee/Contractholder Information (Must be completed for both enrollees and waivers.)

Effective Date	Employer/Group Name		Group Number	Payroll Location/Dept. #

First Name	MI	Last Name	Occupation

Address

City	State	ZIP	County	Phone Number

Email address	Social Security Number (if no SSN, write N/A)*

Marital Status (Please check one.):	Enrollment Status
☐ Single/Widowed ☐ Married	☐ Employment Change From Part-Time to Full-Time ☐ Active Employee ☐ COBRA Continuant Start Date _____ / _____ /_____ ☐ Rehired Employee ☐ Special Enrollment Event _____Date___/___/___

Full-Time Hire (or Rehire) Date (mm/dd/yyyy)	Hours Worked per Week	Primary Care Clinic # (if applicable)
/ /		

Sex	Date of Birth (mm/dd/yyyy)	Age	Product Selection(s) (if your employer offers these coverage options):
☐ Male ☐ Female	/ /		☐ Medical Plan Number: _____ ☐ Dental Product Name: _____ ☐ Vision Product Name: _____

Ethnic Background**: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Choose not to answer

Race (Select one or more)**: ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Asian ☐ American Indian or Alaskan Native ☐ Other, please specify_____ ☐ Choose not to answer

Spoken Language** ☐ English ☐ Spanish ☐ Other, please specify_____ ☐ Choose not to answer

Written Language** ☐ English ☐ Spanish ☐ Braille ☐ Other, please specify_____ ☐ Choose not to answer

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

II Dependent Information (If enrolling more than four dependents, please attach a separate sheet.)

Spouse / Domestic Partner

First Name	MI	Last Name	Relationship to You
			☐ Spouse ☐ Domestic Partner

Social Security Number (if no SSN, write N/A)*	Sex	Date of Birth (mm/dd/yyyy)	Age
	☐ Male ☐ Female	/ /	

Product Selection(s): ☐ Medical ☐ Dental ☐ Vision	Primary Care Clinic # (if applicable)

Ethnic Background**: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Choose not to answer

Race (Select one or more)**: ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Asian ☐ American Indian or Alaskan Native ☐ Other, please specify_____ ☐ Choose not to answer

*Social Security numbers (SSN) for you and your dependents are requested but not required.

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

II Dependent Information (If enrolling more than four dependents, please attach a separate sheet.) **(continued)**

Dependent #1

First Name	MI	Last Name	Relationship to You ☐ Child ☐ Other

Social Security Number (if no SSN, write N/A)*	Sex ☐ Male ☐ Female	Date of Birth (mm/dd/yyyy) / /	Age

Product Selection(s): ☐ Medical ☐ Dental ☐ Vision	Dependent Status if Age 26 or Older: ☐ Disabled	Primary Care Clinic # (if applicable)

Ethnic Background**: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Choose not to answer

Race (Select one or more)**: ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Asian ☐ American Indian or Alaskan Native ☐ Other, please specify_____ ☐ Choose not to answer

Dependent #2

First Name	MI	Last Name	Relationship to You ☐ Child ☐ Other

Social Security Number (if no SSN, write N/A)*	Sex ☐ Male ☐ Female	Date of Birth (mm/dd/yyyy) / /	Age

Product Selection(s): ☐ Medical ☐ Dental ☐ Vision	Dependent Status if Age 26 or Older: ☐ Disabled	Primary Care Clinic # (if applicable)

Ethnic Background**: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Choose not to answer

Race (Select one or more)**: ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Asian ☐ American Indian or Alaskan Native ☐ Other, please specify_____ ☐ Choose not to answer

Dependent #3

First Name	MI	Last Name	Relationship to You ☐ Child ☐ Other

Social Security Number (if no SSN, write N/A)*	Sex ☐ Male ☐ Female	Date of Birth (mm/dd/yyyy) / /	Age

Product Selection(s): ☐ Medical ☐ Dental ☐ Vision	Dependent Status if Age 26 or Older: ☐ Disabled	Primary Care Clinic # (if applicable)

Ethnic Background**: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Choose not to answer

Race (Select one or more)**: ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Asian ☐ American Indian or Alaskan Native ☐ Other, please specify_____ ☐ Choose not to answer

Dependent #4

First Name	MI	Last Name	Relationship to You ☐ Child ☐ Other

Social Security Number (if no SSN, write N/A)*	Sex ☐ Male ☐ Female	Date of Birth (mm/dd/yyyy) / /	Age

Product Selection(s): ☐ Medical ☐ Dental ☐ Vision	Dependent Status if Age 26 or Older: ☐ Disabled	Primary Care Clinic # (if applicable)

Ethnic Background**: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Choose not to answer

Race (Select one or more)**: ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Asian ☐ American Indian or Alaskan Native ☐ Other, please specify_____ ☐ Choose not to answer

☐ **Additional family members on attached page**

*Social Security numbers (SSN) for you and your dependents are requested but not required.

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

Summary of Benefits and Coverage

A Summary of Benefits and Coverage (SBC) is available for medical plans only to assist you in understanding the details of the plan. A Uniform Glossary of insurance-related terms is also available. The SBC and the Uniform Glossary are accessible at bluecrossmn.com or available free of charge when requested by contacting your employer or your employer's agent or broker, or by calling customer service toll free at 1-800-382-2000.

III Waiver of Coverage (ONLY complete this section if you are declining coverage offered to you and/or your family members.)

Medical (if your employer offers this coverage)

I hereby decline medical coverage:	**Reason for declining medical coverage:**
☐ For myself	☐ Other spouse/domestic partner group medical coverage
☐ For family members ONLY	☐ Other parent group medical coverage
☐ For myself and ALL family members	☐ Individual coverage
☐ For the following family members:	☐ Group coverage continuation
_____	☐ No other health coverage
_____	☐ Medicare ☐ Medical Assistance
	☐ General Assistance Medical Care
	☐ TRICARE/VA ☐ Other: _____

Dental (if your employer offers this coverage)

I hereby decline dental coverage:	
☐ For myself	
☐ For family members ONLY	
☐ For myself and ALL family members	
☐ For the following family members:	
_____	
_____	

Vision (if your employer offers this coverage)

I hereby decline vision coverage:	
☐ For myself	
☐ For family members ONLY	
☐ For myself and ALL family members	
☐ For the following family members:	
_____	
_____	

I hereby acknowledge that I have been given the opportunity to participate in the group medical, dental, and/or vision plans provided by my employer. If I and/or any of my eligible dependents desire to apply for this coverage at a later date, I may be required to wait until my group's renewal or until a special enrollment event occurs before coverage will be offered.

Special Enrollment Rights:

If you are declining enrollment for yourself or your dependents (including your spouse), you may in the future be able to enroll yourself and your dependents in this plan, provided that you request enrollment within 31 days after you and your dependent's other coverage ends, or not later than 60 days if the other plan coverage was through Medicaid or a state Children's Health Insurance Program (CHIP). In addition, if you have a new eligible dependent as a result of birth, adoption or placement for adoption, or foster care or court order, you may be able to enroll yourself and your eligible dependents. (For dental and/or vision coverage **only**, you may also enroll an eligible dependent under age 3 anytime up to 30 days following the child's third birthday.) In order to avoid claim delays, you should request enrollment within 30 days after the birth, adoption or placement for adoption, or foster care or court order. Special enrollment may also be available as a result of a marriage, provided that you request enrollment within 30 days after the marriage.

_____ _____

Employee/Contractholder Signature - **Only sign here if you are waiving coverage** Date

IV Other Health (Medical) Insurance Coverage

Other Group or Non Group Health (Medical) Insurance Coverage

Name of Insurance Carrier	Group Number	Effective Date / /	Name of Policyholder

Policyholder Date of Birth / /	Relationship to Policyholder	Policy Number	Policyholder Employment Status ☐ Active ☐ Retired Date of Retirement: ___/___/_____

Medicare Coverage (Please list any family member who is eligible for Medicare benefits.)

Name of Subscriber or Dependent	Health (Medical) Insurance Claim Number	Effective Dates			Check (✓) Reason For Medicare Coverage			Medicare Supplement?
		Hospital (Part A)	Medical (Part B)	Prescription (Part D)	Age	Disability	End-Stage Renal Disease	
					☐	☐	☐	☐ Yes ☐ No
					☐	☐	☐	☐ Yes ☐ No
					☐	☐	☐	☐ Yes ☐ No

V Important: Authorized Signature Required

Read this section and sign and date the Application. Blue Cross and Blue Shield of Minnesota and Blue Plus hereinafter referred to as Blue Cross, will act in reliance on the information you provide on this Application.

For the purposes of the Application, I understand and agree that "employee" is defined as only those individuals subject to FICA and other tax withholding, and performing services for compensation for the employer listed in Section I of this Application.

In order to process this Application, Blue Cross may collect personal information regarding me or my family members listed on this Application. The information collected by Blue Cross or Blue Cross's authorized agents may in certain circumstances be disclosed to third parties without authorization. I have the right to see my personal records that are maintained by Blue Cross and to correct personal information Blue Cross has collected about me or my family members listed on this Application. Upon my request, Blue Cross will furnish a more detailed notice of Blue Cross information practices. Blue Cross keeps this information confidential, but may release it if I authorize release, or if state or federal law permits or requires release without authorization. For purposes of obtaining information in connection with this Application, reinstatement, or change in policy benefits, this release is valid as long as I am continually insured with the insurer. I am entitled to receive a copy of any release I sign.

I agree if I am enrolling in a product that features certain designated providers, Blue Cross may share my name, address and telephone numbers, as well as my past, current and future health and account records with such designated providers about services I've received from such designated providers and other care providers unrelated to such designated providers. These records may be used by the designated providers as needed to manage or coordinate my care and to improve the quality of that care.

Blue Cross primarily relies upon the information provided and full disclosure of the information listed on this Application in the decision whether to accept me and my family members listed on this Application for coverage. I acknowledge the importance of providing accurate and complete information. I acknowledge I must answer all required questions in the Application, even if I and/or my family members listed on this Application currently have coverage or had prior coverage with Blue Cross.

I understand and agree that payment of a claim does not preclude the right of Blue Cross to deny future claims or take any action it determines appropriate, including rescission of the contract and seeking repayment of claims already paid.

I understand that neither the medical plan nor the dental plan includes coverage for the pediatric dental essential health benefit and that Blue Cross has made me aware of pediatric dental coverage available for purchase. For additional information on available pediatric dental plans, please visit mnsure.org.

I agree to notify Blue Cross immediately of any change in my or my family members enrollment information between the date of this Application and the effective date of coverage.

Upon request, I agree to furnish any additional information needed concerning the eligibility of any family member applying for coverage.

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

V Important: Authorized Signature Required (continued)

I acknowledge that I am not applying for this coverage in connection with any offer from any ineligible third party to pay any premium or cost sharing related to this plan.

I understand that the health plan I have selected may contain a limited number of providers in the plan's network. The providers in the plan's network may change from time to time. Some providers will not be in network for my plan, these providers will be considered out of network. I also understand and acknowledge that with limited exceptions if I visit a provider or a location that is out of network, I will pay more for my care, and these costs will count towards any applicable out-of-network cost sharing (e.g., the out-of-network deductible and out-of-pocket [limitation/maximum]). Refer to the member benefit booklet for additional information.

I understand and agree that Blue Cross may share my past, current and future health and account records with my network providers about services I've received from my network providers and non network providers. These records may be used by my network providers as needed to manage or coordinate my care and to improve the quality of that care.

By providing my email address, I agree to receive communications and/or marketing materials related to the plan I selected and products offered by or made available from Blue Cross and its affiliates. I may unsubscribe or change my email address at any time by following the instructions included in each email communication.

By providing my phone number, I expressly consent to accept and receive communications and or marketing materials related to the plan I selected and products offered by or made available from Blue Cross and its affiliates, via text message or voice call to my mobile device and to the cellular/mobile telephone number(s) that I provided.

I have read the preceding instructions, statements and answers and represent them to be true and complete to the best of my knowledge and belief. I understand and agree Blue Cross will act in reliance upon the information I have provided on this Application and I also understand and agree Blue Cross may rescind the contract if Blue Cross determines that (1) I performed an act, practice, or omission that constitutes fraud, and/or (2) I made an intentional misrepresentation or omission of material fact.

WARNING: Email and text messaging transmission cannot be guaranteed to be secure or error-free as information could be intercepted, corrupted, lost, destroyed, arrive late or incomplete, or contain viruses. As the recipient of an email or text message from an unsecured email or device, Blue Cross does not accept liability for any errors or omissions in the contents of this message, which arise as a result of email or text message transmission.

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

_____	_____
Print Employee/Contractholder Name	Print Employer/Group Name
_____	_____
Employee/Contractholder Signature	Date

- Please contact your employer or your employer's producer for assistance.
- Call 1-800-382-2000 (toll free) to request this information in other languages and formats. For TTY, call 711. Hours: 8 a.m. to 6 p.m., Central Time, Monday through Friday.

Submission Instructions - Employees: Please return your completed form to your employer.
Employers: Completed employee forms should be returned to Blue Cross

- **New Group Business:** Please refer to your agent or benefits administrator.
- **Open Enrollment:** Employees and dependents who want the effective date of their coverage to be on the annual renewal date of the employer's plan (during the 30 day period before the annual renewal date) and
- **Ongoing Enrollment:** Adding new employees/contractholders/or dependents to an existing group.

Please submit on the employer portal or via fax: (651) 662-7258), email Enrollment.Forms@bluecrossmn.com, or mail to: Blue Cross and Blue Shield of Minnesota / P.O. Box 982806 / El Paso, TX 79998-2806

BlueCross BlueShield Minnesota

Notice of Nondiscrimination and Accessibility

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

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

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

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

Discrimination is against the law.

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

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

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

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

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

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

M09163 (8/24)

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

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

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

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

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

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

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

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

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

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

M09164 (8/24)
F10936R06 (03/24)

ကညီကျိာ် (Karen)
ဟ်သူဉ်ဟ်သး- နမ့ၢ်ကတိၤ ကညီကျိာ် နှဉ်,
နဃ့ကျိာ်ဂ့ၢ်ဝိတၢ်တိစၢၤမၤစၢၤလၢတလၫ်ဘူးလဲ သ့နှဉ်လီၤ.
နမ့ၢ်အိဉ်ဒီးတၢ်တလၢတပဲၤလၢ မဲာ်တၢ်ထံဉ်, တၢ်နၢ်ဟူ, မ့တမ့ၢ်
တၢ်စံးကတိၤတၢ်နှဉ် ပဆဲးကျၢဆဲးကျိုးတၢ်လၢ
ကျဲကဲထိဉ်လိာ်ထိဉ်အဂ့ၤကတၢ်လၢနဂီၢ်သ့နှဉ်လီၤ. တၢ်အံၤ
ပဉ်ဃုာ်ဒီး တၢ်စူးကါ နီၢ်ခိက့ၢ်ဂီၤကျိာ်အပှၤကျိာ်ထံတၢ်တဖဉ်,
တၢ်ဟ့ဉ်လံာ်လံၢ်တဖဉ်လၢ အလံာ်ဖျၢဉ်ဖးဒိဉ်, မ့တမ့ၢ်
ပှၤမဲာ်ဘျိဉ်အလံာ်, တၢ်ကလုၢ်, မ့တမ့ၢ် တၢ်မၤစၢၤဂုၤဂၤတဖဉ်
လၢတလၫ်အဘူးလဲနှဉ်လီၤ. ကိးလိတဲစိဆူ 1-855-903-2583
(TTY 711) တက့ၢ်.

မြန်မာဘာသာ (Burmese)
သတိပြုရန်- သင်သည် မြန်မာဘာသာ စကားကို ပြောပါက၊ အခမဲ့
ဘာသာစကား အကူအညီ ဝန်ဆောင်မှုများကို တောင်းဆိုနိုင်ပါသည်။
သင့်တွင် အမြင်အာရုံ၊ အကြားအာရုံ သို့မဟုတ် စကားပြောခြင်း
ချို့ယွင်းမှုရှိနေပါက သင့်အတွက် အသင့်လျော်ဆုံးဖြစ်မည့်နည်းလမ်းဖြင့်
ကျွန်ုပ်တို့ထံသို့ ဆက်သွယ်နိုင်ပါသည်။ ၎င်းတွင်
လက်ဟန်ပြဘာသာစကား စကားပြန်များကို အသုံးပြုခြင်း၊
စာရွက်စာတမ်းများကို ပုံနှိပ်စာလုံးကြီးများ သို့မဟုတ် မျက်မြင်စာဖြင့်
ပံ့ပိုးပေးခြင်း၊ အသံဖမ်းယူခြင်းများ သို့မဟုတ်
အခြားအထောက်အကူများဖြင့် အခမဲ့ပံ့ပိုးပေးခြင်းတို့ ပါဝင်ပါသည်။
1-855-903-2583 (TTY 711) သို့ ဖုန်းခေါ်ဆိုပါ။

OROMOO (Oromo)
Xiyyeeffannoon haa kennamuː- Oromo Afaan kan dubbatan yoo ta'e, tajaajiloota gargaarsa afaanii bilisaa gaafachuu ni dandeessu. Rakkoo ilaaluu, dhaga'u ykn dubbachuu yoo qabaattan, karaa isiniif mijatuun haala isiniif galuun mari'achuu ni dandeenya. Kunis of keessatti kan qabatu, hiiktota afaan mallattoo fayyadamuun maxxansa gurguddaa ykn bireeylii, waraabbiiwwan sagalee ykn gargaarsota biroo kaffaltii tokkoo malee gaafachuu dha. 1-855-903-2583 (TTY 711) irratti bilbilaa.

РУССКИЙ (Russian)
ВНИМАНИЕ: Если ваш язык — РУССКИЙ, вы можете запросить бесплатные услуги языковой поддержки. Если у вас есть нарушение зрения, слуха или речи, мы можем общаться таким образом, который лучше всего подходит вам. Это может включать бесплатное использование переводчиков на языке жестов, предоставление документов крупным шрифтом или шрифтом Брайля, использование аудиозаписей или других вспомогательных средств. Звоните по телефону 1-855-903-2583 (TTY 711).

ພາສາລາວ (Lao)
ຂ້ອໃຈໃສ່: ຖ້າທ່ານເວົ້າ ພາສາລາວ,
ທ່ານສາມາດຂໍບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໄດ້ໂດຍບໍ່ເສຍຄ່າ.
ຖ້າທ່ານມີຄວາມບົກພ່ອງດ້ານສາຍຕາ, ການໄດ້ຍິນ ຫຼື ການປາກເວົ້າ,
ພວກເຮົາສາມາດສື່ສານດ້ວຍວິທີທີ່ເໝາະສົມກັບທ່ານທີ່ສຸດ.
ອັນນີ້ອາດຈະລວມເຖິງການໃຊ້ນາຍພາສາມື,
ການຈັດກຽມເອກະສານເປັນໂຕພິມໃຫຍ່ ຫຼື ອັກສອນນູນ,
ການບັນທຶກສຽງ ຫຼື
ການຊ່ວຍເຫຼືອດ້ານສື່ອື່ນໆໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍໃດໆ. ໂທ
1-855-903-2583 (TTY 711).

Tagalog (Tagalog)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang humingi ng mga libreng serbisyo na tulong sa wika. Kung may kapansanan ka sa paningin, pandinig, o pananalita, maaari tayong mag-usap sa paraan na pinakamabuti para sa iyo. Maaaring kabilang dito ang paggamit ng mga interpreter ng sign language, pagbibigay ng mga dokumento na malalaki ang pagkaprinta o Braille, mga audio recording, o iba pang mga tulong nang walang bayad. Tumawag sa 1-855-903-2583 (TTY 711).

VIETNAMESE (Vietnamese)
LƯU Ý: Nếu quý vị nói Vietnamese, quý vị có thể yêu cầu dịch vụ hỗ trợ ngôn ngữ miễn phí. Nếu quý vị bị khiếm thị, khiếm thính hoặc khuyết tật về âm ngữ, chúng tôi có thể giao tiếp theo cách phù hợp nhất với quý vị. Điều này có thể bao gồm việc sử dụng thông dịch viên ngôn ngữ ký hiệu, cung cấp tài liệu dạng bản in cỡ chữ lớn hoặc chữ nổi, bản ghi âm hoặc các phương tiện hỗ trợ khác miễn phí. Xin gọi số 1-855-903-2583 (TTY 711).

简体中文 **(Chinese Simplified)**
注意：如果您说普通话，则可以免费申请语言协助服务。
如果您有视力、听力或语言障碍，我们可以用最适合您的方式与您交流。这可能包括免费提供手语翻译、大字体或盲文文件、录音或其 他辅助工具。 请致电 1-855-903-2583（文字电话 711）。

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