IQChoice® Individual Health Plans from QualChoice

QualChoice® HEALTH INSURANCE

2018 Application for Individual Coverage — POS

Before you begin, please read this information carefully:

This form is available online at *myIQChoice.com* as a writable PDF. You can fill it out, save it to your computer and print it. *For the latest version of Adobe Reader (the free software needed to read the PDF), visit adobe.com.*

- Please answer each question carefully. Type or print neatly. We cannot accept your application if information is missing.
- All applicants must be age 64 or younger, permanent, legal residents of Arkansas, and legal residents of the United States or U.S. citizens.
- POS plans include our *Select* network. To review the network, go to **QualChoice.com** and select *Provider Search*.
- To find your premium amount, you can get a quote or apply online at **myIQChoice.com** — or call an IQChoice sales representative at 866.645.1790, or your broker.
- You must let QualChoice know if you use tobacco, including what type, how much and how often.
- There is an annual Open Enrollment Period (OEP) for all individual plans (dates may vary). For a Special Enrollment Period (SEP), you must have a *qualifying event* (such as a birth, marriage, divorce or other). You must request coverage and provide proof of most *qualifying events* within 60 days of the event or within 90 days of a birth.
- Pediatric dental coverage is required under the Affordable Care Act and is available with our benefit plans. Please contact your broker, the Health Insurance Marketplace, or your dental insurance carrier if you wish to purchase a stand-alone dental product.
- Each applicant age 18 and over must sign and date this application. A digital signature may be used on a writable PDF.

For paper applications only:

- ✓ Use black or dark blue ink.
- ✓ If you make a mistake, mark through it and initial it. Then write in the correct information. Do not use correction fluid or correction tape.
- ✓ Your first month's premium payment must be included with your application.
- ✓ Sign and date any attachments containing additional information.

Policy Effective Date: Your effective date will be assigned in accordance with applicable law. Applications will not be regarded as received until they are complete. A complete application includes all required documents and the first month's premium.

■ Applying during an annual Open Enrollment Period

Policy is Effective on:
01/01/2018

■ Applying during a Special Enrollment Period with a qualifying event (see **Step 2**)

If application is received during a Special Enrollment Period	Policy Effective on:
on or before the 15th of the month	the first of the following month
after the 15th of the month	the first of the second following month

NOTE: Coverage for a newborn is effective on the date of the birth if we are notified within 90 days.

Premium Payment: We must receive your first month's premium payment with your application in order to process it. Please see **Step 10** for payment instructions**.**

Mail or fax your application, any required documents, and your first month's premium to:
QualChoice | ATTN: IQChoice | P.O. Box 26208 | Little Rock, AR 72221 | Fax: 866.645.1788

Step 1: Contact Person

One adult in your family between the ages of 18 and 64 must be the contact person for your application. All information is required.

Legal First Name	MI	Legal Last Name		
Email Address *(will receive important benefit messages)*		Main Phone No.		Other Phone No.
Home Address (No P.O. Box please)	City	State	Zip	County
Mailing Address (if different from home address)	City	State	Zip	County

Step 2: Eligibility

☐ I am applying during an Open Enrollment Period

☐ I am applying during a Special Enrollment Period.

If your application is not received during an Open Enrollment Period, you must send appropriate documentation confirming qualifying event/Special Enrollment Period (such as, copy of birth or death certificate, copy of marriage license, guardianship documentation etc.). This must be sent to us no more than 45 days before the event and no later than 60 days after the event (90 days for birth). Please check (✓) all boxes below that apply and provide date of *qualifying event.*

Qualifying Event	**Date of Qualifying Event**
☐ Birth	Date _____
☐ Adoption	Date _____
☐ Death	Date _____
☐ Divorce/Legal Separation	Date _____
☐ Marriage	Date _____
☐ New guardianship/legal custody/court order to add child	Date _____
☐ Loss of Minimum Essential Coverage	Date _____
☐ Non-Calendar Year Policy expires outside OEP *This is a one-time SEP used for those losing coverage due to expiration of a non-grandfathered policy*	Date _____
☐ New coverage becoming available as a result of a permanent move	Date _____
☐ Errors, misinterpretation, inaction by the Health Insurance Marketplace, HHS, or their agents	Date _____
☐ Qualified Health Plan contract violation in relation to an individual	Date _____
☐ Loss of eligibility for Advanced Premium Tax Credit (APTC)	Date _____

Step 3: Policy Effective Date

Requested Policy Effective Date: (MM/DD/YYYY) _____

■ Applying during an annual Open Enrollment Period

Policy is Effective on:
01/01/2018

■ Applying during a Special Enrollment Period with a qualifying event (see **Step 2**)

If application is received during a Special Enrollment Period	Policy Effective on:
on or before the 15th of the month	the first of the following month
after the 15th of the month	the first of the second following month

NOTE: Coverage for a newborn is effective on the date of the birth if we are notified within 90 days.

Step 4: Applicant(s) Information

Who is applying for health insurance? Check (✓) one box. ☐ Individual ☐ Individual & Spouse ☐ Individual & Children ☐ Family

Is the contact person listed in **Step 1** applying for coverage? ☐ Yes ☐ No

Please list below all who are applying for coverage. Tell us the relationship of each applicant, such as: self, spouse, son, daughter, stepson, or stepdaughter. **IMPORTANT:** All applicants (excluding minor children) **must live in Arkansas**. If you have permanent legal custody of a child, please attach appropriate court documents. Domestic partners are not eligible dependents**. If anyone applying is not a U.S. citizen, they must complete Step 5. If anyone applying uses tobacco products, they must complete Step 6**.

Legal First Name	MI	Legal Last Name	Relationship	Male (M) or Female (F)	Birth Date (MM/DD/YYYY)	Social Security Number	Tobacco Use
1							☐ Yes ☐ No
2							☐ Yes ☐ No
3							☐ Yes ☐ No
4							☐ Yes ☐ No
5							☐ Yes ☐ No
6							☐ Yes ☐ No

Step 5: U.S. Citizenship Status

Are all applicants listed in **Step 4** U.S. citizens? ☐ Yes ☐ No If **NO**, complete the information below.

Legal First Name	MI	Legal Last Name	Immigration Document Type	Immigration Document ID No.
1				
2				
3				
4				
5				
6				

Step 6: Tobacco Use

Has any applicant(s) listed in **Step 4** used a tobacco product (other than for religious or ceremonial use) on an average of 4 or more times per week in the last 6 months? ☐ Yes ☐ No If **YES**, complete the information below.

Legal First Name	MI	Legal Last Name	Date Last Used	Type Used	Amount Used Per Week *Example: 6 packs of cigarettes per week*
1					
2					
3					
4					
5					
6					

Step 7: Email Address

Enter email address of each applicant age 18 and over to receive messages about their benefits.

Legal First Name	MI	Legal Last Name	Email Address
1			
2			
3			
4			
5			
6			

Step 8: Select Your Benefit Plan

For information about the available benefit plans and rates, go to **myIQChoice.com** or call an IQChoice sales representative at 866.465.1790, or your broker. **NOTE:** POS plans include our *Select* network. Pediatric dental coverage is required by the Affordable Care Act. If you already have a qualified pediatric dental plan, you may choose a plan without it.

Pediatric Dental *Please check (✓) one.*	**Benefit Plan** *Please check (✓) one.*
I am requesting a benefit plan: ☐ With pediatric dental ☐ Without pediatric dental	☐ Bronze Classic Saver 5000 — HSA-qualified high deductible health plan ☐ Silver Classic 6500 ☐ Silver Classic Saver 3500 — HSA-qualified high deductible health plan ☐ Silver Classic Saver 4000 — HSA-qualified high deductible health plan ☐ Gold Classic 2000 ☐ Catastrophic *All individuals electing Catastrophic coverage must be under age 30 or qualify for a hardship exemption. Visit www.HealthCare.gov to learn more about hardship exemptions. Applicants reaching age 30 during the plan year will stay enrolled for the rest of the year.*

Step 9: Primary Care Physician (PCP)

Your plan requires you to use a Primary Care Physician (PCP) who is in the *Select* network. To find a PCP and Provider ID, use *Provider Search* at *QualChoice.com*. Search within the *Select* network. You may also call 501.228.7111 or toll free 800.235.7111. You must use your PCP to direct your care, including referrals to specialists. *If you do not have a PCP, you will be assigned one.*

First Name	MI	Last Name	Relationship to Subscriber	PCP Name/Provider ID
1			☐ Self ☐ Spouse ☐ Dependent	Name: ID #:
2			☐ Self ☐ Spouse ☐ Dependent	Name: ID #:
3			☐ Self ☐ Spouse ☐ Dependent	Name: ID #:
4			☐ Self ☐ Spouse ☐ Dependent	Name: ID #:
5			☐ Self ☐ Spouse ☐ Dependent	Name: ID #:
6			☐ Self ☐ Spouse ☐ Dependent	Name: ID #:

Step 10: Premium Payment

Payment for first month's premium must be included with this application.

To find your premium payment amount:
- Get a quote or apply online at *myiqchoice.com*
- Call us at **866.645.1790**
- Call your broker/agent

- **First Month's Premium**

  Amount of first month's premium: $_____

  Choose your first month's payment method below.

  Charge my first month's premium to my: ☐ Visa ☐ MasterCard ☐ Discover

  Card No. _____ Expiration Date _____/_____ Sec. Code (3 digit no. on back of card) _____

  ☐ Check enclosed
  ☐ Cashier's check enclosed
  ☐ Bank draft (must complete *Bank Draft Payment Authorization* below)
  ☐ Cash (*visit the QualChoice office at 12615 Chenal Parkway, Little Rock, AR, Monday through Friday, between 8:00 a.m. and 5:00 p.m.*)

- **Future Premium Payments** Please check (✓) your future payment method below. All future monthly payments are due on the first day of each month's coverage period. If the 'bank draft' method of payment is checked, you must complete the *Bank Draft Payment Authorization* below.

  Choose your future payment method: *(Your application cannot be processed without this information.)*

Monthly Billing *Due first day of each month*	**Quarterly Billing** *Due first day of coverage period*	**Annual Billing** *Due first day of coverage period*
☐ Bank Draft	☐ Bank Draft ☐ Check ☐ Cash	☐ Bank Draft ☐ Check ☐ Cash

ONLINE BILL PAYMENT: You can also pay your premiums quickly, accurately and securely from your bank account. Go to *QualChoice.com,* select Online Bill Payment.

Bank Draft Payment Authorization

1. I authorize QualChoice and the Bank/Financial institution indicated below to debit my health insurance premium from the account listed.
2. This authorization is to remain in full force and effect until my Bank has received written notification from me of the Bank Draft termination. This notice must be received in such time and such manner as to afford the Bank a reasonable opportunity to act on it, or until the Bank has sent me ten (10) days' written notice of the Bank's termination of this agreement.
3. I understand that by revoking the Bank Draft after I have agreed to it, I will also be terminating my insurance coverage, unless QualChoice has received written notice from me of my desire to continue coverage at least **twenty (20) days** prior to the Bank Draft withdrawal date.
4. I understand that if my bank rejects a bank draft due to insufficient funds in my account, QualChoice may charge me a fee of up to $20.00.

☐ I understand and agree that my **first month's premium** will be drafted upon initial acceptance of coverage.
☐ I understand and agree that **future monthly premiums** will be drafted on the 1st day of each month for Monthly Bank Draft, or on 1st day of coverage period for Quarterly or Annual billing.

Name of Bank or Financial Institution	**Account Type (check one)** ☐ Checking ☐ Savings		
9 Digit Bank Routing Number	**Bank Account Number**		
Account Holder Name			
Address	**City**	**State**	**Zip**

By signing this *Bank Draft Payment Authorization*, I agree to all terms and conditions expressed in the payment method I have chosen above. I understand that if I do not follow what has been authorized on this form, QualChoice may cancel my policy.

Signature of Account Holder **X**	**Date Signed** (MM/DD/YYYY)

DISCLOSURES: All applicants must read.

I agree to and understand the following:

1. The insurance I am applying for will not become effective until my application has been approved and I have paid the first month's premium.
2. If an agent/broker has worked with me on this application, he/she may receive compensation (payment) from QualChoice. Any such compensation is included in my insurance premium. (To learn more about any compensation involved, please contact your agent/broker.)
3. If I am not truthful in my answers on this application, QualChoice may, in some cases, cancel my coverage as of the original starting date and I may not reapply for this coverage.
4. If I give false information about tobacco use, QualChoice can change my premium to what it should have been when the policy began.
5. **For Catastrophic plans only**: If any applicant reaches age 30 during the plan year, all will stay enrolled for the remainder of the year and coverage for the applicant who reached age 30 will end at that time.
6. My signature lets QualChoice coordinate my benefits with other insurance I may have.
7. My signature authorizes QualChoice to release to my broker/agent necessary information about myself and any family members listed on this application. This includes information related to substance use or abuse, but not psychotherapy notes, as defined in Department of Health and Human Services HIPAA regulation 45 CFR §164.501. I understand that I may cancel this authorization by sending a written notice to QualChoice, Attn: IQChoice, P.O. Box 26208, Little Rock, AR 72221.
8. QualChoice may call or email me for more information, if needed.

Authorized Signatures: *In signing below, I agree that:*

1. My statements and answers in this application and any signed and dated attachments are true, complete and correct.
2. I must let QualChoice know in writing of any changes to the information on my application before the policy effective date.
3. I signed this application in the State of Arkansas. All applicants listed (excluding minor children) are permanent, legal residents of Arkansas.

Each applicant, who is 18 years of age or older, must sign and date below. Please sign correct line only.

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 fines and confinement in prison.			
Signature of:	**Legal Full Name**	**Signature**	**Date Signed** (MM/DD/YYYY)
Person listed in Step 1 **or** parent/legal guardian *(if applying)*		**X**	
Spouse *(if applying)*		**X**	
Adult *(only if 18 or over and applying)*		**X**	
Adult *(only if 18 or over and applying)*		**X**	
Adult *(only if 18 or over and applying)*		**X**	
Adult *(only if 18 or over and applying)*		**X**	

This section to be completed by Broker/Agent

Broker/Agent Name (Please print)			Phone No.
Agency Federal Tax ID No. *(if applicable)*	Broker Agency Name	Broker/Agent E-mail	
Broker/Agent Signature **X**		Date Signed (MM/DD/YYYY)	National Producer No. (NPN)

IMPORTANT

Privacy Disclosure

We use and disclose *protected health information* (PHI) in a number of different ways in connection with health care operations, the payment for health care, and treatment. The following are only a few examples of the types of uses and disclosures of PHI that we are permitted to make **without individual authorization**.

A. Payment: We will use and disclose PHI to administer health benefits policy or contract, which may involve the determination of eligibility; claims payment; utilization review and care management; medical necessity review; coordination of care, benefits and other services; and responding to complaints, appeals and external review requests. Likewise, we may also share PHI with another entity to assist with subrogation of health claims or to another health plan to coordinate benefit payments. In some instances, we may also use and disclose PHI for purposes of premium billing, underwriting, and the determination of premium rates and co-payments, deductibles, coinsurance and other cost sharing amounts.

B. Treatment**:** We may disclose PHI to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers) who request it in connection with treatment. We may also disclose PHI to health care providers in connection with preventive health, early detection and care management programs, in plans that offer these programs.

C. Health Care Operations: We will use and disclose your Protected Health Information to support other business activities, including the following:

1. Quality assessment and improvement activities: peer review and credentialing of Network Providers and accreditation by independent organizations such as the National Committee for Quality Assurance and URAC;
2. Performance measurement and outcomes assessment, health claims analysis and health services research;
3. Operation of preventive health, early detection, care management, and coordination of care programs in plans that offer these programs, including information about treatment alternatives, therapies, health care providers, settings of care or other health-related benefits and services;
4. Medical care review;
5. Underwriting, premium determination and administration of reinsurance;
6. Risk management, auditing, legal services and detection and investigation of fraud and other unlawful conduct;
7. Transfer of eligibility and plan information to business associates (for example: pharmacists, mental health management companies) for the management of mental health benefits, and other programs as necessary to administer your benefit plan.
8. Other general administrative activities, including data and information systems management and customer service.

Individual Right of Access and Additional Information

QualChoice maintains strict adherence to the protection and confidentiality of PHI. Additional information within QualChoice may be directed to the Privacy Official, Security Official or the Corporate Responsibility Officer. In addition, any individual may request and receive a copy, including an electronic copy of his/her PHI on file with QualChoice. Please submit inquiries or requests to:

QualChoice Privacy Officer
11045 E. Lansing Circle
Englewood, CO 80112
P: 720.874.1261

Individual questions or concerns may also be addressed by the:

- Department of Health & Human Services
  www.hhs.gov/ocr/privacy/hipaa/complaints/

- Office for Civil Rights (OCR) — Will need to file a Health Information Privacy Complaint

Non-Discrimination and Accessibility Notice

QualChoice complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. QualChoice does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

QualChoice:

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

If you need these services, contact Customer Service at (501) 228-7111. If you believe that QualChoice has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

QualChoice Civil Rights Coordinator
QualChoice
P.O. Box 25610
Little Rock, AR 72221-5610
(501) 228-7111
Fax #: 501-707-6729
QCA_COE@qualchoice.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the QualChoice Civil Rights Coordinator 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, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Notice of Discrimination Grievance Procedures

It is the policy of QualChoice not to discriminate on the basis of race, color, national origin, sex, age or disability. QualChoice has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. 18116) and its implementing regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of the QualChoice Civil Rights Coordinator, who has been designated to coordinate the efforts of QualChoice to comply with Section 1557 (the "Section 1557 Coordinator"):

QualChoice Civil Rights Coordinator
QualChoice
P.O. Box 25610
Little Rock, AR 72221-5610
(501) 228-7111
Fax #: 501-707-6729
QCA_COE@qualchoice.com

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for QualChoice to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the Section 1557 Coordinator within sixty (60) days of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 1557 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 1557 Coordinator will maintain the files and records of QualChoice relating to such grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.
- The Section 1557 Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than thirty (30) days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.
- The person filing the grievance may appeal the decision of the Section 1557 Coordinator by writing to the Vice President Corporate Responsibility within fifteen (15) days of receiving the Section 1557 Coordinator's decision. The Vice President Corporate Responsibility shall issue a written decision in response to the appeal no later than thirty (30) days after its filing.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is 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.

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html. Such complaints must be filed within 180 days of the date of the alleged discrimination. QualChoice will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator will be responsible for such arrangements.

QualChoice offers help for members with limited English proficiency (LEP). The following statement is printed in the top languages used in Arkansas, as required by the Federal government:

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-800-235-7111 (TTY: 711).

Spanish
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-235-7111 (TTY: 711).

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-235-7111 (TTY: 711).

Marshallese
LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk 1-800-235-7111 (TTY: 711).

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-235-7111 (TTY: 711).

Lao
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-235-7111 (TTY: 711).

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-235-7111 (TTY: 711).

Arabic
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-235-7111 (رقمهاتف الصم والبكم: 711).

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-235-7111 (TTY: 711).

French
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-235-7111 (ATS: 711).

Hmong
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-235-7111 (TTY: 711).

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-235-7111 (TTY: 711) 번으로 전화해 주십시오.

Portuguese
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-235-7111 (TTY: 711).

Japanese
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-235-7111 (TTY: 711)s まで、お電話にてご連絡ください。

Hindi
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-235-7111 (TTY: 711) पर कॉल करें।

Gujarati
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-235-7111 (TTY: 711).