

# Oregon Large Employer Group Application (51+) Cover Page



**Thank you for choosing Moda Health and Delta Dental.**

Please forward the completed copy to:  
**ModaGroupSales@modahealth.com**

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## New Group Enrollment Checklist for Employers and Agents

*Please note, if any of the below items are not completed in full, enrollment will be delayed*

Is this an existing Moda Health or Delta Dental group with an active line of coverage? ☐ Yes ☐ No

☐ Group Application (completed and signed by the group and agent)

Does the group have COBRA eligible lines of coverage other than Moda Health (medical coverage)? ☐ Yes ☐ No

☐ Quote sheet for selected plans

☐ Enrollment forms have been reviewed for the following:

- ☐ Enrollment forms/Waiver forms provided for all eligible employees
- ☐ Please include hire dates on all enrollment forms/green enrollment spreadsheet
- ☐ Enrollment forms match census information
- ☐ Moda Select plans are only available to employees living in the Portland metro area (Clackamas, Multnomah and Washington counties). Enrollment forms have been reviewed to verify zip codes (if choosing a Moda Select plan).

☐ First Month's Premium (paid electronically)

☐ Electronic Services Agreement

☐ Late Acknowledgement Agreement (if enrolling past the 10th of the month)

All new group enrollment materials must be received by  
Moda Health and Delta Dental ***no later than the 10th of the month***  
for a first of the following month's effective date.

Health plans provided by Moda Health Plan, Inc. Dental plans in Oregon provided by Oregon Dental Service, dba  
Delta Dental Plan of Oregon. Dental plans in Alaska provided by Delta Dental of Alaska.  
Delta Dental is a trademark of Delta Dental Plans Association.

# Oregon Large Employer Group Application (51+)



Effective date: \_\_\_\_\_

Group information			
Legal name		Tax ID #	
DBA name (appears on bills):		NAICS:	
Physical address (no P.O. box)	City	State	ZIP
Group administrator			
Group administrator phone #			
Group administrator email address			
Renewal date:	Advance renewal notice (days) <input type="checkbox"/> 90 days <input type="checkbox"/> 120 days <input type="checkbox"/> 150 days <input type="checkbox"/> 180 days <input type="checkbox"/> 210 days <input type="checkbox"/> 240 days		
Is the group subject to ERISA (Employee Retirement Income Security Act of 1976)? Note: In general, ERISA does not cover group health plans established or maintained by governmental entities, churches for their employees, or plans which are maintained solely to comply with applicable workers compensation, unemployment or disability laws.			<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Form of organization (check all that apply):</b>			
<input type="checkbox"/> Association      Filed date: _____      Approval # _____			
<input type="checkbox"/> Trust      Filed date: _____      Approval # _____			
<input type="checkbox"/> Bargaining agreement (union)			
Effective date: _____			
Expiration date: _____			
<input type="checkbox"/> Corporation <input type="checkbox"/> LLC <input type="checkbox"/> Non-profit <input type="checkbox"/> Partnership <input type="checkbox"/> S Corporation <input type="checkbox"/> Sole proprietor <input type="checkbox"/> Government entity			
<b>What percentage of the medical premium is to be contributed by the employer? If choosing multiple plans, the minimum contribution is 50% of the plan with the lowest premium.</b>			
For employees (minimum 50%): _____ For dependents: _____			
<b>What percentage of the dental premium is to be contributed by the employer?</b>			
For employees (minimum 50%): _____ For dependents: _____			

Existing coverage
Please provide the name for the current insurance carrier(s), both medical and dental:
Medical: _____ Dental: _____
If this plan is replacing an existing plan, will members receive credit from the previous plan? <input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, check the type(s) of report(s) below that will be available for applying credit:
<input type="checkbox"/> Medical deductible <input type="checkbox"/> Dental deductible <input type="checkbox"/> Other: _____

# Group Structure Worksheet

Subgroup setup			
<p>Our standard subgroup setup designates if subscribers are "Active" or have elected "COBRA". Subgroups can be used to categorize your membership by a different billing location or entity. Custom subgroups will create billing statements, separate your members on your invoice and impact reporting (if applicable) for each subgroup defined.</p> <p>If you require additional explanation or assistance with subgroup setup, please speak with your sales representative.</p>			
Subgroup name	Subgroup billing contact name (if different than group administrator)	Subgroup billing address (if different than physical address)	
Active	Name:	Address:	
	Phone number:	City:	
	Email:	State:	Zip:
COBRA	Name:	Address:	
	Phone number:	City:	
	Email:	State:	Zip:
	Name:	Address:	
	Phone number:	City:	
	Email:	State:	Zip:
	Name:	Address:	
	Phone number:	City:	
	Email:	State:	Zip:
<p>Registered domestic partners are eligible dependents. Is domestic partnership coverage also available by declaration?</p> <p>If yes, do you cover:</p> <p> <input type="checkbox"/> Same gender/sex             <input type="checkbox"/> Opposite gender/sex             <input type="checkbox"/> Regardless of gender/sex         </p>			<input type="checkbox"/> Yes <input type="checkbox"/> No

## Class setup

Our standard setup groups all employees into a single class. If a medical group has out of state employees, we will create an additional class to make it easier to identify the correct plan and network combination.

Classes allow you to define the benefits available to a subset of membership. If all of your employees must work the same hours, meet the same probationary period and will have the same benefits available to them, our standard setup should work.

If you require additional explanation or assistance with class setup, please speak with your sales representative.

### Service area for medical groups

Will employees who reside outside of Oregon and Southwest Washington (Clark and Cowlitz counties) be covered by a Moda Health medical plan?

☐ Yes ☐ No

If yes, list state(s): \_\_\_\_\_

**Note:** Employees who reside in the state of Hawaii are not eligible to enroll for medical coverage.

How many hours per week must an employee work to be eligible for benefits? (minimum 17.5): \_\_\_\_\_

Will the minimum hours apply to all eligible employees? ☐ Yes ☐ No

If no, please describe: \_\_\_\_\_

What is the waiting period an employee must complete before becoming eligible for benefits?

☐ Date of hire, no waiting period

OR

1st of the month following:

☐ Date of hire

☐ Date of hire, plus one month orientation period

☐ Date of hire or date of hire when 1st of the month

☐ Date of hire or date of hire when 1st of the month, plus one month orientation period

☐ 30 days

☐ 30 days, plus one month orientation period

☐ 60 days

☐ 60 days, plus one month orientation period

☐ 90 days (dental only)

☐ 90 days, plus one month orientation period (dental only)

☐ Other, please describe \_\_\_\_\_

Will the eligibility period apply to all eligible employees? ☐ Yes ☐ No

If no, please describe: \_\_\_\_\_

For employer's initial enrollment only, will the waiting period be waived for all current eligible employees?

☐ Yes ☐ No

If a part-time employee becomes eligible for coverage, does part-time employment count towards the waiting period for full-time employees?

☐ Yes ☐ No

Will all plans be available to all employees? ☐ Yes ☐ No

If no, please describe: \_\_\_\_\_

Will the Medical and Dental plan be integrated (bundled)? ☐ Yes ☐ No

If yes, indicate which lines are integrated:

☐ Medical, Dental, Vision ☐ Medical, Dental

## COBRA

Moda Health's subsidiary, BenefitHelp Solutions (BHS), provides COBRA administration for Moda Health Medical Groups between 51 – 99 employees at no additional cost.

Fees will apply for employers with 100+ eligible employees and/or when BHS provides administration for product lines outside of Moda Health and Delta Dental.

If a group has COBRA eligible plans outside of Moda, please contact BHS for COBRA administration fees:

BHS-S&Steam@benefithelp solutions.com

Does the group use a third-party administrator (TPA) for COBRA or Retiree Administration?

☐ Yes. Please provide the following:

TPA Name

Address

Phone

☐ No. Please answer the following:

Will the employer elect COBRA administration through BHS? ☐ Yes ☐ No

Who will be paying the COBRA premiums? ☐ Employer ☐ TPA – Do not print bill ☐ TPA – Print bill

# Payment Information

## Premium payment method

☐ ACH pull (complete EFT information) ☐ ACH push (payment will be set up through eBill)

Effective date	Date of transfer <input type="checkbox"/> 25th (prior month for future month's premium) <input type="checkbox"/> 1st
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## Instructions for EFT payments

- 1. Provide your banking information
- 2. If you have ACH security in place, please add company ID 3930989307 to your ACH filter list
- 3. For a checking account, please attach a VOIDED check
- 4. For a savings account, attach a deposit slip

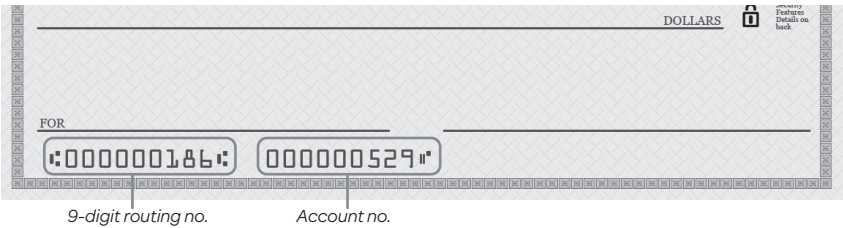
Effective date	Date of transfer <input type="checkbox"/> 25th (prior month for future month's premium) <input type="checkbox"/> 1st
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## Transaction type

☐ Binder and reoccurring payments ☐ Reoccurring payments only ☐ Binder payment only

I (we) hereby authorize Moda Health hereinafter called COMPANY, to initiate debit entries to my (our) Checking account indicated below and the depository named below, hereinafter called DEPOSITORY, to debit the same to such account.

Depository name	Branch	
City	State	ZIP
Bank routing no.	Account no.	



## Agent / Group Signature Page

Agent information	
Agent name	Agency
NPN:	Tax ID# ( For tax purposes, please indicate if tax ID or S/S #): <input type="checkbox"/> Tax ID <input type="checkbox"/> S/S #
<p>I hereby make application to Moda Health/Delta Dental, on behalf of the Group, for the Group Policies indicated in this group application.</p> <p>I understand that there is no coverage in effect until Moda Health/Delta Dental accepts this Application and premium deposit and establishes an effective date. If this Application is not accepted, the premium deposit will be refunded.</p> <p>I hereby certify all eligible employees are enrolling in the selected Group Policies and all enrolling employees meet the eligibility requirements specified above. In addition, I hereby appoint the above agent as our Agent of Record to represent us in matters of group insurance benefits provided by Moda Health/Delta Dental. This appointment is in effect on the same day as this Policy and will remain in force until rescinded in writing.</p> <p>Applicable for medical policies only: I hereby acknowledge responsibility on behalf of the Group to provide the Summary of Benefits &amp; Coverage (SBC), Uniform Glossary, and the Initial Notice of HIPAA Special Enrollment Rights and Exclusion Periods to all employees on or before the date they enroll in the selected Group Policies.</p>	

Authorization	
<b>By signing below, I agree that the signature will be the electronic representation of my signature and initials for all purposes when I (or my agent) uses them on documents, including legally binding contracts.</b>	
Authorized signature for GROUP X	Authorized signer's title
Authorized signer's printed Name X	Date
Authorized AGENT signature X	
Authorized agent's printed name X	Date
Marketing representative signature X	Date

# Electronic Services Agreement

This Electronic Services Agreement (“Agreement”) states the terms and conditions that govern the use of online services by \_\_\_\_\_ (“Employer”) through Employer’s online account (the “Account”).

## 1. Employer Dashboard

Employer Dashboard includes the following (individually and collectively, the “Services”):

**A. Online Services.** Online Services include any or all of the following services dependent upon eligibility criteria: review of employee and dependent enrollment and claims data, electronic entry, modification, termination, designation of primary care physicians, ID card requests, and other group enrollment related functions that may become available from time to time.

Employers using electronic eligibility file processing to manage enrollment and eligibility will be able to access information on the dashboard, but will not be able to add, change or terminate eligibility through the Employer Dashboard. Other functions such as ID card requests, designation of primary care providers and other functions may be available from time to time.

**B. eBill.** eBill includes the electronic distribution of billing invoices and payment of premiums.

**i. Participation.** By signing this Agreement, Employer consents to the electronic distribution of billing invoices.

**ii. Payment.** Payment must be posted by the due date noted on the billing invoice. Please allow up to three days for processing of online payments. Immediate and past-due payments will not be accepted through eBill; Employer should contact their Membership Accounting specialist or Sales and Service representative for immediate or past-due payments.

Employer has the ability to schedule payments for specific dates. Scheduled payments can be changed or cancelled at any time prior to being processed. Moda Health and Delta Dental will not accept scheduled payments on eBill as proof of payment until that payment has been marked “PAID” on the payment history screen.

**iii. Account Information.** eBill uses email as the primary source of communication. Employer will be notified when statements are available online or if a payment cannot be processed. Employer may view or print invoices through the Account. Employer may change the group’s bill delivery preference or discontinue email notifications at any time by changing their preferences. Employer also has the ability to select to be notified when there is payment confirmation. Employer shall ensure that Employer email information is updated.

**C. Other online features,** included but not limited to; reporting when applicable, ability to generate or view enrollment census, etc.

**D. Online access is based on the role assignments below:**

**Company Admin:** This is the highest level of access available to an employer. Specifically, a Company Admin is able to access all features available online (enrollment, billing and claims data and/or reporting when applicable). Each group will have at least one Company Admin. The Company Admin has the ability to assign roles as outlined below within their organization and manage access to those roles as follows;

**Group Admin:** Allows access to view employee and dependent eligibility, make changes to enrollment including address changes, termination of coverage, and primary care provider assignments. The above services are not currently available to employers utilizing an electronic eligibility file. The Company Admin can determine if access to claims data or reporting data (when available) is permitted for this role.

**Financial Admin:** Allows access to view bills, make payments and receive notification of bills electronically. Able to view enrollment data, however there is no access to process enrollment changes or request ID cards. A Company Admin can determine if access to claims data or reporting data (when available) is permitted for this role.

Company Admin will remove any access for any employee who was granted access no later than the last day of employment with the employer.



## 2. Company Admin Contact Information

The Contact Person is the person within the Employer organization who is designated by the Employer to authorize user access to the Account. If Employer changes the Company Admin Contact Person, Employer shall notify Moda Health and/or Delta Dental in writing no later than five business days after such change.

Company Admin Contact Person	
Phone number	Company Admin email Address

## 3. Agreement

Use or access of approved Services by Employer or Employer's authorized representatives constitutes agreement to the terms and conditions of this Agreement. Moda Health Plan, Inc. ("Moda Health") and Delta Dental Plan of Oregon and Delta Dental of Alaska ("Delta Dental") may amend or change this Agreement from time to time, in its sole discretion, by providing Employer written notice by electronic or regular mail, or by posting the updated terms on Moda Health and Delta Dental's website. Continued use of the Services following such change or amendment will be considered Employer's agreement to the change or amendment.

Employer may discontinue use of the Services at any time if these terms and conditions are unacceptable.

## 4. Confidentiality

Employer shall maintain the security and confidentiality of the information maintained through the Account, including individually identifiable health information of a member as defined in 45 CFR §160.103 (collectively the "Information"), as required by all applicable state and federal laws. Employer agrees not to use or further disclose the Information for any purpose except as necessary to carry out this Agreement and to administer Employer's health plan. Employer will use appropriate physical, technical and administrative safeguards to prevent use or disclosure of the Information other than as provided for by this Agreement. Employer will maintain confidentiality of user identifications and passwords and prevent any unauthorized individual(s) from accessing the Account and/or using Information in a manner contrary to this Agreement.

## 5. Access, Passwords, and Security

Employer agrees to follow the security and privacy protocols established by Moda Health and Delta Dental and described in the user guide, website terms of use, or other related documentation that may be provided by Moda Health and Delta Dental (collectively, the "Security and Privacy Protocols"), to ensure that all transactions are authorized and to protect all Information from improper access.

## 6. Reporting Violations

Employer agrees to immediately notify Moda Health and Delta Dental if Employer becomes aware of any of the following:

- Any loss or theft of access codes or passwords
- Any unauthorized use of any access codes or passwords
- Any unauthorized use of the Account
- Any loss, theft or unauthorized use of Information
- Any loss or theft of hardware which contains Information

Employer further agrees to make any and all reasonable efforts to correct or mitigate the effects of any such occurrences and to prevent reoccurrence.

## 7. Enrollment Materials

Employer agrees to retain all written and electronic enrollment materials, including but not limited to, enrollment forms, applications, personal data sheets, and any forms required to update or change employee information (collectively, "Enrollment Materials"), for a period of 10 years from the date they are received by Employer. Employer shall provide Moda Health and Delta Dental with reasonable access to such Enrollment Materials upon request.

## 8. Indemnification

Employer agrees to indemnify and defend Moda Health and Delta Dental from and against any and all claims, losses, damages, liability, costs and expenses (including but not limited to defense costs and reasonable attorneys' fees) arising from or related to Employer's violation of this Agreement, misuse of the Information, or violation of any third-party's rights, including violation of any proprietary right and invasion of any privacy rights. This obligation will survive the termination of this Agreement.

## 9. Termination

Moda Health and Delta Dental reserve the right to terminate Employer access to the Account, or any portion of the Services in its sole discretion, at any time, without notice and without limitation, for any reason whatsoever, including but not limited to unauthorized use of Employer access codes or passwords, misuse or unauthorized use of the Information, failure to adhere to policies set forth in the Security and Privacy Protocols, or breach of this Agreement.

## 10. Assignment

Employer may not assign its rights, interests or obligations or any part thereof under the Agreement without prior written permission of Moda Health and Delta Dental.

## 11. Severability

If any provision of this Agreement shall be invalid or unenforceable in any respect for any reason, the validity and enforceability of any such provision in any other respect and of the remaining provisions of this Agreement shall not be in any way impaired.

## 12. Terms of Use

Employer shall abide by any additional Terms of Use posted on the Moda Health and Delta Dental website.

Employer represents and warrants that the person signing this Agreement has the authority to do so, and is entering into this Agreement on behalf of Employer and all existing and future employees.

The individual signing this Agreement on behalf the Employer must be the owner of the business in a sole proprietorship; a partner in a partnership; the designated principal in a limited partnership, corporation or other licensed entity; an officer; or supervisor or manager at the Employer entity.

**By signing this Agreement, Employer acknowledges that Employer has read, understands and accepts the terms and conditions as stated in this Agreement.**

Employer	
Signature X	Title
Date	Tax Identification #

## Late Acknowledgment



Moda Health and Delta Dental of Oregon and Alaska normally require new group applications be submitted and received by the 10th of the month prior to the effective date. At your direction, we have accepted the application for this group after the 10th.

Because we are accepting this information after the 10th, we are asking you to acknowledge that all aspects of your group's set-up may not be completed by the 1st. Your group's information may not be completely set up in the system, the member's identification cards may not be ready and in the member's hands prior to the effective date.

Moda Health and Delta Dental is committed to completing this process in a timely fashion and will commit to providing your group set-up as timely as possible. Again, thank you for your business!

Best Regards,

A handwritten signature in black ink, appearing to read "Jason Gootee", with a long horizontal flourish extending to the right.

**Jason Gootee**

VP, Sales & Strategic Market Development

X

\_\_\_\_\_  
Group Administrator/Authorized Representative

X

\_\_\_\_\_  
Producer/Agent

# Nondiscrimination notice

**We follow federal civil rights laws. We do not discriminate based on race, religion, color, national origin, age, disability, gender identity, sex or sexual orientation.**

We provide free services to people with disabilities so that they can communicate with us. These include sign language interpreters and other forms of communication.

If your first language is not English, we will give you free interpretation services and/or materials in other languages.

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## **If you need any of the above, call:**

888-217-2363 (TDD/TTY 711)

## **If you think we did not offer these services or discriminated, you can file a written complaint.**

### **Please mail or fax it to:**

Moda Partners, Inc.  
Attention: Appeal Unit  
601 SW Second Ave.  
Portland, OR 97204  
Fax: 503-412-4003

## **If you need help filing a complaint, please call Customer Service.**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights at [ocrportal.hhs.gov/ocr/portal/lobby.jsf](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf), or by mail or phone:

U.S. Department of Health  
and Human Services  
200 Independence Ave. SW, Room 509F  
HHH Building, Washington, DC 20201

800-368-1019, 800-537-7697 (TDD)

You can get Office for Civil Rights complaint forms at [hhs.gov/ocr/office/file/index.html](https://hhs.gov/ocr/office/file/index.html).

## **Scott White coordinates our nondiscrimination work:**

Scott White,  
Compliance Officer  
601 SW Second Ave.  
Portland, OR 97204  
855-232-9111  
[compliance@modahealth.com](mailto:compliance@modahealth.com)

[modahealth.com](https://modahealth.com)

Dental plans in Oregon provided by Oregon Dental Service, dba Delta Dental Plan of Oregon. Dental plans in Alaska provided by Delta Dental of Alaska. Delta Dental is a trademark of Delta Dental Plans Association. Health plans provided by Moda Health Plan, Inc.



ATENCIÓN: Si habla español, hay disponibles servicios de ayuda con el idioma sin costo alguno para usted. Llame al 1-877-605-3229 (TTY: 711).

CHÚ Ý: Nếu bạn nói tiếng Việt, có dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Gọi 1-877-605-3229 (TTY: 711)

注意：如果您說中文，可得到免費語言幫助服務。請致電1-877-605-3229（聾啞人專用：711）

주의: 한국어로 무료 언어 지원 서비스를 이용하시려면 다음 연락처로 연락해주시기 바랍니다. 전화 1-877-605-3229 (TTY: 711)

PAUNAWA: Kung nagsasalita ka ng Tagalog, ang mga serbisyonang tulong sa wika, ay walang bayad, at magagamit mo. Tumawag sa numerong 1-877-605-3229 (TTY: 711)

تنبيه: إذا كنت تتحدث العربية، فهناك خدمات مساعدة لغوية متاحة لك مجانًا. اتصل برقم (الهاتف النصي: 711) 1-877-605-3229

بولتے ہیں تو لسانی (URDU) توجہ دیں: اگر آپ اردو اعانت آپ کے لیے بلا معاوضہ دستیاب ہے۔ 1-877-605-3229 (TTY: 711) پر کال کریں

ВНИМАНИЕ! Если Вы говорите по-русски, воспользуйтесь бесплатной языковой поддержкой. Позвоните по тел. 1-877-605-3229 (текстовый телефон: 711).

ATTENTION : si vous êtes locuteurs francophones, le service d'assistance linguistique gratuit est disponible. Appelez au 1-877-605-3229 (TTY : 711)

توجہ: در صورتی کہ بہ فارسی صحبت می کنید، خدمات ترجمہ بہ صورت رایگان برای شما موجود است. با (TTY: 711) 1-877-605-3229 تماس بگیرید.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपको भाषाई सहायता बिना कोई पैसा दिए उपलब्ध है। 1-877-605-3229 पर कॉल करें (TTY: 711)

Achtung: Falls Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistentendienste zur Verfügung. Rufen sie 1-877-605-3229 (TTY: 711)

注意:日本語をご希望の方には、日本語サービスを無料で提供しております。1-877-605-3229 (TTY、テレタイプライターをご利用の方は711)までお電話ください。

အကူအညီ: ဤကိစ္စ (အမျိုးသားနှင့် အမျိုးအမီး ငါးယောက်) အတွက် ဤကိစ္စ အမျိုးအမီး သမားတို့ ခြားနားမှုများကို ဖယ်ရှားပေးပါ။ 1-877-605-3229 (TTY: 711) နှင့် ခေါ်ဆိုပါ။

ໂປດຊາຍ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການຊ່ວຍເຫຼືອດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທ 1-877-605-3229 (TTY: 711)

УВАГА! Якщо ви говорите українською, для вас доступні безкоштовні консультації рідною мовою. Зателефонуйте 1-877-605-3229 (TTY: 711)

ATENȚIE: Dacă vorbiți limba română, vă punem la dispoziție serviciul de asistență lingvistică în mod gratuit. Sunați la 1-877-605-3229 (TTY 711)

THOV CEEB TOOM: Yog hais tias koj hais lus Hmoob, muaj cov kev pab cuam txhais lus, pub dawb rau koj. Hu rau 1-877-605-3229 (TTY: 711)

ត្រូវចងចាំ៖ បើអ្នកនិយាយភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដោយឥតគិតថ្លៃ គឺមានផ្តល់ជូនលោកអ្នក។ សូមទូរស័ព្ទទៅកាន់លេខ 1-877-605-3229 (TTY: 711)

HUBACHIISA: Yoo afaan Kshtik kan dubbattan ta'e tajaajiloonni gargaarsaa isiniif jira 1-877-605-3229 (TTY: 711) tiin bilbilaa.

โปรดทราบ: หากคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี โทร 1-877-605-3229 (TTY: 711)

FA'AUTAGIA: Afai e te tautala i le gagana Samoa, o loo avanoa fesoasoani tau gagana mo oe e le totogia. Vala'au i le 1-877-605-3229 (TTY: 711)

IPANGAG: Nu agsasaoka iti Ilocano, sidadaan ti tulong iti lengguahe para kenka nga awan bayadna. Umawag iti 1-877-605-3229 (TTY: 711)

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń: 1-877-605-3229 (obsługa TTY: 711)