moda HEALTH

Apply online by visiting modahealth.com/shop.
Questions? We're here to help. Call us Monday-Friday, 8:30 a.m. to 6:30 p.m. Mountain time 844-931-1775.

2026 | Moda Health Plan, Inc.
Individual health plan application – Moda Select service area

For Idaho individuals and families in Ada, Adams, Bannock, Bear Lake, Benewah, Bingham, Boise, Bonner, Bonneville, Boundary, Canyon, Caribou, Cassia, Clearwater, Elmore, Franklin, Fremont, Gem, Jefferson, Idaho, Kootenai, Latah, Lewis, Madison, Nez Perce, Minidoka, Oneida, Owyhee, Payette, Power, Shoshone, Teton and Washington counties.

Note: To be eligible to enroll, subscriber and dependents must reside in the Moda Select service area. Children who live outside of Idaho may be covered if they are full-time students or under a qualified medical child support order (QMCSO).

Please fill out all sections of this application and submit it to us. If the application is incomplete or we need more information, your effective date may be delayed. Be sure information is clearly written. If we can't read something, we will return your application to you. Submit your complete application no later than the 15th of the month before the requested effective date. If your application is received after the 15th, your enrollment may be delayed. For special enrollment, we must receive this application and supporting documentation within 60 days of the special enrollment event date. Your application process could be delayed or denied if supporting documentation is not provided. To expedite your application, please complete the fillable form and include your electronic signature or your Adobe digital ID signature. You also have the option to complete this application form using black or blue ink and include your handwritten signature.

Section 1 › Application type

The reason I am applying or making a change is:

Open enrollment

- ☐ New policy/subscriber
- ☐ Add dependent to existing plan
- ☐ Plan change only

Existing subscriber name
Existing subscriber ID

If this is a special enrollment application, you must include proof of the life event that made you eligible. **A list of acceptable documentation to support your life event and the available effective dates for coverage can be found at modahealth.com/shop/special-enrollment.**

You will need a special enrollment event for changes or new policies made outside of the open enrollment period.

Special enrollment

Date of event *(mm/dd/yyyy)*

- ☐ Marriage or domestic partnership
- ☐ Birth, adoption or placement for adoption
- ☐ Loss of coverage because I turned 26
- ☐ Loss of coverage due to end of marriage or domestic partnership
- ☐ Loss of eligibility for group coverage
- ☐ COBRA ended due to expiration of coverage or the end of employer premium contributions or government subsidy
- ☐ Other _____

Section 2 › Eligibility and residency

You are eligible to enroll if you meet the following requirements.

You must confirm you meet eligibility requirements by checking the boxes below.

I confirm that:

- ☐ I currently live, and have a fixed, permanent home address, in the service area
- ☐ I spend at least 6 months of the year living in the service area
- ☐ Children living outside the service area are in school or covered under a qualified medical child support order (QMCSO)
- ☐ I and any dependents enrolling are not enrolled in Medicare or living in the service area to get health coverage or for another temporary reason such as getting treatment.

Note: Living in a residential care facility to receive treatment does not meet the residency requirement

Section 3 › Plan selection

I select the following medical plan for the requested effective date ___/___/_____:

- ☐ Moda Select Idaho Gold 1100 Separate Rx + Vision Exam
- ☐ Moda Select Idaho Gold 2200 + Vision Exam
- ☐ Moda Select Idaho Silver 3000 Separate Rx + Vision Exam
- ☐ Moda Select Idaho Silver 4000 + Vision Exam
- ☐ Moda Select Idaho Silver 6400 + Vision Exam
- ☐ Moda Select Idaho Bronze 9200 + Vision Exam
- ☐ Moda Select Idaho Bronze HDHP 7500
- ☐ Moda Select Idaho Bronze 10,000 + Vision Exam

Moda Health's individual medical plans are designed to support your healthcare needs through partnership between you and an in-network primary care provider (PCP). Your PCP coordinates your care. We encourage you to find a PCP in our network during this application process. Go to Find Care on modahealth.com/idaho to confirm your PCP is in-network.

Section 4 › Subscriber information

This section must be completed with **subscriber** information.

Is this a child- or children-only plan? ☐ No ☐ Yes
If yes, please list the youngest child as the subscriber. Children age 26 or older must be on their own policy.

Last name	First name	M.I.	Suffix

Date of birth *(mm/dd/yyyy)*	Social Security number

Tobacco user*

☐ No ☐ Yes

**A tobacco user is someone who has lawfully used tobacco in any form (other than religious or ceremonial use) on average four or more times per week in the past month.*

Gender

☐ Male ☐ Female ☐ Prefer not to answer

Gender identity

☐ Male ☐ Female ☐ Transgender ☐ Cisgender ☐ Gender non-conforming ☐ Non-binary / third gender
☐ Questioning ☐ Prefer not to answer ☐ Another

These fields are optional. We are committed to understanding and valuing diversity among our members. We are seeking this information so our staff can refer to and communicate with you in the most appropriate and respectful way.

PCP name

Race (optional)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Caucasian ☐ Hispanic or Latino ☐ Native Hawaiian or other Pacific Islander
☐ Other (please specify) _____

Preferred spoken and written language

☐ English ☐ Spanish ☐ Other (please specify) _____

Residence address	City	State	ZIP

County

Mailing address (if different)	City	State	ZIP

Email address	Home phone	Mobile phone

Section 5 › Dependent Information — spouse or domestic partner (DP)

Please complete this section for spouse or DP to be covered on this medical plan.

Last name	First name	M.I.	Suffix

Date of birth *(mm/dd/yyyy)*	Social Security number	Gender ☐ Male ☐ Female ☐ Prefer not to answer

Gender identity

☐ Male ☐ Female ☐ Transgender ☐ Cisgender ☐ Gender non-conforming ☐ Non-binary / third gender
☐ Questioning ☐ Prefer not to answer ☐ Another

These fields are optional. We are committed to understanding and valuing diversity among our members. We are seeking this information so our staff can refer to and communicate with you in the most appropriate and respectful way.

PCP name

Race (optional)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Caucasian ☐ Hispanic or Latino ☐ Native Hawaiian or other Pacific Islander
☐ Other (please specify) _____

Preferred spoken and written language

☐ English ☐ Spanish ☐ Other (please specify) _____

Section 6 > Dependent Information — children living in the service area only (no dependent coverage outside the service area, except full-time students or children with a QMCSO may be covered outside of the network service area)

Please list all children to be covered on this health plan (children must be under age 26). Attach additional copies of this page, if necessary, to list other family members to be included on this application.

Last name	First name	M.I.	Suffix
Date of birth *(mm/dd/yyyy)*	Social Security number	Gender ☐ Male ☐ Female ☐ Prefer not to answer	
Gender identity ☐ Male ☐ Female ☐ Transgender ☐ Cisgender ☐ Gender non-conforming ☐ Non-binary / third gender ☐ Questioning ☐ Prefer not to answer ☐ Another *These fields are optional. We are committed to understanding and valuing diversity among our members. We are seeking this information so our staff can refer to and communicate with you in the most appropriate and respectful way.*			
PCP name			

Last name	First name	M.I.	Suffix
Date of birth *(mm/dd/yyyy)*	Social Security number	Gender ☐ Male ☐ Female ☐ Prefer not to answer	
Gender identity ☐ Male ☐ Female ☐ Transgender ☐ Cisgender ☐ Gender non-conforming ☐ Non-binary / third gender ☐ Questioning ☐ Prefer not to answer ☐ Another *These fields are optional. We are committed to understanding and valuing diversity among our members. We are seeking this information so our staff can refer to and communicate with you in the most appropriate and respectful way.*			
PCP name			

Last name	First name	M.I.	Suffix
Date of birth *(mm/dd/yyyy)*	Social Security number	Gender ☐ Male ☐ Female ☐ Prefer not to answer	
Gender identity ☐ Male ☐ Female ☐ Transgender ☐ Cisgender ☐ Gender non-conforming ☐ Non-binary / third gender ☐ Questioning ☐ Prefer not to answer ☐ Another *These fields are optional. We are committed to understanding and valuing diversity among our members. We are seeking this information so our staff can refer to and communicate with you in the most appropriate and respectful way.*			
PCP name			

Last name	First name	M.I.	Suffix

Date of birth *(mm/dd/yyyy)*	Social Security number	Gender ☐ Male ☐ Female ☐ Prefer not to answer

Gender identity

☐ Male ☐ Female ☐ Transgender ☐ Cisgender ☐ Gender non-conforming ☐ Non-binary / third gender
☐ Questioning ☐ Prefer not to answer ☐ Another

These fields are optional. We are committed to understanding and valuing diversity among our members. We are seeking this information so our staff can refer to and communicate with you in the most appropriate and respectful way.

PCP name

Last name	First name	M.I.	Suffix

Date of birth *(mm/dd/yyyy)*	Social Security number	Gender ☐ Male ☐ Female ☐ Prefer not to answer

Gender identity

☐ Male ☐ Female ☐ Transgender ☐ Cisgender ☐ Gender non-conforming ☐ Non-binary / third gender
☐ Questioning ☐ Prefer not to answer ☐ Another

These fields are optional. We are committed to understanding and valuing diversity among our members. We are seeking this information so our staff can refer to and communicate with you in the most appropriate and respectful way.

PCP name

If any children listed above have a different race or primary language than the subscriber, please list their name, race (optional), and primary language below. If a child lives outside of the network service area, please email, fax or mail the QMCSO or documentation of the child's enrollment in an out-of-area school to: individualapp@modahealth.com. Fax: 503-219-3696 Mail: Membership Accounting, 601 SW Second Ave., Portland, OR 97204-3156. The enrolled child will be eligible for out-of-area coverage on the first day of the month after the date documentation is received and the address is updated in Moda Health's system.

Section 7 › Other insurance

Will you have other medical insurance?

☐ Yes ☐ No

Section 8 › Go paperless!

By giving consent, you have some electronic delivery options from your Member Dashboard.

- Manage billing and payment by eBill
- View your explanation of benefits (EOBs)
- View your Member Handbook and outline of coverage
- Get an electronic ID card

After your application is approved, you will receive a welcome letter with your member ID number. With this ID number, please set up a Member Dashboard account by visiting modahealth.com/idaho and start reviewing your benefits and managing your billing online.

☐ I consent to receive the insurance documents and communication by electronic delivery. Electronic delivery includes billing, explanation of benefits (EOB), individual policy and outline of coverage, insurance notices and emails.

Section 9 › Payment method

We offer several payment options for you to choose from, including:

1. Automatic eBill payment through your Member Dashboard.
2. Electronic fund transfer (EFT), see authorization agreement below.
3. Personal check, money order or cashier's check.

EFT authorization agreement

EFT initiates around the 5th of the month and usually takes one or two days to post to your account. Your first payment may initiate on a later date if your enrollment is processed after the 5th of the month. Your premium invoice will be paperless and located in the eBill section of your Member Dashboard.

1. Complete and sign below as the account holder for monthly automatic premium deductions from your bank.
2. Attach a photocopy of a voided personal check from the account, or provide the bank routing and account numbers below.

Subscriber		Account holder	
Name of bank	Routing number	Account number	Account type ☐ Checking ☐ Savings

I authorize Moda Health to charge my account for monthly premiums for the above named individual. I also authorize my bank, named here, to honor these monthly charges. This authority will remain in effect until I give my bank a reasonable chance to act upon it. I can stop payment by notifying my bank before my account has been charged.

Account holder signature X	Signature date

Section 10 > Billing options

If you are set up for EFT, your premium invoice will be paperless. If you are not set up for EFT, you will receive paper invoices in the mail. You may change your billing preference to paperless by going to the eBill section of your Member Dashboard.

If the bill needs to go to an address other than your mailing address, please note the billing address below.

Billing address	City	State	ZIP

Section 11 > Agent (to be completed by agent only)

I (the agent) certify that I have explained the eligibility provisions to the subscriber. I have not made any statements about benefits, conditions or limitations of the contract except through written material furnished by Moda Health. I have informed the subscriber that the effective date of coverage is assigned only by Moda Health.

For you to become the agent, you must be actively appointed with Moda Health.

Please sign and date below.

Agent name	Agency name	Phone	Agent/Agency NPN

Address	City	State	ZIP

I certify that the information supplied to me by the subscriber has been truly and accurately recorded.

Agent signature (required)	Signature date
X	

Note to agent: Payment does not have to be included with the application, but the first payment is required to activate coverage.

Section 12 > Basic terms of enrollment

By signing Section 13, I understand and agree that:

- I understand and agree that this application is not an offer of coverage, and coverage does not begin until this application is received and reviewed by Moda Health and an effective date of coverage is assigned.
- I understand and agree that this application becomes a part of my plan.
- I understand that no benefits are available under a Moda Health plan for services or supplies, including those related to an inpatient confinement, that were received before the effective date of coverage.
- I understand that acceptance for coverage has the following requirements:
  A. Subscribers must be Idaho residents living in the service area to apply for and maintain coverage under a Moda Health plan. Moda Health reserves the right to request documentation at any time.
  B. Members cannot be covered by more than one Moda Health individual medical plan at any time.
  C. No one listed on this application is enrolled in Medicare on the date coverage would begin.
- If I am eligible for Medicare Part B but not enrolled, Moda Health will estimate what Medicare would have paid and reduce my benefits by that amount.
- "**Resident**" means a person who lives in the plan's service area and intends to live in the service area permanently or indefinitely. Moda Health may require proof of residency from time to time. Such proof shall include, but not be limited to, the street address of the individual's residence and not a post office box.
- I have the right to examine and return the policy within 10 days of receipt.
- Potential changes due to state or federal mandates, effective in January, may alter the benefits or rates of my current plan.
- Regardless of my enrollment date, my plan premium will renew January 1.
- Moda Health pays a commission to appointed brokers for the work they do on your behalf. Our current commission schedule is located at modahealth.com/idaho/broker-commission.

Section 13 > Certification of completion and correctness

Be sure to sign and date the application below. Your spouse, domestic partner and any children over age 18 are required to sign the application.

I affirm that the answers given on this application are complete and correct to the best of my knowledge. I have provided these answers as part of the application process required by Moda Health to enroll in insurance coverage. I understand that if this application contains any intentional misrepresentations of material fact that Moda Health may deny coverage, modify or cancel the contract, rescind the contract or take other legal action. I will promptly inform Moda Health in writing if anything happens before my coverage takes effect that makes this application incomplete or incorrect. I understand and agree that no coverage will be in force until approved by Moda Health. If approved, coverage will be in force as of the effective date determined by Moda Health. Moda Health may contact me to clarify answers on this application. As the applicant, I understand I have the right to inspect the information in my file.

I acknowledge that I have read and understand this application, terms and certification, and privacy statement.

Print name of responsible party[1] if child- or children-only policy X	Relationship[2]
Signature of subscriber (if subscriber is under age 18, signature of responsible party) X	**Signature date**
Signature of subscriber's legal spouse or DP, if applying for coverage X	**Signature date**
Signature of dependent(s), age 18 and older, if applying for coverage X	**Signature date**
Signature of dependent(s), age 18 and older, if applying for coverage X	**Signature date**

1 *Responsible party: If you are an adult not covered by this plan and you bear financial responsibility or act as the primary caregiver for the subscriber and others covered by this plan, then you are the responsible party*

2 *If not a parent, please attach legal documentation if you are the legal guardian or holder of Power of Attorney.*

By providing your contact information and consent, you are consenting to receive communications from Moda Health Plan, Inc., and its affiliates and business partners regarding your health plan benefits, payments and treatment. Please keep in mind that communications via email over the internet may not be secure. Although it is unlikely, there is a possibility that information included in an email could be obtained by other parties besides the person to whom it is addressed. We recommend that you do not include personal identifying information such as your birth date, or personal medical information in any emails you send to us. There is no requirement to provide your email address or phone number as a condition to purchasing any goods or services.

Ready to submit? Mail, fax or email this form to Moda Health
Mail: Membership Accounting, 601 SW Second Ave., Portland, OR 97204-3156
Fax: 503-219-3696
Email: Scan and send to individualapp@modahealth.com.

New to Moda Health? Visit modahealth.com to log in to your Member Dashboard and view your Member Handbook and bill. Once you sign up for your Member Dashboard and go paperless (see Section 8), you'll receive an email when your first bill is ready.

Questions? Contact Moda Health at 844-931-1775.

modahealth.com/idaho

To view the summary of benefits and coverage (SBC) for the medical plans, please visit modahealth.com/shop. A uniform glossary is available to help you understand the most common healthcare terms at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf.

For free print copies of the SBC or uniform glossary, contact Moda Health at 844-931-1775.

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-877-605-3229 (TTY: 711) or speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-877-605-3229 (TTY: 711) o hable con su proveedor.

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số (Người khuyết tật: 1-877-605-3229 (TTY: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-877-605-3229 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-877-605-3229 (TTY: 711) или обратитесь к своему поставщику услуг.

注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-877-605-3229 (TTY: 711) までお電話ください。または、ご利用の事業者にご相談ください。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-877-605-3229 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-877-605-3229 (TTY: 711) o makipag-usap sa iyong provider.

УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-877-605-3229 (TTY: 711) або зверніться до свого постачальника».

ማሳሰቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር 1-877-605-3229 (TTY: 711) ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ።

FIIRO GAAR AH: Haddaad ku hadasho Soomaali, adeegyo kaalmada luuqadda ah oo bilaash ah ayaad heli kartaa. Qalab caawinaad iyo adeegyo oo habboon si loogu bixiyo macluumaadka qaabab la adeegsan karo ayaa sidoo kale bilaa lacag heli karaa. Wac 1-877-605-3229 (TTY: 711) ama la hadal bixiyahaaga.

ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-877-605-3229 (TTY: 711) ou parlez à votre fournisseur.

注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电（文本电话：1-877-605-3229 (TTY: 711)）或咨询您的服务提供商。

ຊາບຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ,
ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ.
ມີເຄື່ອງຊ່ວຍ ແລະ
ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບ
ແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-877-605-3229
(TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

หมายเหตุ: หากคุณใช้ภาษา ไทย
เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้
ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1-877-605-3229 (TTY: 711) หรือปรึกษาผู้ให้บริการของคุณ

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ - (1-877-605-3229 (TTY: 711 پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔"

LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau 1-877-605-3229 (TTY: 711) los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob.

सावधान: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि निःशुल्क भाषिक सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायता र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-877-605-3229 (TTY: 711) मा फोन गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।

ശ്രദ്ധിക്കുക: നിങ്ങൾ മലയാളം ഭാഷ സംസാരിക്കുമെങ്കിൽ, സൗജന്യ ഭാഷാ സഹായ സേവനങ്ങൾ നിങ്ങൾക്ക് ലഭ്യമാണ്. ആക്സസ് ചെയ്യാവുന്ന ഫോർമാറ്റുകളിൽ വിവരങ്ങൾ നൽകാനുള്ള ഉചിതമായ അനുബന്ധ സഹായങ്ങളും സേവനങ്ങളും കൂടെ സൗജന്യമായി ലഭ്യമാണ്. 1-877-605-3229 (TTY: 711) ലേക്ക് വിളിക്കുക അല്ലെങ്കിൽ നിങ്ങളുടെ ദാതാവിനോട് സംസാരിക്കുക.

PANANGIKASO: No agsasaoka iti Ilocano, magun-odmo dagiti libre a serbisio ti tulong iti pagsasao. Libre met laeng a magun-odan dagiti maitutop a katulongan ken serbisio a mangipaay iti impormasion kadagiti ma-akses a format. Awagan ti 1-877-605-3229 (TTY: 711) wenno makisarita iti mangipapaay kenka.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-877-605-3229 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

సావధానం: మీరు తెలుగు మాట్లాడితే, మీకు ఉచిత భాషా సహాయ సేవలు అందుబాటులో ఉంటాయి. యాక్సెస్ చేయగల ఫార్మాట్‌లలో సమాచారాన్ని అందించడానికి తగిన సహాయక సహాయాలు మరియు సేవలు కూడా ఉచితంగా అందుబాటులో ఉంటాయి. 1-877-605-3229 (TTY: 711) కి కాల్ చేయండి లేదా మీ ప్రొవైడర్‌తో మాట్లాడండి.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 877-605-3229 (TTY: 711) أو تحدث إلى مقدم الخدمة".

AKIYESI: Ti o ba sọ Yorùbá, awọn iṣẹ iranlọwọ ede ọfẹ wa fun ọ. Awọn iranlọwọ iranlọwọ ti o yẹ ati awọn iṣẹ lati pese alaye ni awọn ọna kika wiwọle tun wa laisi idiyele. Pe 1-877-605-3229 (TTY: 711) tabi sọrọ si olupese rẹ.

MAKINIKA: Ikiwa wewe huzungumza Kiswahili, msaada na huduma za lugha bila malipo unapatikana kwako. Vifaa vya usaidizi vinavyofaa na huduma bila malipo ili kutoa taarifa katika mifumo inayofikiwa pia inapatikana bila malipo. Piga simu 1-877-605-3229 (TTY: 711) au zungumza na mtoa huduma wako.

ATENÇÃO: Se você fala Português do Brasil, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-877-605-3229 (TTY: 711) ou fale com seu provedor.