Alaska Group Application

Thank you for choosing Moda Health and Delta Dental of Alaska.

Please forward the completed copy to:
ModaGroupSalesAK@modahealth.com

Or

Print and mail a completed copy to:
Moda Health and Delta Dental
Attn: Sales and Account Services
510 L St., Suite 270, Anchorage, AK 99501

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

- ☐ Group Application (completed and signed by the group and agent)
- ☐ Enrollment forms/Waiver forms for all eligible employees
  - ☐ Please include hire dates on all enrollment forms
  - ☐ Enrollment forms must match census information
- ☐ Declinations for all employees waiving or opting out (applicable to groups with all levels of participation)
- ☐ First Month's Premium (make check payable to Moda Health)
- ☐ ESA Agreement/EFT (Electronic Funds Transfer) Authorization Form (if applicable)
- ☐ Late Acknowledgement Agreement (if enrolling past the 10th of the month)

Member Handbooks

We encourage our members to view their handbooks online using their Member Dashboard account.

Electronic Application

Please note, this application is intended to be completed electronically, saved, then emailed to our Group Sales inbox. If this application is not completed electronically, drop downs and embedded calculations will not be functional. Please feel free to contact the Sales Team with any questions that you may have.

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.

Alaska Master Group Application

Groups Sized 1-50

Application Type
Effective Date
Renewal Date

Submit

Print

Group Information

The following characters ? | / \ * > < : are not accepted.

Legal name			
Physical address	City	State	ZIP
Principal Business Address	City	State	ZIP

Is the group's billing information the same as their legal name and physical address? ☐ Yes ☐ No

DBA Name (appears on bills)			
Mailing address	City	State	ZIP

Is the group administrator the same as the billing contact? ☐ Yes ☐ No

Group Administrator			
E-Mail Address	Phone	Ext	Fax
Billing Contact			
E-Mail Address	Phone	Ext	Fax

Employer Tax ID #	NAICS Code	Rate Finder Quote #

1. What percentage of the medical premium is contributed by the employer? If choosing multiple plans, the minimum contribution is 50% of the plan with the lowest premium.

Your contribution for employee (minimum is 50%)	Your contribution for dependents

2. What percentage of the dental premium is contributed by the employer?

Standard Plan: Your contribution for employee (minimum is 50%) Voluntary Plan: Your contribution for employee (minimum is 0%)	Your contribution for dependents

3. If enrolling in a dental plan, can employees and their dependents enroll in the dental plan without enrolling in the group's medical plan regardless if Moda Health is or is not the medical carrier? ☐ **Yes (Standalone)** ☐ **No (Integrated)**

Eligibility

1. How many hours per week must employees work to be eligible for benefits? (20 minimum) _____

2. What is the eligibility period employees must complete before being eligible for benefits? _____

   The first of the month following:

   OR Coverage begins following _____ days of employment with the group

   2a. For initial enrollment only, do you want to waive the waiting period for all current eligible employees? ☐ Yes ☐ No

   2b. Time served as a part-time employee will count towards the waiting period when the employee moves to full-time ☐ Yes ☐ No

3. Is the group subject to ERISA (Employee Retirement Income Security Act of 1974)? ☐ Yes ☐ No

4. Is Domestic Partner coverage available? ☐ Yes - either sex ☐ No

5. What business entity type is the group registered as? (LLC, sole proprietor, s-corp., etc.) _____

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

Employee Participation

1. **Medical**
   - For groups of 1-4, minimum of 100% of eligible employees must participate.
   - For groups of 5-50, minimum of 70% of eligible employees must participate.

   Dental Only
   - Non-voluntary Delta Dental
   - For dental only groups of 2-4, minimum of 100% of eligible employees and eligible dependents must participate
   - For dental only groups of 5-50, minimum of 70% of eligible employees and 25% of eligible dependents must participate

   Voluntary Delta Dental
   - For groups of 2-50, minimum of 2 enrolling employees and 25% eligible employees.

   ☐ 1-4 enrolled employees ☐ 5-50 enrolled employees

Attestation	
Is the group a small employer based on the Group Size Determination Form?	☐ Yes ☐ No
Is this an employee only plan?	☐ Yes ☐ No
Is the group subject to COBRA? Count the employees employed on a typical business day in the previous calendar year. Do not count self-employed individuals, independent contractors, and members of the board of directors. If the group had 20 or more employees during at least 50% of the previous calendar year, the group is subject to COBRA.	☐ Yes ☐ No
Is the group subject to Medicare Secondary Payer (MSP) provision? Count the current total number of full-time employees, part-time employees, seasonal employees and partners. Do not count retirees, COBRA members, individuals on other continuation options or self-employed individuals. If the employee count is 20 or more, the group is subject to MSP.	☐ Yes ☐ No

Is the group's principal business address in compliance with the ACA? Principal business address is the address required to be used for rating, per 45 CFR 147.102. It may be different than the address a business uses for billing, etc. For most small groups, principal business address is the address of a substantial worksite that is registered with the State. If the business address isn't registered with the State or doesn't represent a substantial worksite, then one of the following addresses should be used for rating. **For plans with a statewide network** • The business address within the state where the greatest number of employees work. **For plans with a partial-state network** • The business address within the plan's service area where the greatest number of employees work, live or reside as of the beginning of the plan year. • If there is no such business address, the zip code that reflects where the greatest number of employees within the plan's service area reside as of the beginning of the plan year.	☐ Yes ☐ No
The group consents to the following statements. 1. I have read and understand the information in this group application. For questions about the information on this group application, I have received advice and counsel from my agent or legal counsel. 2. There is no coverage in effect until this Application and premium deposit are accepted by Moda Health/Delta Dental, and an effective date is assigned. If this Application is not accepted, the premium deposit will be refunded. 3. All eligible employees are enrolling in the selected Group Policies and all enrolling employees must meet the eligibility requirements specified above. 4. Minimum contribution and participation requirements must be met and maintained for the group to remain eligible for coverage. 5. Employees opting out due to other group or individual coverage are not counted toward the participation requirement. 6. The group's designated representative has reviewed the creditable coverage status of prescription drug plans for Alaska small employer plans at www.modahealth.com/employers/compliance.shtml with the producer before selection of medical plans. 7. The group is responsible of providing 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. 8. The group is responsible of providing the Summary of Benefits and Coverage (SBC) to eligible employees at open enrollment and to new hires and newly eligible employees as required under the ACA. 9. The agent listed in this Application is the group's Agent of Record to represent the group in matters of group insurance benefits provided by Moda Health/Delta Dental. This appointment is in effect on the same day as the Application and will remain in force until rescinded in writing. 10. The final rates will be based on actual enrollment and may be different than the rates originally quoted, and that additional information may be required to verify eligibility of the group. 11. To the best of the group's knowledge and belief, the statements in this attestation section and all the information provided in this Application is correct. 12. The group understands it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. Moda Health/Delta Dental reserve the right to require documentation of employee status and any other criteria related to group and member plan eligibility.	☐ Yes ☐ No

Types of Coverage

1. Rate Finder Medical Plan design 1 name: _____
2. Rate Finder Medical Plan design 2 name: _____
3. Rate Finder Medical Plan design 3 name: _____
   For groups selecting multiple medical plans only: Please note, a maximum of three plans may be selected from our plan portfolio with a minimum of one enrolled in each plan
4. Will Moda Health or Delta Dental cover out of state employees? ☐ Yes ☐ No
   Employees who reside in the state of Hawaii are not eligible to enroll for medical coverage.
   If yes, list state(s) and number of employees in each: _____
5. Please indicate your chosen Rate Finder Dental Plan Design name: _____
6. Indicate your chosen Orthodontia Plan Design name: _____
   Only those groups with 15 or more enrolling are eligible for Orthodontia Plans
7. Do you currently have another medical group policy? If yes, please indicate the carrier. _____
8. Do you currently have another dental group policy? If yes, please indicate the carrier. _____
9. If this plan is replacing an existing plan, will members receive deductible credit from the previous plan? ☐ Yes ☐ No
10. If this plan is replacing an existing plan, will members receive out-of-pocket credit from the previous plan? ☐ Yes ☐ No

Rates

	EE only	EE + Spouse	EE + Family	EE + Child	Total
Medical Employee Counts					
Medical Plan 1					
Subtotal Medical	**$0.00**	**$ 0.00**	**$ 0.00**	**$ 0.00**	
Medical Employee Counts					
Medical Plan 2					
Subtotal Medical	**$ 0.00**	**$ 0.00**	**$ 0.00**	**$ 0.00**	
Medical Employee Counts					
Medical Plan 3					
Subtotal Medical	**$ 0.00**	**$ 0.00**	**$ 0.00**	**$ 0.00**	**$ 0.00**
Dental Employee Counts					
Dental					
Orthodontia					
Subtotal Dental	**$ 0.00**	**$ 0.00**	**$ 0.00**	**$ 0.00**	**$ 0.00**
Total Billed					**$ 0.00**

COBRA Administration	
1. **Do you use a COBRA Third Party Administrator (TPA)?** If your group is 20 or greater and is choosing BenefitHelp Solutions as your TPA for standalone COBRA, please call 1-800-556-3137 to speak with a Representative regarding a quote.	☐ Yes ☐ No
2. **If yes, enter the TPA Name and contact information:** Name Address Phone	
3. **If no, will you elect COBRA administration through BenefitHelp Solutions (BHS)**	☐ Yes ☐ No
4. **Who will be remitting payment to Moda Health/Delta Dental for COBRA premiums?**	☐ Group ☐ TPA

Payment	
1. **Will the group make payments via EFT, eBill or by check?** If remitting payments via EFT, complete and return the Authorization Agreement for Electronic Funds Transfer Debits as well as a copy of a voided check. If remitting payments via eBill, complete and return the Electronic Services Agreement.	☐ EFT ☐ eBill ☐ Check
2. **If the group elects EFT, will the initial payment be pulled via ACH?** If "Yes" complete and return ACH form for a one-time pull for the initial payment. If "No" complete and return a check for the initial payment.	☐ Yes ☐ No

Agent Information	
Agent Name	Agency Name
Agent NPN	Agency Tax ID

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) use them on documents, including legally binding contracts.

Authorized Signature for Group X	Title
Authorized Signer's Printed Name	Date
Authorized Agent Signature X	Date
Authorized Agent's Printed Name	Date
Moda Health/Delta Dental 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	Ext	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:

a. Any loss or theft of access codes or passwords

b. Any unauthorized use of any access codes or passwords

c. Any unauthorized use of the Account

d. Any loss, theft or unauthorized use of Information

e. 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 #

Voluntary EFT Premium Groups Authorization Agreement For Electronic Funds Transfer (EFT) Debits

Delta Dental of Oregon & Alaska

Section 1 > Transaction type

☐ Binder and reoccuring payments ☐ Reoccuring payments only ☐ Binder payment only ☐ Change/edit current account

Effective date	Date of transfer ☐ 25th (prior month for future month's premium) ☐ 1st

Section 2 > Instructions

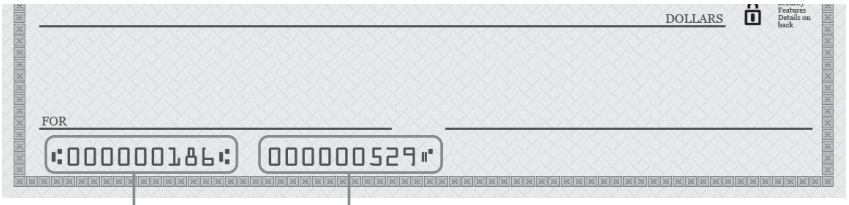
1. Complete and sign the authorization form
2. For a checking account, please attach a VOIDED check
3. For a savings account, attach a deposit slip
4. Return the authorization form with the voided check or deposit slip to Moda Health Plan, Inc.

Section 3 > Payment

Company name	Company tax ID number

I (we) hereby authorize Moda Health and/or Delta Dental 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.	



9-digit routing no. *Account no.*

Section 4 > Authorization

This authority is to remain in full force and effect until COMPANY and DEPOSITORY has received written notification from me (or either of us) of its termination in such time in such manner to afford GO:MP ANY and DEPOSITORY a reasonable opportunity to act on it.

Signature X	Signature X
Date	Date

Ready to submit? Mail or fax this form with a copy of a voided check to Moda Health and/or Delta Dental:

Mail: Moda Health and/or Delta Dental, Attn: Membership Accounting, 601 S.W. Second Ave., Portland, OR 97204-3156

Fax: 503-219-3696 Attn: Membership Accounting Individual

Questions? Contact Customer Service at 888-217-2365. (TTY users, dial 711.)

modahealth.com | DeltaDentalOR.com | DeltaDentalAK.com

Nondiscrimination notice

We follow federal civil rights laws. We do not discriminate based on race, 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.

If you need any of the above, call:

Medicare Customer Service,
877-299-9062 (TDD/TTY 711)

Medicaid Customer Service,
888-788-9821 (TDD/TTY 711)

Customer Service for all other plans,
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

Dave Nesseler-Cass coordinates our nondiscrimination work:

Dave Nesseler-Cass,
Chief Compliance Officer
601 SW Second Ave.
Portland, OR 97204
855-232-9111
compliance@modahealth.com

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, 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.

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. Health plans provided by Moda Health Plan, Inc. Individual medical plans in Alaska provided by Moda Assurance Company. 42677508 (9/19)

moda HEALTH

DELTA DENTAL
Delta Dental of Oregon & Alaska

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 serbisyong 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 1-877-605-3229 (الهاتف النصي: 711)

توجہ دیں: اگر آپ اردو بولتے ہیں تو لسانی (URDU) 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)

توجه: در صورتی که به فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما موجود است. با 1-877-605-3229 (TTY: 711) 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 Sprachassistenzdienste 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（TYY、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。

અગત્યનું: જો તમે (ભાષાંતર કરેલ ભાષા અહીં દર્શાવો) બોલો છો તો તે ભાષામાં તમારે માટે વિના મૂલ્યે સહાય ઉપલબ્ધ છે. 1-877-605-3229 (TTY: 711) પર કૉલ કરો

ໂປດຊາບ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການຊ່ວຍເຫຼືອດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສັຍຄ່າ. 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)

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