SHARP Health Plan

Individual & Family Plans Open Enrollment Period Application for Health Insurance

Purpose

The purpose of this form is to help you apply for health insurance during our yearly open enrollment period. Filling out this form means you are applying for an Individual or Family Plan with Sharp Health Plan.

Instructions

One application is required and all enrollees must be on the same plan design. A separate application is required if any family members want a different plan design, or if a child is enrolling without a parent. If a child is enrolling without a parent, the information must be filled out in the subscriber section of the application.

Covered California™ Members: To add a dependent or change your benefit plan, please contact Covered California at 1-800-300-1506. You can also change or update your account online by logging in to your Covered California account at **coveredca.com**.

Submit

By mail or in person:
Sharp Health Plan
Attention: IFP Sales
8520 Tech Way, Suite 200
San Diego, CA 92123

By email:
ifpsales@sharp.com

By fax:
Attention: IFP Sales
1-858-499-8246

Expedite this application by applying online at **sharphealthplan.com/get-a-quote.**

Make a Payment

To pay your premium with your debit or credit card, please visit **sharphealthplan.com/payment**, or mail your check or money order to:

Sharp Health Plan
P.O. Box 57248
Los Angeles, CA 90074-7248

Sharp Health Plan Customer Care
1-858-499-8300



If you need assistance, we're here to help.
You can call our IFP sales team at 1-858-499-8211 or email us at **ifpsales@sharp.com**.
We are available to assist you Monday through Friday, 8 a.m. to 5 p.m.

Preliminary Information

Are you currently enrolled in a Sharp Health Plan Individual or Family Plan? ☐ Yes ☐ No

If yes, please enter your subscriber identifier number (provided on member ID card): _____

Will you be enrolled in any other health insurance with another carrier? ☐ Yes ☐ No

If yes, please provide insurance company: _____

Do you have an Individual Coverage Health Reimbursement Arrangement (ICHRA) offer from your employer? ☐ Yes ☐ No ☐ Not applicable

How Did You Hear About Us?

☐ Advertisement ☐ Doctor's office ☐ Event ☐ Insurance broker ☐ Previous member ☐ Word of mouth ☐ Other

Step 1a. Subscriber Information (Policyholder) Please print.

First name:	Middle initial:	Last name:

Birth date: MM/DD/YYYY / /	Social Security number: – –	Marital status: ☐ Single ☐ Married ☐ Widowed ☐ State registered domestic partner ☐ Child-only application

Sex assigned at birth:	Gender identity:	Pronouns:	Sexual orientation
☐ Male ☐ Female ☐ Unknown ☐ Choose not to disclose	☐ Man ☐ Woman ☐ Transgender male/trans man/ female-to-male (FTM) ☐ Transgender female/trans woman/male-to-female (MTF) ☐ Nonbinary, neither exclusively male nor female ☐ Additional gender category or other, please specify: _____ ☐ Choose not to disclose	☐ He/him/his ☐ She/her/hers ☐ They/them/theirs ☐ Something else, please specify: _____ ☐ Choose not to disclose	☐ Lesbian or gay or homosexual ☐ Straight or heterosexual ☐ Bisexual ☐ Something else, please specify: _____ ☐ Choose not to disclose

Which race best represents you? Please select all that apply.		Are you of Hispanic, Latino or Spanish origin?	
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian and other Pacific Islander	☐ White ☐ Other: _____ ☐ Unknown ☐ Choose not to disclose	☐ No, not of Hispanic, Latino or Spanish origin ☐ Yes, Cuban ☐ Yes, Mexican, Mexican American or Chicano ☐ Yes, Puerto Rican	☐ Yes, another Hispanic, Latino or Spanish origin ☐ Two or more races ☐ Yes, other ☐ Unknown ☐ Choose not to disclose

Home address (P.O. Box is not allowed):		
City:	State:	ZIP code:
Billing address (if different from above):		
City:	State:	ZIP code:

Cell phone number: ( )	Home phone number: ( )	Other phone number: ( )

Email address:

☐ I have read and consent to receive text messages or automated, prerecorded voice calls according to the terms and conditions set forth by Sharp Health Plan. Visit **sharphealthplan.com/terms** for more information.

Please note any communication assistance or special needs:

Preferred spoken or written language (if not English):

To find a Sharp Health Plan-affiliated provider who meets your needs, and their Provider NPI, please visit **sharphealthplan.com/findaprovider** or call Customer Care at 1-800-359-2002.

Primary care physician (If left blank, Sharp Health Plan will assign a PCP.):		Are you currently a patient with this doctor? ☐ Yes ☐ No
Name:	Provider NPI:	

Pediatric Dental
Please note applicants under age 19 will automatically be enrolled in a pediatric dental plan with Delta Dental of California. To find a Delta Dental dentist in your network, visit **deltadentalins.com**, click "Find a Dentist" and choose a dentist in the DeltaCare USA Network.
You must use a dentist in the DeltaCare USA network to be eligible for dental benefits.

DeltaCare USA is underwritten in these states by these entities: AL — Alpha Dental of Alabama, Inc.; AZ — Alpha Dental of Arizona, Inc.; CA — Delta Dental of California; CO, MA, MI, NC, OK, OR, WA — Dentegra Insurance Company; CT, DC, DE, FL, GA, LA, MS, TN — Delta Dental Insurance Company; ID, KY, MD, MO, NJ, OH, TX — Alpha Dental Programs, Inc.; UT — Alpha Dental of Utah, Inc.; NY — Delta Dental of New York, Inc.; PA — Delta Dental of Pennsylvania. Delta Dental Insurance Company acts as the DeltaCare USA administrator in all these states. These companies are financially responsible for their own products.

Pediatric Vision
Please note: Applicants under age 19 will automatically be enrolled in a pediatric vision plan. Services are provided by Vision Service Plan (VSP). Visit **vsp.com/advantage** to see a list of available eye doctors.

Step 1b. Parent or Legal Guardian

Complete the following information if the subscriber applicant indicated in Step 1a. above is a child under 18 years of age. Otherwise, skip to Step 1d.

First name:	Middle initial:	Last name:
Birth date: MM/DD/YYYY / /	Social Security number: – –	
Home address (P.O. Box is not allowed):		
City:	State:	ZIP code:
Cell phone number: ( )	Home phone number: ( )	Other phone number: ( )
Email address:		

Step 1c. Second Parent or Legal Guardian

Complete the following information if the subscriber applicant indicated in Step 1a. above is a child under 18 years of age. Otherwise, skip to Step 1d.

First name:	Middle initial:	Last name:
Birth date: MM/DD/YYYY / /	Social Security number: – –	
Home address (P.O. Box is not allowed):		
City:	State:	ZIP code:
Cell phone number: ( )	Home phone number: ( )	Other phone number: ( )
Email address:		

Step 1d. Spouse or Domestic Partner

Complete the following information if you wish to add a spouse/domestic partner to this policy. Otherwise, skip to Step 1e.

First name: Middle initial: Last name:

Birth date: MM/DD/YYYY
/ /

Social Security number:
– –

Relationship to subscriber:
☐ Spouse ☐ State registered domestic partner

Sex assigned at birth:
☐ Male
☐ Female
☐ Unknown
☐ Choose not to disclose

Gender identity:
☐ Man
☐ Woman
☐ Transgender male/trans man/ female-to-male (FTM)
☐ Transgender female/trans woman/male-to-female (MTF)
☐ Nonbinary, neither exclusively male nor female
☐ Additional gender category or other, please specify:
_____
☐ Choose not to disclose

Pronouns:
☐ He/him/his
☐ She/her/hers
☐ They/them/theirs
☐ Something else, please specify:
_____
☐ Choose not to disclose

Sexual orientation
☐ Lesbian or gay or homosexual
☐ Straight or heterosexual
☐ Bisexual
☐ Something else, please specify:
_____
☐ Choose not to disclose

Which race best represents you? Please select all that apply.

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian and other Pacific Islander
☐ White
☐ Other: _____
☐ Unknown
☐ Choose not to disclose

Are you of Hispanic, Latino or Spanish origin?

☐ No, not of Hispanic, Latino or Spanish origin
☐ Yes, Cuban
☐ Yes, Mexican, Mexican American or Chicano
☐ Yes, Puerto Rican
☐ Yes, another Hispanic, Latino or Spanish origin
☐ Two or more races
☐ Yes, other
☐ Unknown
☐ Choose not to disclose

Cell phone number:
( )

Home phone number:
( )

Other phone number:
( )

Email address:

To find a Sharp Health Plan-affiliated provider who meets your needs, and their Provider NPI, please visit **sharphealthplan.com/findaprovider** or call Customer Care at 1-800-359-2002.

Primary care physician (If left blank, Sharp Health Plan will assign a PCP.):

Name:

Provider NPI:

Is your spouse/domestic partner currently a patient with this doctor?

☐ Yes ☐ No

Step 1e. Dependents

Complete the following information for each additional dependent, parent or stepparent dependents who meet the definition of a qualifying relative. Otherwise, skip to Step 2.

1. First name: Middle initial: Last name:

Birth date: MM/DD/YYYY / /	Social Security number: – –	Relationship to subscriber:	Sex ☐ M ☐ F ☐ Other

Cell phone number: ( )	Home phone number: ( )	Other phone number: ( )

Email address:

To find a Sharp Health Plan-affiliated provider who meets your needs, and their Provider NPI, please visit **sharphealthplan.com/findaprovider** or call Customer Care at 1-800-359-2002.

Primary care physician (If left blank, Sharp Health Plan will assign a PCP.):		Is your dependent currently a patient with this doctor? ☐ Yes ☐ No
Name:	Provider NPI:	

2. First name: Middle initial: Last name:

Birth date: MM/DD/YYYY / /	Social Security number: – –	Relationship to subscriber:	Sex ☐ M ☐ F ☐ Other

Cell phone number: ( )	Home phone number: ( )	Other phone number: ( )

Email address:

To find a Sharp Health Plan-affiliated provider who meets your needs, and their Provider NPI, please visit **sharphealthplan.com/findaprovider** or call Customer Care at 1-800-359-2002.

Primary care physician (If left blank, Sharp Health Plan will assign a PCP.):		Is your dependent currently a patient with this doctor? ☐ Yes ☐ No
Name:	Provider NPI:	

3. First name: Middle initial: Last name:

Birth date: MM/DD/YYYY / /	Social Security number: – –	Relationship to subscriber:	Sex ☐ M ☐ F ☐ Other

Cell phone number: ( )	Home phone number: ( )	Other phone number: ( )

Email address:

To find a Sharp Health Plan-affiliated provider who meets your needs, and their Provider NPI, please visit **sharphealthplan.com/findaprovider** or call Customer Care at 1-800-359-2002.

Primary care physician (If left blank, Sharp Health Plan will assign a PCP.):		Is your dependent currently a patient with this doctor? ☐ Yes ☐ No
Name:	Provider NPI:	

Step 2. Plan Selection

When selecting a plan, you must ensure that you live in a ZIP code that is within that plan's network. Go to **sharphealthplan.com/networks-by-zip** to see which ZIP codes are included in each plan network. Once you have confirmed your plan network, you must then select one benefit plan from the list below.

Premier Network	
Plan Name	**Metal Tier**
☐ Sharp Platinum 90 Premier HMO	Platinum
☐ Sharp Gold 80 Premier HMO	Gold
☐ Sharp Silver 70 Off Exchange Premier HMO	Silver
☐ Sharp Bronze 60 HDHP Premier HMO[1]	Bronze

Performance Network	
Plan Name	**Metal Tier**
☐ Sharp Platinum 90 Performance HMO	Platinum
☐ Sharp Gold 80 Performance HMO	Gold
☐ Sharp Silver 70 Off Exchange Performance HMO	Silver
☐ Sharp Bronze 60 Performance HMO[1]	Bronze
☐ Sharp Minimum Coverage Performance HMO[1,2]	Minimum Coverage

Additionally, each plan has a designated group of physicians and hospitals associated with it, known as a plan medical group (PMG). The plan network you select will determine the providers that are available to you. To find a Sharp Health Plan-affiliated provider who meets your needs, and their provider NPI, please visit **sharphealthplan.com/findaprovider** or call Customer Care at 1-800-359-2002. Please be sure to select a provider that is affiliated with the plan network for the benefit plan you would like to enroll in. **If you leave the primary care physician (PCP) field blank in Step 1, then Sharp Health Plan will assign a PCP to you automatically**.

Effective date of coverage

What is the requested effective date of coverage? _____

During our yearly open enrollment period (Nov. 1 – Jan. 31*), the following effective dates will apply:

Completed Application Received	Effective Date
Nov. 1, 2026 - Dec. 15, 2026	Jan. 1, 2027
Nov. 1, 2026 – Jan. 31, 2027*	Feb. 1, 2027

In order to activate your coverage on time, Sharp Health Plan must receive your first payment before your effective date.

1 Applicants enrolled in a High-Deductible Health Plan (HDHP), Individual & Family Bronze plan, or Individual & Family Minimum Coverage plan may be eligible to open a Health Savings Account (HSA) with a bank or financial institution of their choice.

2 Minimum coverage plans are available to individuals under the age of 30, as of the effective date of coverage. They are also available to those who have been granted a hardship exemption from the federal government due to affordability or hardship. If an applicant is 30 years of age or older, the certificate of exemption must be provided to Sharp Health Plan in order to process the application. Please visit **healthcare.gov** for additional details.

* Dates for the yearly open enrollment period are subject to change. Please call for the latest deadline information.

Verification of residency is required for all applicants.

This application requires a verification of residency for the subscriber. If the applicant is a minor applying for coverage as a subscriber, the parent(s) or legal guardian(s) must provide proof of residency. In the case of surrogacy, the residence of the legal guardian is required. Surrogate mother proof of residency is not required. Approval for a Sharp Health Plan individual or family plan requires proof that you live in Sharp Health Plan's service area. Proof of residency documents must be received within 10 business days of the receipt of your application.

- Sharp Health Plan requires two documents clearly stating your full name and the address at which you currently reside.
- Proof of residency documents should be the most recent version of the document available.

Examples of acceptable residency documents: gas, electricity, water, or internet billing statement, bank statement, California driver's license, rental agreement, school records, paystub, tax return, property tax statement.

Sharp Health Plan may accept other types of documents on a case-by-case basis. No handwritten or expired documents will be accepted.

Step 3. Broker/Agent/Staff Member

Did you work with a broker/agent/staff member? ☐ Yes ☐ No
If an agent, broker or Sharp Health Plan staff member helped you with this application, please make sure they complete this section. Otherwise, skip to Step 4.

Broker/agent/staff member name:	Agency name:
License number:	National Producer Number (NPN):

Notice to broker/agent/staff member: If you have assisted the applicant in submitting this application, the law requires that you attest to this assistance. If you state any material fact you know to be false, you are subject to a civil penalty of up to ten thousand dollars ($10,000), as authorized under California Health and Safety Code section 1389.8(c).

Select one:

☐ I assisted the applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information, and the applicant understood the explanation.

☐ I did not assist the applicant in any way in completing or submitting this application. All information was completed by the applicant with no assistance or advice from me.

Broker/agent/staff member signature: **x**	Date:

Step 4. Disclosures and Signatures

Please read the following carefully. Each applying family member age 18 and older is required to review the completed application and provide their own signature on the following page. Keep a copy of this application for your records.

Dental Disclosures

I understand that if I have indicated that coverage under the Plan is to be provided only for the dependent child on this form, I am responsible for payment of the required Premium and compliance with all of the provisions and conditions of the Disclosure Form/Contract.

RIGHT OF REIMBURSEMENT: I, on my behalf of my Dependent(s) listed on this Enrollment Application, hereby agree that in the event any dental services provided to me or my Dependent(s) covered by Delta Dental of California are the primary financial responsibility of another party because of other dental coverage, I will fully inform Delta Dental of California and will execute such assignments, liens or other documents which may be necessary to enable Delta Dental of California to recover the value of services and supplies provided.

NOTICE: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud and may be subject to fines and confinement in prison.

Sharp Health Plan Disclosures

- I alone am responsible for the accuracy and completeness of the information provided on this application. I have personally reviewed all information provided on this application, even if I did not fill out the application myself. To the best of my knowledge and belief, all information on this application is accurate, true and complete. If Sharp Health Plan determines that there is fraud (by act, practice or omission) or an intentional misrepresentation of material fact in the information on this application, I understand that coverage may be rescinded as allowed by law.
- Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud and may be subject to fines and confinement in prison.
- In accordance with the disclosure requirements of California Health & Safety Code, Section 1363 (h), this is to advise you that Sharp Health Plan's ratio of health care expenses to premiums received for the last fiscal year with respect to the Sharp Health Plan Individual and Family Plans was 89%.
- Sharp Health Plan's 2027 broker compensation commission schedule is $18 per month, per member for initial enrollments and renewals.

(continued on next page)

Step 4, Continued

- I understand that I may be subject to an audit by Sharp Health Plan, at which time I will need to provide proof of residency, date of birth and dependent eligibility (if applicable). I further understand that I must provide Sharp Health Plan with any new information that arises after the submission of this application but before my enrollment with Sharp Health Plan begins.
- I understand that this plan will only cover services provided through my plan's network of providers and facilities, unless I receive prior written authorization from Sharp Health Plan, or unless the services are emergency care services or out-of-area urgent care.
- If I indicated in Step 1 that I have a language preference other than English and have completed the English version of this application (or version other than in my language preference), I confirm that I understand the questions on this application.
- I understand that California law prohibits an HIV test from being required or used by health care plans as a condition of obtaining coverage.
- Depending on income level and family size, I understand that I may be eligible for financial assistance to help pay for health coverage if I purchase my coverage through Covered California. Sharp Health Plan benefit plans are available through Covered California. I must apply during an open or special enrollment period. Open enrollment is from Nov. 1 through Jan. 31. However, I understand that in order for coverage to begin on Jan. 1, I must submit my application on or before Dec. 15 of the preceding calendar year. If I have a life change such as marriage, divorce, a new child or loss of a job, I can apply at the time the life change occurs ("special enrollment period").
- I understand that I have the right to use Sharp Health Plan's internal dispute resolution process if any dispute or controversy arises regarding the performance, interpretation or breach of the agreement between myself (and/or enrolled dependent) and Sharp Health Plan, whether in contract, tort or otherwise. If I am unsatisfied with the result of the dispute resolution process, I understand that I have the right to voluntary binding arbitration, which is the final step for resolving complaints. Upon receipt of a demand for arbitration, Sharp Health Plan agrees to utilize a neutral arbiter from an appropriate entity. Arbitration will be conducted in accordance with the rules and regulations of the chosen entity.
- The undersigned expressly consents and agrees that Sharp Health Plan, its business associates and other third parties, including debt collectors, may send periodic electronic communications for any lawful purpose, including routine business and/or marketing purposes, at any email address or phone number he/she provides. Messages may be sent by text (SMS), email, automatic telephone dialing systems (auto-dialer), prerecorded messages or live operator calls. Message frequency will vary. Message and data rates apply. The undersigned may opt out of receiving further automated, electronic communications at any time by texting STOP or calling 1-800-827-4277. Whether the undersigned agrees to receive these messages will not affect care or coverage in any way. Visit **sharphealthplan.com/terms** for complete Terms of Use.
- Sharp Health Plan provides health care coverage to you. We are required by state and federal law to protect your health information. We have internal processes to protect your oral, written and electronic Protected Health Information (PHI). And we must give you this Notice that tells how we may use and share your information and what your rights are. We have the right to change the privacy practices described in this Notice. If we do make changes, the new Notice will be available upon request, in our office, and on our website. Sharp Health Plan will utilize data to address disparities and focus quality improvement efforts toward providing appropriate services for race, ethnicity, access and language (REAL) data, sexual orientation and gender identity (SOGI) data, and disability status services. Impermissible use of this data includes use of the data for underwriting and denial of coverage and benefits.

HICAP Notice

- If you or your dependent parent or stepparent is eligible for or enrolled in Medicare, you have the right to be informed of and understand your specific rights and options before enrolling. The Health Insurance Counseling and Advocacy Program (HICAP) provides insurance counseling to senior California residents free of charge.
  - Statewide HICAP Program Telephone: 1-800-434-0222
  - Local HICAP Program:
    Address: 5151 Murphy Canyon Road, Suite 110
    San Diego, CA 92123
    Telephone: 1-858-565-8772

Subscriber (parent or legal guardian for subscriber if under 18)

Name:	Signature: **x**	Date:

Nondiscrimination Notice

Sharp Health Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. Sharp Health Plan does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. A copy of the Nondiscrimination Notice can also be accessed at **sharphealthplan.com/members/notices-and-disclosures**.

Sharp Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters.
- Provides reasonable modifications for individuals with disabilities, and appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternative formats, such as braille or large print, free of charge and in a timely manner, when such modifications, aids, and services are necessary to ensure accessibility and an equal opportunity to participate to individuals with disabilities.
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters and language assistance services, including electronic and written translated documents and oral interpretation, free of charge and in a timely manner, when such services are a reasonable step to provide meaningful access to an individual with limited English proficiency. If you need these services, contact Customer Care at 1-800-359-2002 (TTY 711).

If you believe that Sharp Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability, you can file a grievance with our Civil Rights Coordinator and Section 1557 Nondiscrimination Coordinator at:

- Address: Sharp Health Plan Compliance Department, Attn: Director of Compliance and Regulatory Affairs Department, 8520 Tech Way, Suite 200, San Diego, CA 92123-1450
- Telephone: 1-800-359-2002 (TTY 711)
- Fax: 1-619-740-8572
- Email: shpcompliance@sharp.com

You can file a grievance in person or by mail or fax, or you can also complete the online Grievance / Appeal form on the plan's website, **sharphealthplan.com**. Please call our Customer Care team at 1-800-359-2002 if you need help filing a grievance. You can also file a discrimination complaint if there is a concern of discrimination based on race, color, national origin, age, disability or sex 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 **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, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at **hhs.gov/ocr/office/file/index.html**.

The California Department of Managed Health Care is responsible for regulating health care service plans. If your grievance has not been satisfactorily resolved by Sharp Health Plan or your grievance has remained unresolved for more than 30 days, you may call toll-free the Department of Managed Health Care for assistance:

- 1-888-466-2219 Voice
- 1-877-688-9891 TDD

The Department of Managed Health Care's website has complaint forms and instructions online: **www.dmhc.ca.gov**

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call Sharp Health Plan right away at 1-858-499-8300 or 1-800-359-2002.

IMPORTANTE: ¿Puede leer esta carta? Si no le es posible, podemos ofrecerle ayuda para que alguien se la lea. Además, usted también puede obtener esta carta en su idioma. Para ayuda gratuita, por favor llame a Sharp Health Plan inmediatamente al 1-858-499-8300 o 1-800-359-2002.

Language Assistance Services

English
ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-359-2002 (TTY:711).

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-359-2002 (TTY:711).

繁體中文 **(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 1-800-359-2002 (TTY:711).。

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-359-2002 (TTY:711).

Tagalog (Tagalog – Filipino):
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-359-2002 (TTY:711).

한국어 **(Korean):**
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-359-2002 (TTY:711) 번으로 전화해 주십시오.

Հայերեն **(Armenian):**
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-359-2002 (TTY (հեռատիպ)՝ 711).

فارسی **(Farsi):**

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما

فراهم می باشد. با (TTY:711) 1-800-359-2002 تماس بگیرید.

Русский (Russian):
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-359-2002 (телетайп: 711).

日本語 (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。1-800-359-2002 (TTY:711) まで、お電話にてご連絡ください。

العربية **(Arabic):**

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-359-2002 (رقم هاتف الصم والبكم: 711).

ਪੰਜਾਬੀ **(Punjabi):**
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-359-2002 (TTY:711) 'ਤੇ ਕਾਲ ਕਰੋ।

ខ្មែរ **(Mon Khmer, Cambodian):**
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-359-2002 (TTY:711)។

Hmoob (Hmong):
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-359-2002 (TTY:711).

हिंदी (Hindi):
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध है। 1-800-359-2002 (TTY:711) पर कॉल करें।

ภาษาไทย **(Thai):**
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-359-2002 (TTY:711).