Medicare SUPPLEMENT℠
BROUGHT TO YOU BY HEALTH ALLIANCE

301 S. Vine St.
Urbana, IL 61801-3347
1-877-933-0028 (TTY 711)

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

For Office Use Only: Member Assigned #:

Note: Future requested effective date must be within 60 days of today's date. Requested Effective Date:

SECTION 1: APPLICANT(S)

Applicant A	**Applicant B**
Name *(Last, First, Middle Initial)*	Name *(Last, First, Middle Initial)*
Medicare Number *(required)* ___ ___ ___–___ ___–___ ___ ___ ___ ___	Medicare Number *(required)* ___ ___ ___–___ ___–___ ___ ___ ___ ___
Hospital Insurance (Part A) Entitlement Date *(mm/dd/yyyy)*	Hospital Insurance (Part A) Entitlement Date *(mm/dd/yyyy)*
Hospital Insurance (Part B) Entitlement Date *(mm/dd/yyyy)*	Hospital Insurance (Part B) Entitlement Date *(mm/dd/yyyy)*
Social Security Number ___ ___ ___–___ ___–___ ___ ___ ___	Social Security Number ___ ___ ___–___ ___–___ ___ ___ ___
Permanent Address or P.O. Box including City, State and ZIP Code	Permanent Address or P.O. Box including City, State and ZIP Code
Mailing Address including City, State and ZIP Code *(if different from above)*	Mailing Address including City, State and ZIP Code *(if different from above)*
Home Telephone	Home Telephone
Sex: ❑ Male ❑ Female / Date of Birth	Sex: ❑ Male ❑ Female / Date of Birth
Marital Status: ❑ Married ❑ Single ❑ Widowed	Marital Status: ❑ Married ❑ Single ❑ Widowed

SECTION 2: PLAN SELECTION

Applicant A	Applicant B
Select One: ❑ Plan A ❑ Plan C ❑ Plan F ❑ Plan G ❑ Plan N	Select One: ❑ Plan A ❑ Plan C ❑ Plan F ❑ Plan G ❑ Plan N

SECTION 3: CONSUMER PROTECTION INFORMATION

If you lost or are losing other health insurance coverage and received a notice from you prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application.

Please answer all questions to the best of your knowledge.	**Please answer all questions to the best of your knowledge.**
1. **Yes No** a. Did you turn age 65 in the last six months? ❑ ❑ b. Did you enroll in Medicare Part B in the last six months? ❑ ❑ c. If Yes, what is the effective date? ___________________	1. **Yes No** a. Did you turn age 65 in the last six months? ❑ ❑ b. Did you enroll in Medicare Part B in the last six months? ❑ ❑ c. If Yes, what is the effective date? ___________________
2. Are you covered for medical assistance through the state Medicaid program? (*Note to Applicant:* If you are participating in a "Spend-Down Program" and have not met your "Share of Cost, " please answer No to this question.) ❑ ❑ **If Yes**: a. Will Medicaid pay your premiums for this Medicare Supplement policy? ❑ ❑ b. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ❑ ❑	2. Are you covered for medical assistance through the state Medicaid program? (*Note to Applicant:* If you are participating in a "Spend-Down Program" and have not met your "Share of Cost, " please answer No to this question.) ❑ ❑ **If Yes**: a. Will Medicaid pay your premiums for this Medicare Supplement policy? ❑ ❑ b. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ❑ ❑

Yes No

3. If you had coverage from any Medicare plan other than Original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO, POS or PPO), fill in your start and end dates. (If you are still covered under this plan, leave "End Date" blank)

   Start Date: ________________ End Date: ________________

   a. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ❑ ❑
   (If Yes, read and fill out * section on page 6)

   b. Was this your first time in this type of Medicare plan? ❑ ❑

   c. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ❑ ❑

4. Do you have another Medicare Supplement policy in force? ❑ ❑

   a. If Yes, with what company and what plan do you have?

   ____

   ____

   b. If Yes, do you intend to replace your current Medicare Supplement policy with this policy? ❑ ❑
   (If Yes, read and fill out * section on page 6)

5. Have you had coverage under any other health insurance within the past 64 days? (For example, an employer, union or individual plan) ❑ ❑

   a. If Yes, with what company, and what kind of policy?

   ____

   ____

   b. What are your dates of coverage under the other policy? (If you are still covered under this policy, leave "End Date" blank.)

   Start Date: ________________ End Date: ________________

I certify that (1) the statements and answers above are true, complete and correct to the best of my knowledge and belief. (2) I have read and understand the statements in this document regarding Medicare Supplement coverage. (3) I have received an Outline of Coverage and the *Guide to Health Insurance for People With Medicare*. (4) If applicable, I have read and understand the section called "Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage."

Applicant Signature: ______________________________________

Date: _________________

Legal Guardian Signature: __________________________________
(must provide documentation)

Date: _________________

Yes No

3. If you had coverage from any Medicare plan other than Original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO, POS or PPO), fill in your start and end dates. (If you are still covered under this plan, leave "End Date" blank)

   Start Date: ________________ End Date: ________________

   a. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ❑ ❑
   (If Yes, read and fill out * section on page 6)

   b. Was this your first time in this type of Medicare plan? ❑ ❑

   c. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ❑ ❑

4. Do you have another Medicare Supplement policy in force? ❑ ❑

   a. If Yes, with what company and what plan do you have?

   ____

   ____

   b. If Yes, do you intend to replace your current Medicare Supplement policy with this policy? ❑ ❑
   (If Yes, read and fill out * section on page 6)

5. Have you had coverage under any other health insurance within the past 64 days? (For example, an employer, union or individual plan) ❑ ❑

   a. If Yes, with what company, and what kind of policy?

   ____

   ____

   b. What are your dates of coverage under the other policy? (If you are still covered under this policy, leave "End Date" blank.)

   Start Date: ________________ End Date: ________________

I certify that (1) the statements and answers above are true, complete and correct to the best of my knowledge and belief. (2) I have read and understand the statements in this document regarding Medicare Supplement coverage. (3) I have received an Outline of Coverage and the *Guide to Health Insurance for People With Medicare*. (4) If applicable, I have read and understand the section called "Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage."

Applicant Signature: ______________________________________

Date: _________________

Legal Guardian Signature: __________________________________
(must provide documentation)

Date: _________________

SECTION 4: HEALTH INFORMATION

If "Yes" is answered to any of the following questions, that person is not eligible for coverage

Please answer all questions to the best of your knowledge.	**Applicant A**	**Applicant B**
1. Are you currently confined to a wheelchair or any motorized mobility device?	❑ Yes ❑ No	❑ Yes ❑ No
2. Are you currently hospitalized, confined to a bed, in a nursing home or assisted living facility where you receive skilled nursing care, or receiving any occupational or physical therapy?	❑ Yes ❑ No	❑ Yes ❑ No
3. Have you been advised by a medical professional to have treatment, furthur diagnostic evaluation, diagnostic testing or any surgery that has not been performed?	❑ Yes ❑ No	❑ Yes ❑ No
4. At any time have you been medically diagnosed with, treated for, or had surgery for any of the following:		
A. Chronic kidney disease, kidney failure, or kidney disease requiring dialysis?	❑ Yes ❑ No	❑ Yes ❑ No
B. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), any other chronic pulmonary disorder or any cardio-pulmonary disorder requiring oxygen?	❑ Yes ❑ No	❑ Yes ❑ No
C. Alzheimer's Disease, dementia or any other cognitive disorder?	❑ Yes ❑ No	❑ Yes ❑ No
D. Parkinson's Disease, Multiple Sclerosis or Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)?	❑ Yes ❑ No	❑ Yes ❑ No
E. Systemic Lupus or Myasthenia Gravis?	❑ Yes ❑ No	❑ Yes ❑ No
F. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	❑ Yes ❑ No	❑ Yes ❑ No
G. An organ transplant or been advised to have an organ transplant (excluding cornea transplants)?	❑ Yes ❑ No	❑ Yes ❑ No
H. Chronic hepatitis or cirrhosis?	❑ Yes ❑ No	❑ Yes ❑ No
I. Osteoporosis with fractures?	❑ Yes ❑ No	❑ Yes ❑ No
5. Do you have diabetes with complications including retinopathy, neuropathy, peripheral vascular disease, any related heart disorder (including hypertension/high blood pressure) or kidney disease?	❑ Yes ❑ No	❑ Yes ❑ No
6. Do you have an implanted cardiac defibrillator?	❑ Yes ❑ No	❑ Yes ❑ No
7. Within the past two years, have you been treated for, or been advised by a physician to have treatment for:		
A. Coronary artery disease, angina, heart attack, cardiac angioplasty, bypass surgery or stent placement?	❑ Yes ❑ No	❑ Yes ❑ No
B. Cardiomyopathy, Congestive Heart Failure, aortic or cardiac aneurysm, peripheral vascular disease, vascular angioplasty, endarterectomy, carotid artery disease, heart or heart valve disorder, atrial fibrillation, other heart rhythm disorder, or implantation of a pacemaker?	❑ Yes ❑ No	❑ Yes ❑ No
C. Alcoholism or drug abuse?	❑ Yes ❑ No	❑ Yes ❑ No
D. Any mental or nervous disorder requiring treatment (including hospital confinement) by a psychiatrist, psychologist, counselor or therapist?	❑ Yes ❑ No	❑ Yes ❑ No
E. Internal cancer, lymphoma or melanoma?	❑ Yes ❑ No	❑ Yes ❑ No
F. A stroke or transient ischemic attack (TIA)?	❑ Yes ❑ No	❑ Yes ❑ No
G. Degenerative bone disease, spinal stenosis, rheumatoid arthritis, psoriatic arthritis, arthritis that restricts mobility or have you been advised to have a joint replacement?	❑ Yes ❑ No	❑ Yes ❑ No
8. Have you been advised by a medical professional that surgery may be required within the next 12 months for cataracts?	❑ Yes ❑ No	❑ Yes ❑ No
9. Have you been hospital confined three or more times in the past two years for the same or similar condition?	❑ Yes ❑ No	❑ Yes ❑ No

SECTION 5: MEDICATION INFORMATION

Please list all over-the-counter or prescription medications you have taken in the past 24 months in the table below.

Applicant A

Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than two years?	Prescribed by Primary Physician?	Diagnosis/Condition
			❑ Yes ❑ No	❑ Yes ❑ No	
			❑ Yes ❑ No	❑ Yes ❑ No	
			❑ Yes ❑ No	❑ Yes ❑ No	
			❑ Yes ❑ No	❑ Yes ❑ No	
			❑ Yes ❑ No	❑ Yes ❑ No	
			❑ Yes ❑ No	❑ Yes ❑ No	
			❑ Yes ❑ No	❑ Yes ❑ No	
			❑ Yes ❑ No	❑ Yes ❑ No	
			❑ Yes ❑ No	❑ Yes ❑ No	

Applicant B

Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than two years?	Prescribed by Primary Physician?	Diagnosis/Condition
			❑ Yes ❑ No	❑ Yes ❑ No	
			❑ Yes ❑ No	❑ Yes ❑ No	
			❑ Yes ❑ No	❑ Yes ❑ No	
			❑ Yes ❑ No	❑ Yes ❑ No	
			❑ Yes ❑ No	❑ Yes ❑ No	
			❑ Yes ❑ No	❑ Yes ❑ No	
			❑ Yes ❑ No	❑ Yes ❑ No	
			❑ Yes ❑ No	❑ Yes ❑ No	
			❑ Yes ❑ No	❑ Yes ❑ No	

SECTION 6: PREMIUM PAYMENT INFORMATION

You can pay your monthly plan premium by (choose one):
❑ Mail
❑ Electronic Funds Transfer (EFT) (fill out option A below)
❑ Credit Card (fill out option B below)

Automatic Premium Payment Program

Sign up for automatic payments and enjoy knowing your payment is on time. It's the easy way to pay. Your payment will happen on the first day of each month or on the closest business day. If the amount is going to change, we'll let you know at least 30 days before it does.

If you have any questions, please call our Customer Service Department at 1-877-933-0028, Monday through Friday, 8 a.m. to 5 p.m.

To get started, choose one of the options below and fill out the form.
Option A – Pay from your checking or savings account.
Option B – Pay with your credit card.

John Q Public 1001
102 East Main Street
Urbana, IL 61801 Date
Pay to the Order of Void $
Dollars
① First State Bank
② 102 East Main Street Urbana, IL 61801
Memo ③ ④ Void
⑆012345678⑆ 1001 ⑈12345 678 9⑈

Sample voided check

1. Name of financial institution, **2**. Branch, City, State, ZIP, **3**. ABA routing number, **4**. Account number

Option A – Automatic Premium Payment Authorization (please print)

Name (First, Middle Initial, Last)

Social Security Number

Phone Number ( )

Make this deduction from:

☐ **Checking** (Enclose voided check) ☐ **Savings**

See voided check sample for this information.

Financial Institution of Payor

Name ______

Branch ______

City ______ **State** ______ **ZIP** ______

ABA# ______

Account# ______

I hereby authorize Health Alliance Connect, Inc., and the financial institution named above to initiate monthly debit entries on the 10th of every month and in the amount of the current premium for my plan and to initiate, if necessary, credit entries and adjustments for any debit entries in error to the account and financial institution indicated above. This authority is to remain in effect until Health Alliance has received written notification from me of its termination in such time as to afford Health Alliance and the financial institution a reasonable opportunity to act on it.

Signature ______ Date ______

Option B – Authorization for Monthly Recurring Credit Card Transactions to Pay Premium (please print)

I hereby authorize Health Alliance to keep my signature on file and to process a monthly recurring credit card transaction for payment of my health insurance premium, which is processed on the 1st of every month. I understand this will begin with my next payment.

I acknowledge that this recurring payment will continue until the expiration date of the credit card listed below or until I notify Health Alliance in writing to discontinue the recurring payment.

Member Name: ______

Member Number (if known): ______

Cardholder Name: ______

Card Type: ☐ Visa ☐ MasterCard ☐ Discover

Credit Card Number: ______

Expiration Month/Year: ______

Cardholder Billing Address: ______

City, State, ZIP: ______

Three-digit security code located on the back of the card in the signature strip: ______

Cardholder Signature: ______

Date: ______

*Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to the information furnished in your application you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by Health Alliance Medical Plans, Inc. Your new policy will provide 30 days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY INSURANCE PRODUCER:
I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement or, if applicable, policy will not duplicate your existing Medicare Supplement coverage because you intend to terminate your existing Medicare Supplement or leave your Medicare Advantage Plan. The replacement policy is being purchased for the following reason (Check one and explain below):

	Additional benefits.		My plan has outpatient prescription drug coverage, and I am enrolling in Medicare Part D for disenrollment.
	No change in benefits, but lower premiums.		Fewer benefits and lower premiums.
	Disenrollment from a Medicare Advantage Plan.		Other

Please specify and/or explain:

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy. (Note: If the insurer of the Medicare Supplement policy being applied for does not, or is otherwise prohibited from imposing, preexisting limitations, please skip to statement below.)

2. Section 363(7)(b) of the Illinois Insurance Code 215 ILCS 5/363(7)(b) provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The issuer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

To Be Completed By Insurance Producer:

<table>
<tr><td>
1. List any policies personally sold to the applicant that are still in force. Indicate if policy is to be replaced.

Name of Company ____________________

Type of Coverage ____________________
To be replaced? ❑ Yes ❑ No
</td><td>
1. List any policies personally sold to the applicant that are still in force. Indicate if policy is to be replaced.

Name of Company ____________________

Type of Coverage ____________________
To be replaced? ❑ Yes ❑ No
</td></tr>
<tr><td>
2. List policies personally sold to the applicant in the past five (5) years that are no longer in force.

Name of Company ____________________

Type of Coverage ____________________

Policy Number ____________________
</td><td>
2. List policies personally sold to the applicant in the past five (5) years that are no longer in force.

Name of Company ____________________

Type of Coverage ____________________

Policy Number ____________________
</td></tr>
</table>

To the best of my knowledge, replacement ❑ is / ❑ is not involved in the purchase. I certify that I have reviewed the current health insurance coverage of the applicant and find that additional coverage, of the type and amount applied for, is appropriate for the applicant's needs.

Insurance Producer Signature ____

Printed Full Name of Insurance Producer ____

Important Information Regarding Medicare Supplement Coverage

You do not need more than one Medicare Supplement policy. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

Disabled individuals under age 65 who are enrolled in Medicare Part B may enroll in the Medicare Supplement policy during their Open Enrollment period.

If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy. The benefits and premiums under your Medicare Supplement policy will be suspended during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstituted if requested within 90 days of losing Medicaid eligibility.

If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days after losing your employer or union-based group health plan.

If you are under 65 and on Medicare, but you declined a Medicare Supplement policy because you were still covered under an employer group health plan, you will have a 63-day Open Enrollment period if the employer plan terminates or ceases to provide health benefits that supplement Medicare. If you are currently enrolled in a Medicare Advantage plan or have a Medicare Supplement policy and the insurance company goes out of business, withdraws from the market, or misrepresented the product you purchased, you will be eligible for a 63-day Open Enrollment period.

Counseling services are available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the State Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low Income Medicare Beneficiary (SLMB). For information on Medicaid eligibility, call 1-800-252-8635. For questions on Medicare Supplement insurance, call 1-800-MEDICARE (1-800-633-4227).

I hereby apply for membership and request an inspection policy for the Medicare Supplement policy indicated. I understand that once my first premium payment is received, I will be covered as of the date specified on my Medicare Supplement Policy Schedule. Once coverage begins, I understand I have 30 days to return my policy materials and receive a full refund for any premiums paid. Services are covered only when received on or after the effective date of the policy chosen, except in the case of inpatient services, where the admission must occur on or after the effective date to be covered.

I hereby authorize and direct Health Alliance Medical Plans, Inc., (Health Alliance) and/or the plan administrator to obtain all information and medical records from any health care provider that, either before or after acceptance of my application and enrollment in the plan, advised, treated, attended or rendered service to me, or that has in their possession any information or records with respect to advice, treatment or services. This authorization is limited only to such personal information and medical records as are necessary for Health Alliance and/or the plan administrator to determine the acceptability of this application; post-enrollment claims review; treatment; coordination of care; quality improvement; measurement, including reporting activities, surveys and accreditation; medical management and reporting activities; utilization review; complaints and appeals and requests for services or benefits under the plan, or for establishment and maintenance of proper records. A copy of this authorization and release shall be as valid as the original and will remain in effect as long as I am enrolled in the plan or until rescinded by me in writing.

I authorize Health Alliance, at its option, to pay providers directly for services rendered. In addition, I hereby authorize the Centers for Medicare & Medicaid Services, or its duly appointed Part A or Part B carriers or intermediaries, to release to Health Alliance information they may require in the processing of my supplement insurance or other insurance coverage I may have through them. This information may include Explanations of Medical Benefits (EOMBs), “deduct-not-met” or denial letters, Part B billing forms and date of entitlement to Part B of Medicare. I further authorize ongoing release of this information to Health Alliance for as long as I am enrolled under the supplement coverage. I understand I may revoke this authorization for release of Title XVIII (Medicare) information for supplement insurance coverage at any time by notifying Health Alliance in writing. I understand that if I do rescind my authorization for the release of Title XVIII information, I will need to fill out claim forms, and some records could be released before the rescission takes effect.

DISCRIMINATION IS AGAINST THE LAW

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

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

If you need these services, contact customer service.

If you believe that Health Alliance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Health Alliance Medicare, Member Services, 301 S. Vine Street, Urbana, IL 61801 or 316 Fifth Street, Wenatchee, WA 98801, telephone for members in Illinois, Indiana, Iowa and Ohio: 1-800-965-4022; telephone for members in Washington: 1-877-750-3550 TTY: 711, fax: 217-337-3425, MemberServices@healthalliance.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Member Services is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, TTY: 1-800-537-7697.

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: Si habla Español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. IA, IL, IN, OH: Llame 1-800-965-4022, WA Llame: 1-877-750-3550 (TTY: 711).

注意：如果你講中文，語言協助服務，免費的，都可以給你。IA, IL, IN, OH: 呼叫 1-800-965-4022, WA: 呼叫 1-877-750-3550（TTY: 711）。

UWAGA: Jeśli mówić Polskie, usługi pomocy języka, bezpłatnie, są dostępne dla Ciebie. IA, IL, IN, OH: Zadzwoń 1-800-965-4022, WA: Zadzwoń 1-877-750-3550 (TTY: 711).

Chú ý: Nếu bạn nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ, miễn phí, có sẵn cho bạn. IA, IL, IN, OH: Gọi 1-800-965-4022, WA: Gọi 1-877-750-3550 (TTY: 711).

주의 : 당신이한국어, 무료 언어 지원 서비스를 말하는 경우 사용할 수 있습니다. 1-800-965-4022 IA, IL, IN, OH: 전화 WA: 1-877-750-3550 전화 (TTY: 711).

ВНИМАНИЕ: Если вы говорите русский, вставки услуги языковой помощи, бесплатно, доступны для вас. IA, IL, IN, OH: Вызов 1-800-965-4022, WA: Вызов 1-877-750-3550 (TTY: 711).

Pansin: Kung magsalita ka Tagalog, mga serbisyo ng tulong sa wika, nang walang bayad, ay magagamit sa iyo. IA, IL, IN, OH: Tumawag 1-800-965-4022, WA: Tumawag 1-877-750-3550 (TTY: 711).

انتباه: إذا كنت تتكلم العربية، فإن خدمات المساعدة اللغوية متوفرة لك مجاناً. إيلينوي، إنديانا، أوهايو: اتصل بالرقم 4022-965-800-1، ولاية واشنطن: اتصل بالرقم: 3550-750-877-1 (إذا كنت تعاني من الصمم أو صعوبة في السمع فاتصل على الرقم 711)

Aufmerksamkeit: Wenn Sie Deutsch sprechen, Sprachassistenzdienste sind kostenlos, zur Verfügung. IA, IL, IN, OH: Anruf 1-800-965-4022, WA: Anruf 1-877-750-3550 (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. IA, IL, IN, OH: Appelez 1-800-965-4022, WA: Appelez 1-877-750-3550 (TTY: 711).

ધ્યાન: તમે વાત તો ગુજરાતી, ભાષા સહાય સેવાઓ, મફત, તમારા માટે ઉપલબ્ધ છે. IA, IL, IN, OH: કૉલ 1-800-965-4022, WA: કૉલ 1-877-750-3550 (TTY: 711).

注意：あなたは、日本語 、無料で言語支援サービスを、話す場合は、あなたに利用可能です。1-800-965-4022 IA, IL, IN, OH: コール 1-877-750-3550 WA: コール（TTY: 711）。

LET OP: Als je spreekt pennsylvania nederlandse, taalkundige bijstand diensten, gratis voor u beschikbaar zijn. IA, IL, IN, OH: Bel 1-800-965-4022, WA: Bel 1-877-750-3550 (TTY: 711).

УВАГА: Якщо ви говорите український, вставки послуги мовної допомоги, безкоштовно, доступні для вас. IA, IL, IN, OH: Виклик 1-800-965-4022, WA: Виклик 1-877-750-3550 (TTY: 711).

ATTENZIONE: Se si parla italiano, servizi di assistenza linguistica, a titolo gratuito, sono a vostra disposizione. IA, IL, IN, OH: Chiamare 1-800-965-4022, WA: Chiamare 1-877-750-3550 (TTY: 711).