



# Level Funded plan participant enrollment application form

## UnitedHealthcare Level Funded

Send correspondence to: P.O. Box 31394, Salt Lake City, UT 84131 • Phone: 1-877-797-8812

Fill out the entire enrollment application form to avoid processing delay. Please clearly print all information.

Enrollee Social Security Number

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Group No.

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### Enrollee Information

Plan Sponsor Name

Plan Sponsor Address (If more than one location)

Last Name

First Name

Initial

Single  
 Married

Address

Apt #

City

State

ZIP

County

Phone #

Email Address

Cell Phone #

Occupation

Date Employed Full Time

Average Hours Worked Per Week

Are you an independent contractor?  Yes  No

## Enrollee and Dependent Information (only for those applying)

If you need to list additional dependents, please use lined paper, sign and date it, and check this box:

	Enrollee	Spouse	Child 1	Child 2	Child 3
First Name					
Middle Initial					
Last Name					
Gender	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F
Date of Birth					
Height					
Weight					
Social Security Number					
Primary Care Physician's Name					
<b>Eligibility and Other Insurance (insurance that will be kept in addition to this coverage)</b>					
Currently Working Full Time	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Plan to Keep Other Insurance Coverage	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Other Insurance Policy Number					
Name of Other Insurance Company(ies)					
Covered by Medicare/Medicaid	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Medicare/Medicaid Coverage Effective Date					

## Coverage and Change Request Information

Medical:  Plan Participant  Family  Plan Participant/Spouse  Plan Participant/Dependent Child(ren)

Name of Medical Plan You Have Selected: \_\_\_\_\_

Change Request:  Marriage  Divorce  Adoption  Returning to School Full Time  Court Order

Date of Event: \_\_\_\_\_ (you may be required to provide proof of event)

Attach a written and signed statement by the plan sponsor for a requested coverage effective date other than plan participant effective date. Effective date may not be guaranteed.

## Medical History

Please answer the following questions for yourself and each person listed on the Enrollee and Dependent Information Section on page 2 of this form. Please answer completely and truthfully. Has anyone on this enrollment application form been diagnosed, consulted with, or been examined or treated by any health care professional during the last 5 years for any illness, injury, or health condition in any of the categories listed below? If yes, please check the box that most appropriately describes the problem and explain fully below. Please note that, if you fraudulently leave out or fraudulently misrepresent information, we may terminate or not renew your coverage, or we may change your monthly payment retroactive to the date your coverage became effective.

**All statements contained in this entire form must be true and correct and no material information can be withheld or omitted.**

1 Cancer/Tumor <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Breast <input type="checkbox"/> Colon <input type="checkbox"/> Leukemia <input type="checkbox"/> Lymphoma <input type="checkbox"/> Liver <input type="checkbox"/> Lung <input type="checkbox"/> Melanoma <input type="checkbox"/> Testicular <input type="checkbox"/> Brain <input type="checkbox"/> Ovarian <input type="checkbox"/> Cervical <input type="checkbox"/> Prostate <input type="checkbox"/> Other Cancer <input type="checkbox"/> Non-Malignant Tumor-Location of Tumor_____
2 Heart/ Circulatory <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Aneurysm <input type="checkbox"/> Bypass <input type="checkbox"/> Angioplasty/Stent <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Heart Disease <input type="checkbox"/> Elevated Cholesterol/Triglycerides <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Stroke <input type="checkbox"/> Angina <input type="checkbox"/> Hemophilia <input type="checkbox"/> Blood Clots <input type="checkbox"/> Pacemaker/ICD <input type="checkbox"/> Blood Disorder <input type="checkbox"/> Sickle Cell Anemia <input type="checkbox"/> Other_____
3 Reproductive <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Current Pregnancy (due date_____ if multiples #_____) <input type="checkbox"/> Pregnancy Complications <input type="checkbox"/> Fibroids <input type="checkbox"/> Menstrual Disorders <input type="checkbox"/> Breast Disorders <input type="checkbox"/> Endometriosis <input type="checkbox"/> Infertility <input type="checkbox"/> Other_____
4 Intestinal/ Endocrine <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Chronic Pancreatitis <input type="checkbox"/> Colon Disorder <input type="checkbox"/> Crohn's <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Diabetes <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Hepatitis B/C <input type="checkbox"/> Reflux <input type="checkbox"/> Liver Disorder <input type="checkbox"/> Ulcer <input type="checkbox"/> Growth Hormones <input type="checkbox"/> Gallbladder <input type="checkbox"/> Gastric Bypass <input type="checkbox"/> Other_____
5 Brain/Nervous <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Alzheimer's <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Migraines <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Paralysis <input type="checkbox"/> Seizures/Epilepsy <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Head Injury <input type="checkbox"/> Cyst <input type="checkbox"/> Other_____
6 Immune <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Scleroderma <input type="checkbox"/> ALS <input type="checkbox"/> Psoriasis <input type="checkbox"/> AIDS <input type="checkbox"/> HIV+ <input type="checkbox"/> Lupus <input type="checkbox"/> Immunodeficiency <input type="checkbox"/> Other_____
7 Lung/Respiratory <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Allergies <input type="checkbox"/> Asthma <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Emphysema <input type="checkbox"/> Sarcoidosis <input type="checkbox"/> Lung Disorders <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Chronic Bronchitis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Other_____
8 Eyes/Ears/ Nose/Throat <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Acoustic Neuroma <input type="checkbox"/> Cataracts <input type="checkbox"/> Cleft Lip/Palate <input type="checkbox"/> Deviated Septum <input type="checkbox"/> Glaucoma <input type="checkbox"/> Retinopathy <input type="checkbox"/> Chronic Ear Infections <input type="checkbox"/> Chronic Sinusitis <input type="checkbox"/> Other_____
9 Urinary/Kidney <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Kidney Stones <input type="checkbox"/> Kidney Disorders <input type="checkbox"/> Bladder Disorders <input type="checkbox"/> Polycystic Kidney Disease <input type="checkbox"/> Prostate Disorder <input type="checkbox"/> Renal Failure <input type="checkbox"/> Other_____
10 Bones/ Muscles <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Bulging/Herniated Disc <input type="checkbox"/> Joint Injury <input type="checkbox"/> Fibromyalgia/Chronic Fatigue Syndrome <input type="checkbox"/> Chronic Pain Syndrome <input type="checkbox"/> Shoulder Disorder <input type="checkbox"/> Knee Disorder <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Back Disorder <input type="checkbox"/> Neck Disorder <input type="checkbox"/> Other_____
11 Behavioral Health <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Anxiety/Depression <input type="checkbox"/> ADHD <input type="checkbox"/> Bipolar Depression <input type="checkbox"/> Manic Depression <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Autism <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Inpatient Alcohol/Drug <input type="checkbox"/> Inpatient Mental Health Hospital <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Other_____
12 Transplant <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Bone Marrow <input type="checkbox"/> Organ <input type="checkbox"/> Discussed Possible Future Transplant <input type="checkbox"/> Stem Cell <input type="checkbox"/> Transplant Complications <input type="checkbox"/> Other_____
13 Other <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Condition not mentioned above with claims in excess of \$5,000 <input type="checkbox"/> Disability <input type="checkbox"/> Congenital Disorder
14 Tobacco/ E-cigarette <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Anyone on this enrollment form used tobacco or nicotine products including e-cigarette or similar devices in the past 12 months: Person _____
15 Medications <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Current Medications: Person_____ # of Meds ___ Person_____ # of Meds ___ (list meds below) <input type="checkbox"/> Medications taken within the past 12 months: Person_____ # of Meds ___ Person_____ # of Meds ___ (list meds below)

Please give details of all "yes" answers above. (If additional space is required, please attach a separate sheet and date and sign that sheet.)

Question #	Person	Condition/Diagnosis	Treatment/Meds	Physician's Name	Dates Treated	Prognosis

## Prior Medical Coverage Information

Yes  No Have you or any dependents applying for coverage been covered by this plan sponsor's prior group medical plan?

Yes  No Have you or any dependents applying for coverage been covered by any medical plan other than this plan sponsor's prior group plan?

If yes:

Insurance Company Name \_\_\_\_\_ Phone # \_\_\_\_\_ Policy/Group # \_\_\_\_\_

Termination Date \_\_\_\_\_ Effective Date \_\_\_\_\_ Reason for Termination \_\_\_\_\_

Who was covered? \_\_\_\_\_

Type of Plan:  Prior Plan Sponsor Group Plan  Spouse's Plan Sponsor Group Plan  Individual Policy  Other \_\_\_\_\_

## Signature

I declare that all statements and responses contained in this entire form, and in any other health insurance administration and/or coverage application form that I completed within the last 120 days that was provided to UnitedHealthcare, are true and correct and that no material information has been withheld or omitted. I also understand that the information provided on this form is used to make decisions regarding eligibility and pricing. I understand that misrepresentation, concealment or omission of fact, or a mistake of fact (whether or not a mutual mistake), could materially affect the underwriting, premium, rating or terms and conditions of my plan sponsor's Excess Loss Insurance Policy ("Policy") which could result in changes to the terms and conditions of my plan sponsor's Excess Loss Insurance Policy, including retroactive increased premium rates and attachment points, or termination of that Policy. I also understand that willful or intentional misrepresentation, concealment or omission of any material fact affecting terms, conditions, or underwriting of my plan sponsor's Excess Loss Insurance Policy could result in that Policy being null and void in its inception.

I understand and agree that the Plan Sponsor is not bound by any statement made by or to any agent unless written herein. I agree that no medical benefits will be effective until the date specified in the Summary Plan Description. If I am now waiving medical coverage for myself and/or for my dependents, I have read the entire Waiver provision and understand the enrollment requirements if I make a request for such coverage at a later date. Coverage is effective only after approval and satisfaction of any probationary period.

In some states, any person who, knowingly and with intent to defraud an insurance company or plan administrator, submits an enrollment application form or files a claim containing any materially false information may be guilty of fraud, which is a crime.

All pages must be attached and complete, including this authorization, for the enrollment application form to be considered complete. Incomplete enrollment application forms may be rejected.

I (we) understand that UnitedHealthcare and Affiliates is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments. I have a continuing obligation to report changes in health status (e.g. received medical advice, diagnosis, care or treatment) after I sign the enrollment form and before receipt of my identification card. Please maintain a copy of this authorization for your records.

### Authorization to Disclose Medical Information for Enrollment

I hereby authorize those physicians, medical practitioners, hospitals, clinics, veterans administration facilities, pharmacy benefit managers, medical information services, urgent care facilities, and other medical or medically related entities, insurance or reinsurance companies, and consumer reporting agencies that have information available as to the present or former physical health condition, including drug or alcohol abuse, and/or treatment of me or my dependents proposed for coverage to release any and all such information, including, but not limited to, medical records, health care provider notes, laboratory tests and results, diagnoses, treatment, and prognoses. I understand the information obtained by use of this authorization may be used to determine eligibility for issuance of health coverage for me and my dependents. This authorization is not applicable to psychotherapy notes.

I agree that a photographic copy of this authorization shall be as valid as the original and that this authorization shall expire 15 months after the termination of any coverage I obtain. I understand that I may request a copy of this authorization. I understand that I may revoke this authorization at any time in writing unless action has been taken in reliance on my authorization. Any information obtained will not be released to any person or organization, except to reinsuring companies or other persons or organizations performing business or legal services in connection with my enrollment for the coverage, for any claim, for medical management purposes, or as may be otherwise lawfully required or as I may further authorize.

Applicant Signature X \_\_\_\_\_ Date \_\_\_\_\_

If signed by a representative of enrollee, please indicate the representative's legal authority to act on behalf of enrollee.

## Waiver (please complete if you are waiving medical coverage)

I waive medical coverage for:  Self (and dependents) Please state reason for waiving coverage:

Spouse

Dependent Children

Qualifying Coverage: \_\_\_\_\_ Other: \_\_\_\_\_

If I have waived coverage for myself and/or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself and/or my dependents in the plan, provided that I request enrollment within 31 days after my other coverage ends because of involuntary loss of other coverage (divorce, death, legal separation, termination of employment, reduction in number of hours of employment). In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll my dependents, provided that I request enrollment within 31 days after the date of the event.

Applicant Signature X \_\_\_\_\_ Date \_\_\_\_\_

**YOUR RIGHTS REGARDING THE RELEASE AND USE OF GENETIC INFORMATION** – The results of any genetic test, including genetic test information, shall not be used as the basis to: (1) terminate, restrict, limit or otherwise apply conditions to the coverage of an individual or family member under the plan, or restrict the sale of the plan to an individual or family member; (2) cancel or refuse to renew the coverage of an individual or family member under the plan; (3) deny coverage or exclude an individual or family member from coverage under the plan; (4) impose a rider that excludes coverage for certain benefits or services under the plan; (5) establish differentials in monthly costs or cost-sharing for coverage under the plan; (6) otherwise discriminate against an individual or family member in the provision of insurance.

**ATTENTION:** Free language assistance services and free communications in other formats, such as large print, are available to you. Call the toll-free number on your member identification card. (TTY 711).

**ማሳሰቢያ፡- አማርኛ (Amharic)** የሚናገሩ ከሆኑ፣ ነፃ የቋንቋ እገዛ አገልግሎቶች እና ነፃ ተግባሮች እንደ ትልቅ እትም ባሉ ሌሎች ቅርፀቶች ለእርስዎ ይገኛሉ። በአባልነት መታወቂያ ካርድዎ ላይ ያለውን ነፃ የስልክ ቁጥር ይደውሉ።

**ملاحظة:** إذا كنت تتحدث اللغة العربية (Arabic)، ستوفر لك خدمات المساعدة اللغوية المجانية والمراسلات المجانية بتنسيقات أخرى، مثل الطباعة بأحرف كبيرة. اتصل بالرقم المجاني المدون على بطاقة تعريف العضو خاصتك.

**দেখুন:** আপনি যদি বাংলায় (Bengali-Bangala) কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়তা পরিষেবা এবং বড় মুদ্রণের মতো অন্যান্য ফরম্যাটে যোগাযোগগুলি আপনার জন্য বিনামূল্যে উপলব্ধ। আপনার সদস্যের পরিচয়পত্রের কার্ডের টোল-ফ্রি নম্বরে কল করুন

**ចំណាំ:** ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ (Cambodian-Mon-Khmer) សេវាជំនួយភាសាភីតិភីត្រៃ និងការទំនាក់ទំនងភីតិភីត្រៃក្នុងប្រព័ន្ធផ្សព្វផ្សាយដទៃទៀត ដូចជាពុម្ពអក្សរធំ មានសម្រាប់អ្នក។ ទូរសព្ទមកលេខភីតិភីត្រៃនៅលើបណ្ណសម្គាល់សមាជិករបស់អ្នក។

**ATENSHUN:** Gare kapetal **Faluwasch (Carolinian)**, ye toore paliuwal kapetal Faluwasch lane bwe me sew format, ta tipel lane, bwe bwale tepangiyom. Kol yegili nampa la ye toore paliuwal woal kard la laumw.

**ATENSYON:** Yanggen fifino' hao **CHamoru (Chamorro)**, guaha setbisio siha para hãgu ni' fãtto, i setbision fino' pat lengguãhi yan fina'uma'epiha gi otro na manera siha taiguihi i para mana'dångkolo i inemprenta. Ågang i dibãtdi na numiru gi kattã-mu aidentifikasion membro.

**請注意：**如果您說中文 (Chinese - Traditional)，您可以獲得免費語言協助服務和大字體等其他格式的免費通訊。請致電您的會員身份卡上的免付費電話號碼。

**ATTENTION:** Si vous parlez **français (French)**, des services d'assistance linguistique et des communications dans d'autres formats, notamment en gros caractères, sont mis à votre disposition gratuitement. Appelez le numéro gratuit figurant sur votre carte de membre.

**ATANSYON:** Si w pale **Kreyòl Ayisyen (French Creole-Haitian Creole)**, gen sèvis lang gratis ak kominikasyon nan lòt fòm lo disponib, tankou sa ki enprime ak gwo lèt. Rele nimewo gratis ki sou kat idantifikasyon manm ou an.

**ACHTUNG:** Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlose Sprachassistentendienste und kostenlose Kommunikation in anderen Formaten, wie zum Beispiel große Schrift, zur Verfügung. Rufen Sie die gebührenfreie Nummer auf Ihrer Mitgliedskarte an.

**ΠΡΟΣΟΧΗ:** Εάν μιλάτε **ελληνικά (Greek)**, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες γλωσσικής βοήθειας και δωρεάν επικοινωνία σε άλλες μορφοποιήσεις, όπως μεγάλα γράμματα. Καλέστε τον αριθμό χωρίς χρέωση στην κάρτα μέλους σας.

**ध्यान आपो:** જો તમે **ગુજરાતી (Gujarati)** બોલતા હો તો વિના મૂલ્યે ભાષાકીય મદદરૂપ સેવાઓ અને અન્ય ફોર્મેટમાં વિના મૂલ્યે સંચાર, જેમ કે મોટી પ્રિન્ટ, તમારા માટે ઉપલબ્ધ છે. તમારા સભ્ય ઓળખ કાર્ડ પરના ટોલ-ફ્રી નંબર પર કોલ કરો.

**ध्यान दें:** यदि आप **हिंदी (Hindi)** बोलते हैं, तो आपके लिए मुफ्त भाषा सहायता सेवाएँ और अन्य प्रारूपों में मुफ्त संचार, जैसे कि बड़े प्रिंट, उपलब्ध हैं। अपने सदस्य पहचान पत्र पर दिए गए टोल-फ्री नंबर पर कॉल करें।

**LUS TSEEM CEEB:** Yog tias koj hais **lus Hmoob (Hmong)**, muaj cov kev pab cuam txhais lus thiab muaj kev sib txuas lus pab dawb ua lwm hom ntawv, xws li luam ua ntawv loj rau koj. Thov hu rau tus xov tooj hu dawb ntawm koj daim npav ID.

**ATENSIÓN:** No agsasaoka iti **Ilocano (Ilocano)**, magun-odmo dagiti libre a serbisio ti tulong iti pagsasao ken libre a komunikasion iti dadduma a pormat, kas iti dadakkel a letra. Tawagan ti awan-bayadna a numero a masarakan iti kard a pakabigbigam kas miembro.

**ATTENZIONE:** se parla **italiano (Italian)**, può usufruire di servizi di assistenza linguistica gratuiti e comunicazioni gratuite in altri formati, come ad esempio la stampa a caratteri grandi. Chiami il numero verde riportato sul Suo tesserino identificativo.

**注意事項：**日本語 (**Japanese**) を話される場合、無料の言語支援サービスや、拡大文字など他の形式での無料のコミュニケーションをご利用いただけます。会員証に記載されているフリーダイヤルにお電話ください。

**알림 사항:** **한국어(Korean)**를 사용하시는 경우 무료 언어 지원 서비스와 대형 활자체 등 다른 형식으로 된 의사 소통 매체를 이용하실 수 있습니다. 회원 ID 카드에 나와 있는 무료 전화번호로 전화해 주십시오.

**ໝາຍເຫດ:** ຖ້າຫາກທ່ານເວົ້າ**ພາສາລາວ (Lao)**, ທ່ານສາມາດໃຊ້ບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາພຣີ ແລະ ການສື່ສານໃນຮູບແບບອື່ນໆພຣີ, ເຊັ່ນ: ການພິມຕົວອັກສອນຂະໜາດໃຫຍ່. ໂທຫາເບີໂທພຣີຢູ່ທີ່ບັດປະຈຳຕົວສະມາຊິກຂອງທ່ານ.

**BAA'ÁKONÍNÍZIN: Diné (Navajo)** saad bee yáníłti'go, t'áá jíík'eh saad bee áka'e'eyeed bee áka'anída'wo'í dóó nááná łahgo át'éego bee hadadilyaa bee ahxít hane'í, díí nitsaago bee ak'eda'ashchínígíí, náhóló. Bee atah nil'íní ninaaltsoos nitł'izí bee nééhoziní bąąh t'áá hiik'eh bee hane'í námboo bee hodíilnih.

**ध्यान दिनुहोस्:** यदि तपाईंले **नेपाली (Nepali)** बोल्नुहुन्छ भने, निःशुल्क भाषा सहायता सेवाहरू र अन्य ढाँचाहरूमा निःशुल्क संचारहरू, जस्तै ठूलो छाप, तपाईंका लागि उपलब्ध छन्। आफ्नो सदस्य पहिचान कार्डमा रहेको टोल फ्री नम्बरमा कल गर्नुहोस्।

**WICHDICH:** Wann du **Deutsch (Pennsylvania Dutch)** schwetzscht, kannscht du Schprouch-Hilf un differnti Sadde Schreiwes griege, so wie Gross-Druck (large print), unni as es dich ennich eppes koschde zellt. Call die Toll-Free-Nummer as uff dei Member Identification Card is.

**توجه:** اگر به زبان **فارسی (Persian-Farsi)** صحبت می‌کنید، خدمات رایگان کمک زبانی و ارتباطات رایگان در قالب‌های دیگر، مانند چاپ بزرگ، در دسترس شما هستند. با شماره رایگان مندرج روی کارت شناسایی عضویت‌تان تماس بگیرید.

**UWAGA:** Dla osób mówiących po **polsku (Polish)** dostępne są bezpłatne usługi pomocy językowej i bezpłatne komunikaty w innych formatach, takich jak duży druk. Prosimy zadzwonić pod bezpłatny numer podany na karcie identyfikacyjnej.

**ATENÇÃO:** se você fala **português (Portuguese)**, tem à sua disposição serviços gratuitos de assistência linguística e comunicações gratuitas em outros formatos, como caracteres grandes. Ligue para o número gratuito que se encontra no seu cartão de identificação de membro.

**ਧਿਆਨ ਦਿਓ:** ਜੇ ਤੁਸੀਂ **ਪੰਜਾਬੀ (Punjabi)** ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਹੋਰ ਫਾਰਮੈਟਾਂ, ਜਿਵੇਂ ਕਿ ਵੱਡੇ ਪ੍ਰਿੰਟ, ਵਿੱਚ ਮੁਫਤ ਸੰਚਾਰ ਉਪਲਬਧ ਹਨ। ਆਪਣੇ ਮੈਂਬਰ ਪਛਾਣ ਕਾਰਡ 'ਤੇ ਟੋਲ-ਫ੍ਰੀ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ।

**ВНИМАНИЕ!** Если вы говорите на **русском** языке (**Russian**), вам доступны бесплатные услуги языковой поддержки и бесплатные материалы в других форматах, например напечатанные крупным шрифтом. Звоните по бесплатному номеру телефона, указанному на вашей идентификационной карте участника.

**FA'AALIGA:** Afai e te tautala i le **Faa-Samoa (Samoan-Fa'asamoa)**, o lo'o avanoa mo oe 'au'aunaga fesoasoani tau gagana e leai se totogi ma feso'ota'iga e leai se totogi i isi faiga, e pei o lomiga e lapopo'a mata'itusi. Valaau i le numera e leai se totogi i lau kata faailo o le sui auai (ID).

**ATENCIÓN:** Si habla **español (Spanish)**, hay servicios de asistencia de idiomas y comunicaciones en otros formatos como letra grande, sin cargo, a su disposición. Llame al número gratuito que figura en su tarjeta de identificación de miembro. (TTY 711).

**PAUNAWA:** Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika at libreng komunikasyon sa ibang mga format, tulad ng malalaking print. Tawagan ang walang bayad na numero na nasa iyong ID card ng miyembro.

**โปรดทราบ หากคุณพูดภาษาไทย (Thai) ได้**

คุณสามารถใช้บริการช่วยเหลือด้านภาษาฟรีและการสื่อสารในรูปแบบอื่น ๆ ฟรี เช่น การพิมพ์ด้วยตัวอักษรขนาดใหญ่ โทรไปยังหมายเลขโทรฟรีสำหรับสมาชิกตามบัตรประจำตัวของคุณ

**ЗВЕРНІТЬ УВАГУ!** Якщо ви розмовляєте **українською (Ukrainian)**, ви можете безоплатно користуватися послугами мовної підтримки, а також безоплатно отримувати інформаційні матеріали в інших форматах, як от набрані великим шрифтом. Телефонуйте на безкоштовний номер телефону, зазначений на вашій ідентифікаційній картці учасника.

**توجہ دیں:** اگر آپ اردو (Urdu) زبان بولتے ہیں تو زبان کی معاون خدمات اور دیگر فارمیٹس میں مواصلات، جیسے بڑے پرنٹ، آپ کے لیے مفت دستیاب ہیں۔ اپنے ممبر شناختی کارڈ پر دیئے گئے ٹول فری نمبر پر کال کریں۔

**LƯU Ý:** Nếu quý vị nói **Tiếng Việt (Vietnamese)**, quý vị sẽ được cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí và các phương tiện trao đổi liên lạc miễn phí ở các định dạng khác, chẳng hạn như bản in chữ lớn. Gọi đến số điện thoại miễn phí có trên thẻ định danh thành viên của quý vị.