GROUP #	SECTION #	SOC. SEC. #	ACCOUNT #	CATEGORY

SECTION 1 — ENROLLMENT EVENTS

PLEASE CHECK ALL THAT APPLY – IF YOU ARE DECLINING COVERAGE, COMPLETE SECTIONS 2, 8 AND 9 ONLY

☐ **NEW ENROLLEE** ☐ **ADD DEPENDENT** ☐ **OPEN ENROLLMENT** ☐ **OTHER CHANGES**

ARE YOU APPLYING AS A RESULT OF A SPECIAL ENROLLMENT EVENT? ☐ NO ☐ YES, EVENT DATE:

EVENT: ☐ **NEW HIRE** ☐ **MARRIAGE*** ☐ **BIRTH**

☐ ADOPTION, PLACEMENT FOR ADOPTION OR SUIT FOR ADOPTION (PROVIDE LEGAL DOCUMENTS)

☐ COURT ORDER (PROVIDE COURT ORDER OR DECREE)

☐ LOSS OF OTHER COVERAGE

☐ OTHER (EXPLAIN):

EFFECTIVE DATE OF BENEFITS: ☐ **COMPLETION OF OTHER ELIGIBILITY REQUIREMENTS**

☐ **CANCEL ENROLLEE** ☐ **CANCEL DEPENDENT**

CANCEL COVERAGE: ☐ HEALTH ☐ DENTAL

☐ TERM LIFE ☐ DEPENDENT LIFE

☐ SHORT-TERM DISABILITY ☐ LONG-TERM DISABILITY

LIST NAMES OF THOSE CANCELING IN SECTION 4 BELOW

EVENT: ☐ DIVORCE** ☐ DEATH

☐ TERMINATED EMPLOYMENT ☐ OTHER

INDICATE EVENT DATE:

SECTION 2 — PLEASE TELL US ABOUT YOURSELF

COMPLETE EVEN IF DECLINING COVERAGE

LAST NAME	FIRST NAME	MI (OPT)	SUFFIX	BIRTH DATE (MM/DD/YYYY)	SOCIAL SECURITY #

MAILING ADDRESS - STREET - APT #	CITY	STATE	ZIP CODE

EMAIL ADDRESS	☐ MALE ☐ FEMALE	HOME/CELL PHONE #

NAME OF EMPLOYER	JOB TITLE	BUSINESS PHONE #	EMPLOYMENT DATE (MM/DD/YYYY)	ON AVERAGE, HOW MANY HOURS A WEEK DO YOU WORK? (REQUIRED)

ELIGIBILITY STATUS: ☐ ACTIVE EMPLOYEE ☐ RETIRED EMPLOYEE - DATE OF RETIREMENT: ☐ COBRA COVERAGE START DATE PROJECTED END DATE

☐ ILLINOIS CONTINUATION (INSURED PLANS ONLY) START DATE PROJECTED END DATE

SECTION 3 — SELECT YOUR COVERAGE

PLEASE CHECK ALL THAT APPLY

SMALL GROUP PLANS (1-50 EMPLOYEES)

AFFORDABLE CARE ACT PLANS

☐ PPO ☐ OTHER

☐ BLUE CHOICE PREFERRED PPO℠

☐ BLUE OPTIONS℠

☐ BLUE PRECISION HMO℠

☐ BLUECARE DIRECT℠

PLAN # (REQUIRED)

GRANDFATHERED AND GRANDMOTHERED/TRANSITIONAL PLANS

☐ BLUE ADVANTAGE ENTREPRENEUR PPO℠ ☐ BLUE ADVANTAGE HMO℠

☐ BLUE CHOICE SELECT PPO℠ ☐ BLUE ADVANTAGE HMO VALUE CHOICE℠

☐ BLUE EDGE SELECT HSA℠ ☐ COMMUNITY PARTICIPATION ORGANIZATION (CPO)

☐ BLUE EDGE HSA℠ ☐ CPO VALUE CHOICE

☐ BLUE EDGE HCA DIRECT℠ ☐ OTHER

☐ PPO VALUE CHOICE PLAN # (REQUIRED)

MID-MARKET AND LARGE GROUP STANDARD PLANS (51+ EMPLOYEES)

MID-MARKET & LARGE GROUP STANDARD PLANS 51+

☐ PPO ☐ BLUE CHOICE OPTIONS℠ ☐ BLUE EDGE SELECT HSA℠

☐ BLUE ADVANTAGE HMO℠ ☐ BLUE CHOICE SELECT PPO℠ ☐ PLAN # (REQUIRED)

☐ BLUE ADVANTAGE HMO VALUE CHOICE℠ ☐ BLUE EDGE HSA℠ ☐ OTHER

PREVIOUS BCBSIL OR HMO MEMBERSHIP

GROUP #:

SECTION #:

IDENTIFICATION #:

LARGE GROUP CUSTOM PLANS (151+ EMPLOYEES)

☐ TRADITIONAL ☐ BLUE ADVANTAGE HMO℠ W/HCA ☐ BLUE EDGE SELECT HSA℠

☐ PPO ☐ BLUE CHOICE OPTIONS℠ ☐ BLUE EDGE SELECT HCA DIRECT℠

☐ CPO ☐ BLUE CHOICE SELECT PPO℠ ☐ VISION

☐ CPO VALUE CHOICE ☐ BLUE EDGE HCA℠ ☐ HEARING

☐ HMO ILLINOIS® ☐ BLUE EDGE HSA℠ ☐ MEDICARE SUPPLEMENT

☐ HMO ILLINOIS® W/HCA ☐ BLUE EDGE HCA DIRECT℠ ☐ OTHER

☐ BLUE ADVANTAGE HMO℠ ☐ BLUE EDGE SELECT HCA℠

DENTAL

☐ BLUECARE DENTAL PPO℠ ☐ BLUECARE DENTAL HMO℠

☐ DENTAL GROUP # (IF DIFFERENT THAN MEDICAL GROUP POLICY #)

☐ EMPLOYEE AND PARTY TO A CIVIL UNION OR DOMESTIC PARTNER ☐ MALE ☐ FEMALE

☐ INDIVIDUAL/EMPLOYEE ☐ EMPLOYEE/SPOUSE

☐ EMPLOYEE/CHILDREN ☐ FAMILY

PRIMARY LANGUAGE

GROUP TERM LIFE, ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) AND DISABILITY INSURANCE

☐ I AM NOT APPLYING FOR GROUP TERM LIFE, AD&D OR DISABILITY INSURANCE COVERAGE

EMPLOYEE OCCUPATION/JOB TITLE: WAGE RATE $ PER ☐ HOUR ☐ WEEK ☐ MONTH ☐ YEAR

GROUP BASIC TERM LIFE AND AD&D	☐ I DO NOT APPLY	☐ I DO APPLY	AMOUNT $
GROUP DEPENDENTS' LIFE	☐ I DO NOT APPLY	☐ I DO APPLY	
GROUP SUPPLEMENTAL LIFE	☐ I DO NOT APPLY	☐ I DO APPLY	EMPLOYEE ELECTION: $ SPOUSE ELECTION: $ CHILD ELECTION: $
SHORT-TERM DISABILITY	☐ I DO NOT APPLY	☐ I DO APPLY	LONG-TERM DISABILITY ☐ I DO NOT APPLY ☐ I DO APPLY

	FIRST NAME	INITIAL	LAST NAME	RELATIONSHIP	BIRTH DATE (MM/DD/YYYY)	SOCIAL SECURITY #
PRIMARY BENEFICIARY						
CONTINGENT BENEFICIARY						

LAST NAME	SOC. SEC. #	GROUP #

SECTION 4 — COVERAGE OPTIONS

PLEASE COMPLETE ALL AREAS THAT APPLY
(IF YOU ARE ADDING AN ELIGIBLE MILITARY PERSONNEL DEPENDENT WHO IS OVER THE AGE LIMIT OF YOUR EMPLOYER'S PLAN, COMPLETION OF A DEFENSE DEPARTMENT FORM 214 (DD 214) IS REQUIRED IN ADDITION TO THIS APPLICATION.)

EMPLOYEE/ ENROLLEE'S NAME | PCP NAME / PCP # | IPA NAME / IPA #

WPHCP NAME / WPHCP # | NEW PATIENT? ☐ YES ☐ NO | HMO OB/GYN NAME (OPTIONAL) | HMO OB/GYN #

DEPENDENT'S NAME ☐ HUSBAND ☐ WIFE ☐ DOMESTIC PARTNER ☐ PARTY TO A CIVIL UNION | DEPENDENT'S PCP NAME | PCP # | NEW PATIENT? ☐ YES ☐ NO

IPA NAME / IPA # | WPHCP NAME / WPHCP # | HMO OB/GYN NAME (OPTIONAL) / HMO OB/GYN #

DEPENDENT'S SOCIAL SECURITY # | BIRTH DATE (MM/DD/YYYY) | HOME ADDRESS (IF DIFFERENT) STREET/CITY/STATE/ZIP CODE

DEPENDENT'S NAME ☐ SON ☐ DAUGHTER ☐ OTHER ELIGIBLE DEPENDENT | DEPENDENT'S PCP NAME | PCP # | NEW PATIENT? ☐ YES ☐ NO

BIRTH DATE (MM/DD/YYYY) | HOME ADDRESS (IF DIFFERENT) STREET/CITY/STATE/ZIP CODE | IS THIS DEPENDENT A NATURAL CHILD, STEPCHILD, FOSTER CHILD, ADOPTED CHILD OR A CHILD IN SUIT FOR ADOPTION? ☐ YES ☐ NO | IF NOT YOUR ELIGIBLE NATURAL CHILD, STEPCHILD, FOSTER CHILD, ADOPTED CHILD OR CHILD IN SUIT FOR ADOPTION, ARE YOU (OR YOUR SPOUSE) RESPONSIBLE FOR THIS DEPENDENT? ☐ YES ☐ NO

DEPENDENT'S SOCIAL SECURITY # | IPA NAME / IPA # | HMO OB/GYN NAME (OPTIONAL) / HMO OB/GYN #

DEPENDENT'S NAME ☐ SON ☐ DAUGHTER ☐ OTHER ELIGIBLE DEPENDENT | DEPENDENT'S PCP NAME | PCP # | NEW PATIENT? ☐ YES ☐ NO

BIRTH DATE (MM/DD/YYYY) | HOME ADDRESS (IF DIFFERENT) STREET/CITY/STATE/ZIP CODE | IS THIS DEPENDENT A NATURAL CHILD, STEPCHILD, FOSTER CHILD, ADOPTED CHILD OR A CHILD IN SUIT FOR ADOPTION? ☐ YES ☐ NO | IF NOT YOUR ELIGIBLE NATURAL CHILD, STEPCHILD, FOSTER CHILD, ADOPTED CHILD OR CHILD IN SUIT FOR ADOPTION, ARE YOU (OR YOUR SPOUSE) RESPONSIBLE FOR THIS DEPENDENT? ☐ YES ☐ NO

DEPENDENT'S SOCIAL SECURITY # | IPA NAME / IPA # | HMO OB/GYN NAME (OPTIONAL) / HMO OB/GYN #

DEPENDENT'S NAME ☐ SON ☐ DAUGHTER ☐ OTHER ELIGIBLE DEPENDENT | DEPENDENT'S PCP NAME | PCP # | NEW PATIENT? ☐ YES ☐ NO

BIRTH DATE (MM/DD/YYYY) | HOME ADDRESS (IF DIFFERENT) STREET/CITY/STATE/ZIP CODE | IS THIS DEPENDENT A NATURAL CHILD, STEPCHILD, FOSTER CHILD, ADOPTED CHILD OR A CHILD IN SUIT FOR ADOPTION? ☐ YES ☐ NO | IF NOT YOUR ELIGIBLE NATURAL CHILD, STEPCHILD, FOSTER CHILD, ADOPTED CHILD OR CHILD IN SUIT FOR ADOPTION, ARE YOU (OR YOUR SPOUSE) RESPONSIBLE FOR THIS DEPENDENT? ☐ YES ☐ NO

DEPENDENT'S SOCIAL SECURITY # | IPA NAME / IPA # | HMO OB/GYN NAME (OPTIONAL) / HMO OB/GYN #

SECTION 5 — DISABLED DEPENDENT

PLEASE COMPLETE IF APPLICABLE

NAME OF DISABLED DEPENDENT	NATURE OF DISABILITY
NAME OF DISABLED DEPENDENT	NATURE OF DISABILITY

IF DISABLED CHILD IS OVER THE DEPENDENT AGE LIMIT OF YOUR EMPLOYER'S PLAN, PLEASE ATTACH A COMPLETED DISABLED DEPENDENT CERTIFICATION AND THE DISABLED DEPENDENT PHYSICIAN CERTIFICATION DOCUMENT.

SECTION 6 — OTHER COVERAGE INFORMATION

PLEASE COMPLETE IF APPLICABLE

COMPLETE THIS SECTION ONLY IF YOU OR ANY OF YOUR DEPENDENTS HAVE OTHER HEALTH AND/OR DENTAL COVERAGE THAT WILL NOT BE CANCELED WHEN THE COVERAGE UNDER THIS APPLICATION BECOMES EFFECTIVE. **LIST NAMES OF EACH INDIVIDUAL COVERED:**

GROUP COVERAGE ☐ YES ☐ NO | INDIVIDUAL COVERAGE ☐ YES ☐ NO | NAME AND ADDRESS OF OTHER INSURANCE CARRIER | EFFECTIVE DATE (MM/DD/YYYY) | TYPE OF POLICY ☐ EMPLOYEE ONLY ☐ EMPLOYEE/SPOUSE ☐ EMPLOYEE/CHILD(REN) ☐ FAMILY

NAME OF POLICYHOLDER | BIRTH DATE (MM/DD/YYYY) | ☐ MALE ☐ FEMALE | RELATIONSHIP TO APPLICANT ☐ SELF ☐ SPOUSE ☐ DEPENDENT

EMPLOYER'S NAME | EMPLOYMENT DATE (MM/DD/YYYY) | HEALTH GROUP # | HEALTH ID # | DENTAL GROUP # | DENTAL ID #

SECTION 7 — MEDICARE COVERAGE INFORMATION

PLEASE COMPLETE IF APPLICABLE

NAME OF PERSON COVERED: | MEDICARE A (HOSPITAL) EFFECTIVE DATE: END DATE:
MEDICARE B (MEDICAL) EFFECTIVE DATE: END DATE:
MEDICARE D (DRUG) EFFECTIVE DATE: END DATE:
MEDICARE D (DRUG) CARRIER: | MEDICARE HIC # (FROM MEDICARE CARD)

PLEASE INDICATE REASON FOR MEDICARE ELIGIBILITY: ☐ ENTITLED AGE ☐ ENTITLED DISABILITY ☐ END-STAGE RENAL DISEASE ☐ DISABILITY AND CURRENT RENAL DISEASE

NAME OF PERSON COVERED: | MEDICARE A (HOSPITAL) EFFECTIVE DATE: END DATE:
MEDICARE B (MEDICAL) EFFECTIVE DATE: END DATE:
MEDICARE D (DRUG) EFFECTIVE DATE: END DATE:
MEDICARE D (DRUG) CARRIER: | MEDICARE HIC # (FROM MEDICARE CARD)

PLEASE INDICATE REASON FOR MEDICARE ELIGIBILITY: ☐ ENTITLED AGE ☐ ENTITLED DISABILITY ☐ END-STAGE RENAL DISEASE ☐ DISABILITY AND CURRENT RENAL DISEASE

LAST NAME	SOC. SEC. #	GROUP #

SECTION 8 — DECLINATION OF COVERAGE

PLEASE COMPLETE IF YOU ARE DECLINING COVERAGE

THIS IS TO CERTIFY THE AVAILABLE COVERAGE HAS BEEN EXPLAINED TO ME. I HAVE BEEN GIVEN THE OPPORTUNITY TO APPLY FOR THE COVERAGE OFFERED TO ME AND MY ELIGIBLE DEPENDENTS AND HAVE VOLUNTARILY ELECTED TO DECLINE THE COVERAGE AS INDICATED BELOW. IF I DESIRE TO APPLY FOR COVERAGE AT A LATER DATE, I UNDERSTAND THERE MAY BE A DELAY IN THE EFFECTIVE DATE OF THE COVERAGE.

NAME ☐ EMPLOYEE	REASON FOR DECLINING HEALTH: ☐ OTHER GROUP HEALTH COVERAGE – CARRIER: ☐ MEDICARE ☐ MEDICAID ☐ OTHER INDIVIDUAL HEALTH COVERAGE – CARRIER: ☐ OTHER (EXPLAIN) ☐ I AM NOT ENROLLED IN ANY HEALTH INSURANCE PLAN, BUT DO NOT WANT THIS COVERAGE	
NAME ☐ EMPLOYEE	REASON FOR DECLINING DENTAL: ☐ OTHER GROUP DENTAL COVERAGE ☐ MEDICAID ☐ INDIVIDUAL DENTAL COVERAGE ☐ OTHER (EXPLAIN) ☐ I AM NOT ENROLLED IN ANY DENTAL INSURANCE PLAN, BUT DO NOT WANT THIS COVERAGE	
NAME ☐ SPOUSE	REASON FOR DECLINING: ☐ OTHER GROUP HEALTH COVERAGE ☐ MEDICAID ☐ INDIVIDUAL HEALTH COVERAGE ☐ OTHER (EXPLAIN) ☐ I AM NOT ENROLLED IN ANY HEALTH INSURANCE PLAN, BUT DO NOT WANT THIS COVERAGE	
NAME ☐ DEPENDENT	REASON FOR DECLINING: ☐ OTHER GROUP HEALTH COVERAGE ☐ MEDICAID ☐ INDIVIDUAL HEALTH COVERAGE ☐ OTHER (EXPLAIN) ☐ I AM NOT ENROLLED IN ANY HEALTH INSURANCE PLAN, BUT DO NOT WANT THIS COVERAGE	
NAME ☐ DEPENDENT	REASON FOR DECLINING: ☐ OTHER GROUP HEALTH COVERAGE ☐ MEDICAID ☐ INDIVIDUAL HEALTH COVERAGE ☐ OTHER (EXPLAIN) ☐ I AM NOT ENROLLED IN ANY HEALTH INSURANCE PLAN, BUT DO NOT WANT THIS COVERAGE	

SECTION 9 — COVERAGE CONDITIONS

- I am an employee or a retiree of the employer named in this enrollment application. I am eligible to participate in the coverage(s) afforded by my employer's plan, which is either underwritten or administered by Blue Cross and Blue Shield of Illinois or Dearborn Life Insurance Company. On behalf of myself and any dependents listed on this enrollment application, I apply for those coverage(s) for which I am eligible. I state that the information given on this enrollment application is true and correct. I understand and agree that any intentional misrepresentation of a material fact made by me will invalidate my coverage(s).
- Only those coverage(s) and amounts for which I am eligible will be available to me. I understand that if this enrollment application is accepted, the coverage(s) will become effective in accordance with the provisions of the Contract(s)/Plan(s).
- I agree that my employer acts as my agent. I authorize necessary payroll deduction by my employer, if any, to cover the cost of my coverage(s).
- I understand that my participation in the coverage(s) is subject to any future amendment. I also understand that all notices given to my employer are applicable to me.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

APPLICANT'S SIGNATURE DATE

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator	Phone:	855-664-7270 (voicemail)
300 E. Randolph St.	TTY/TDD:	855-661-6965
35th Floor	Fax:	855-661-6960
Chicago, Illinois 60601	Email:	CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building 1019	Fax:	855-661-6960
Washington, DC 20201	Complaint Portal:	https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
	Complaint Forms:	http://www.hhs.gov/ocr/office/file/index.html

BlueCross BlueShield of Illinois

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
Ελληνικά Greek	Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να μιλήσετε σε έναν διερμηνέα, καλέστε 855-710-6984.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવા કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे है उसके, प्रश्न है, तो आपको अपनी भाषा मे निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें ।.
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká ánánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił h odoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.