2026 Alaska Individual Medicare Supplement Application

Please mail your completed application to:
Moda Health Plan, Inc., Attn: Medicare Membership Accounting, 601 SW Second Ave., Portland, OR 97204-9748
Email: Scan and send to bemc@modahealth.com
phone 844-235-8012 • fax 503-224-1975 • modahealth.com/medicare

This application must be completed and signed in black or blue ink. All enrollment questions must be answered legibly and to the best of your knowledge. If your application is incomplete or unsigned, it will be returned to you and your effective date may be delayed.

Enrollment information

Last name	First name	Middle initial
Social Security number	Date of birth	Age (65 and older as of the month of enrollment)
Gender*	Gender identity*	

**These fields are optional. We are committed to understanding and valuing diversity among our members. We are seeking this information so our staff can refer to and communicate with you in the most appropriate and respectful way.*

Alaska residence address

Home address		
City	State	ZIP
Telephone number	Borough	

Mailing address (if different)

Name (c/o)	Relationship to applicant		
Address	City	State	ZIP
Email address			
Primary language: ☐ English ☐ Spanish ☐ Other:	Have you used any tobacco products within the last 12 months? ☐ Yes ☐ No You may reapply for nonsmoker rates after you are tobacco free for 12 continuous months (subject to review).		

Health insurance Social Security Act

Please copy the information from your Medicare Identification Card into the area below and attach a copy of your Medicare Identification Card or the letter of verification from the Social Security Administration or Railroad Retirement Board. This information is required to process your application.

Medicare number: **Please attach a copy of your Medicare card.**	Entitled to: Hospital (Part A) Medical (Part B)	Coverage starts: _____ _____

Choose a Medicare Supplement plan

☐ Plan A	☐ Plan F (Only applicants first eligible for Medicare before 1/1/2020 may purchase Plan F.)	☐ Plan High-deductible F (Only applicants first eligible for Medicare before 1/1/2020 may purchase high-deductible Plan F.)	☐ Plan G	☐ Plan High-deductible G	☐ Plan N

I'd like to purchase a Delta Dental Individual dental plan to supplement my Moda Health Medicare Supplement plan for an additional monthly premium.

☐ Delta Dental Premier for $58 per month. Available throughout Alaska

☐ Delta Dental PPO 1500 for $67 per month. Available in Anchorage, Fairbanks North Star Borough, and Mat-Su Valley

See Page 10 for additional dental enrollment information

Requested future effective date: 1st of **month:** _____ **year:** _____

Statements

- It is an eligibility requirement at the time of enrollment that the applicant is eligible for Medicare due to age (65 and older) and an Alaska resident.
- You do not need more than one Medicare Supplement policy. If you currently have a Medicare Supplement policy, you cannot be enrolled unless you intend to replace your current coverage.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
- If after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, 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 suspended Medicare Supplement policy (or if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility.
- Counseling services may be available 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).

Statements *(continued)*

Please answer each of the questions to the best of your knowledge:

1. (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? _____	☐ Yes ☐ No ☐ Yes ☐ No
2. Are you covered for medical assistance through the state Medicaid program? (NOTICE 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 ☐ Yes ☐ No ☐ Yes ☐ No
3. (a) 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 or PPO), fill in your start and end dates below. If you are still covered under this plan, leave the end date blank. START: _____ END: _____ (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? (c) Was this your first time in this type of Medicare plan? (d) Did you drop a Medicare Supplement policy to enroll in the Medicare plan?	 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
4. (a) Do you have another Medicare Supplement policy in force? (b) If so, with what company, and what plan do you have? _____ (c) If so, do you intend to replace your current Medicare Supplement policy with this policy?	☐ Yes ☐ No ☐ Yes ☐ No
5. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union or individual plan)? (a) If so, 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 the other policy, leave end date blank. START: _____ END: _____ **If you are replacing current Medicare Supplement coverage, please complete the enclosed "Notice to Applicant Regarding Replacement of Medicare Supplement Coverage" form.**	☐ Yes ☐ No

Open enrollment

1. Are you applying for coverage within the six-month period beginning with the first day of the first month you enrolled for benefits under Medicare Part B? (You must also have Medicare Part A to enroll.)	☐ Yes ☐ No

If the answer above is "Yes," please attach proof of eligibility and do not complete the "Personal History Questions" section.

Protected enrollment periods

Complete this section if you are not applying during your open enrollment period.

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, as outlined in the scenarios below, 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.**

You are applying for coverage within 63 days from the date your previous Medicare coverage ended and:	☐ Yes ☐ No
1. Your Medicare Advantage plan or Program of All-Inclusive Care for the Elderly (PACE) terminates or no longer provides service in your area, or you move out of the service area.	☐ Yes ☐ No
2. You were covered by an employer's group health plan or a state Medicaid plan as described in Title XIX of the Social Security Act that provides health benefits, and the plan terminates your benefits or no longer provides benefits.	☐ Yes ☐ No
3. Your Medicare Supplement policy and enrollment terminates because the insurer becomes insolvent or bankrupt.	☐ Yes ☐ No
4. Your Medicare Supplement insurer has violated a material provision of the policy or the producer materially misrepresented the plan's provisions in marketing the plan.	☐ Yes ☐ No
5. You terminated your Medicare Supplement policy and enrolled in a Medicare Advantage plan and voluntarily disenrolled from that plan within the first 12 months of enrolling. (You may re-enroll in the same Medicare Supplement policy you had previously if available from the same issuer; however, if that Medicare Supplement policy is not available, you may enroll in plans A, F, high-deductible F, G, high-deductible G or N from us.)	☐ Yes ☐ No
6. You joined a Medicare Advantage plan or a PACE program when you were first eligible for Medicare. (Within the first year of joining that plan, if you decide to disenroll, you may enroll in any of our Medicare Supplement plans.	

Personal history questions - Complete this section only if you are NOT applying during a guaranteed issue period. Guaranteed issue periods are listed on page 3 within the Protected enrollment periods.

1. Have you been prescribed or taken any prescription medications within the past 12 months? If "YES," please indicate below. If "NO," indicate "None." Agent - This is to assist in preparing the Applicant to answer questions in sections 4 through 6.

Name of Medication, Date Prescribed and Condition

(Example: Vytorin, 10/2009, High Cholesterol) _____

2. Height ft._____in._____Weight lbs._____

3. Have you ever been diagnosed with diabetes?	☐ Yes ☐ No
4. Have you ever:	
a. been advised by a physician to have or are you currently waiting for an organ transplant?	☐ Yes ☐ No
b. been diagnosed with, treated, or advised to receive treatment for Alzheimer's Disease, dementia, mental incapacity, organic brain disease or any other cognitive disorder?	☐ Yes ☐ No
c. been diagnosed with, treated or advised to receive treatment for Lou Gehrig's disease (ALS), Huntington's disease or any terminal medical condition?	☐ Yes ☐ No
d. been diagnosed with, treated or advised by a licensed member of the medical profession to receive treatment for Systemic Lupus, Osteoporosis with Fractures, or kidney disease or failure requiring dialysis?	☐ Yes ☐ No
e. used insulin to treat or control diabetes?	☐ Yes ☐ No
f. had any type of diabetes with complications including retinopathy, neuropathy, nephropathy, peripheral vascular disease, heart disease, stroke, transient ischemic attack (TIA), high blood pressure, or skin ulcers?	☐ Yes ☐ No
g. been in a diabetic coma or had or been advised to have an amputation due to disease or disorder?	☐ Yes ☐ No
h. been diagnosed with, treated or advised to receive treatment for Cirrhosis, Emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders?	☐ Yes ☐ No
i. to the best of your knowledge and belief, within the last 10 years, been told by a member of the medical profession that you had a diagnosis of AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or the HIV (Human Immunodeficiency Virus) infection?	☐ Yes ☐ No
j. been diagnosed, treated or advised to receive treatment for any neurological disease or disorder such as Myasthenia Gravis, Multiple or Lateral Sclerosis, or Parkinson's disease?	☐ Yes ☐ No

5. Within the past 2 years have you:	
a. been advised to or do you currently use a wheelchair?	☐ Yes ☐ No
b. been advised to enter or do you reside in a nursing home, assisted living facility, long term care facility, received hospice, attended an adult day care facility, required home healthcare, or been bedridden?	☐ Yes ☐ No
c. been admitted to a hospital 3 or more times or are you currently admitted to a hospital?	☐ Yes ☐ No
d. been diagnosed, treated or advised to receive treatment for cancer (other than basal cell carcinoma)?	☐ Yes ☐ No
e. been diagnosed, treated or advised to receive treatment for alcoholism or drug abuse, mental or nervous disorder requiring psychiatric care?	☐ Yes ☐ No
f. been diagnosed, treated or advised to receive treatment for heart attack, coronary or carotid artery disease (not including high blood pressure), peripheral vascular disease, congestive heart failure or enlarged heart, stroke, transient ischemic attacks (TIA) or heart rhythm disorders?	☐ Yes ☐ No
g. been diagnosed, treated or advised to receive treatment for degenerative bone disease impacting multiple joints, crippling/disabling or rheumatoid arthritis or been advised to have a joint replacement?	☐ Yes ☐ No
h. been advised to have surgery, medical tests, treatment or therapy that has not yet been performed or undergone testing by a medical professional for which the results have not yet been received?	☐ Yes ☐ No
6. Have you been advised by a physician that surgery may be required within the next 12 months for cataracts or have you used or been advised to use oxygen equipment, respirator or a catheter?	☐ Yes ☐ No

If any question in 4, 5 and 6 is answered "YES," please STOP.
The Applicant is NOT eligible for underwritten Medicare Supplement.

For producer use only

Producers must list any other medical or health insurance policies sold to the applicant.
List policies sold that are still in force: _____
List such policies sold in the past five years that are no longer in force: _____

I (the producer) have explained the eligibility provisions to the applicant. I have not made any statements about benefits, conditions or limitations of the policy except through written material furnished by Moda Health.
I CERTIFY THAT THE INFORMATION SUPPLIED TO ME BY THE APPLICANT HAS BEEN TRULY AND ACCURATELY RECORDED HERE.

Producer name (print or type)			
Agent NPN	Agency name	Telephone number	
Street address	City	State	ZIP
Producer's signature (required)			Date

Note to agent: Payment does not have to be included with the application, but the first payment is required to activate coverage.

Authorization

Be sure to sign and date the application below. Signature applies to "Certification of completeness and correctness," "Authorization for release of information" and "Applicant's statement."

Certification of completion and correctness

I affirm that, to the best of my knowledge, the answers given in this application are complete and correct. I am providing these answers as part of the application procedure required by Moda Health to enroll in its insurance coverage. I understand that if this application contains any material misstatements or omissions, Moda Health may, within the first two years of coverage, deny coverage, modify or cancel the policy, and/or take any other legal action available to it by law. I will promptly inform Moda Health in writing if anything happens before my coverage takes effect that makes this application incomplete or incorrect. Moda Health may phone me to clarify answers on this application. As the applicant, I understand I have the right to inspect the information in my file.

Authorization for release of information

To any physician; healthcare provider; hospital; insurance or reinsurance company; the Medical Information Bureau, Inc. (MIB) or other insurance information exchange:

I authorize you to give medical information (including alcohol, chemical dependency, mental treatment or HIV treatment) you have about me to Moda Health or its representatives. This authorization takes effect on the date shown below. This authorization shall be valid for 24 months from the date following my signature below unless the authorization is revoked. I have the right to revoke this authorization in writing at any time by sending a written request to Moda Health, Privacy Office at 601 SW Second Ave., Portland, OR 97204 and stating that I am revoking the authorization. Any uses or disclosures already made with my permission cannot be taken back. A photocopy of this authorization is as valid as the original.

Applicant's statement

I understand that if this application contains material misstatements or omissions, Moda Health may do any or all of the following:

- Cancel the policy as though it were never effective
- Take any other legal action available to it by law

I understand that my producer is not authorized to make any statements about the benefits, conditions or limitations of the policy except through written materials furnished by Moda Health. If my producer completed any answers on my behalf, I have reread all answers and verified that they are true and complete. I understand that only Moda Health can determine whether to issue a policy to me, and that my producer has no authority to do so.

I am enrolled in Medicare due to age (65 and over). I understand that I am applying for Moda Health Medicare Supplement coverage. My signature below also acknowledges that I have received the Moda Health Medicare Supplement packet.

I understand that during a guaranteed issue period, my effective date will be the first day of the month following receipt of my application or other requested future effective date. If I am applying for coverage during a non-guaranteed issued period, my effective date will be the first day of the month following Moda Health approval, and I will be notified in writing within 60 days of receipt of my application.

I understand, upon acceptance, that this application becomes part of the policy.

Signature of Applicant	Date

Please mail your completed application to:

Moda Health Plan, Inc., Attn: Medicare Membership Accounting, 601 SW Second Ave., Portland, OR 97204-9748
Email: Scan and send to bemc@modahealth.com
phone 844-235-8012 • fax 503-224-1975 • modahealth.com/medicare

Payment method

We offer three payment options for you to choose from.

1. Electronic fund transfer (EFT), see authorization agreement below. ☐
2. Automatic eBill payment through your Member Dashboard. ☐
3. Personal check, money order or cashier's check. ☐

EFT authorization agreement

EFT initiates on the 5th of the month or the following business day and typically takes one or two days to post to your account. Your initial payment may initiate on a later date in the event that the enrollment is processed after the 5th of the month. Your premium invoice will be paperless and located in the eBill section of your Member Dashboard.

1. Complete and sign below as the account holder for monthly automatic premium deductions from your bank.
2. Attach a photocopy of a voided personal check from the account, or provide the bank routing and account numbers below.

Applicant	Account holder

Name of bank	Routing number	Account number

I authorize Moda Health to charge my checking account for monthly premiums for the above named individual. I also authorize my bank, named here, to honor these monthly charges. This authority will remain in effect until I give my bank a reasonable chance to act upon it. I can stop payment by notifying my bank before my account has been charged.

Account holder signature	Signature date
X	

You may be billed for the premium payment necessary to begin electronic deductions. If you want to cancel your bank deductions, we must receive written notice 15 days before the next deduction date.

Billing options

If you are set up for EFT, your premium invoice will be paperless. If you are not set up for EFT, you will be set up for paper invoices. You may change your billing preference to paperless by going to the eBill section of your Member Dashboard.

If the bill needs to go to an address other than your mailing address, please note the billing address below.

Billing address	City	State	ZIP

Notice to applicant regarding replacement of Medicare Supplement insurance or medicare advantage

Moda Health Plan, Inc.
601 SW Second Ave.
Portland, OR 97204

Save a copy of this notice. It may be important to you in the future.

According to your application, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by Moda Health. Your new policy will provide thirty (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 the 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 issuer, agent, broker or other representative:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

- ☐ Additional benefits.
- ☐ No change in benefits, but lower premiums.
- ☐ Fewer benefits and lower premiums.
- ☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- ☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.
- ☐ Other, (please specify) _____

1. Note: If Moda Health does not, or is otherwise prohibited from imposing pre-existing condition limitations to the policy being applied for, please skip to statement 2 below. Health conditions that you may presently have (pre-existing 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.
2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing 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.

Signature of Applicant	Date
Printed Name of Applicant	

Signature of Agent, Broker, or other Representative *	Date
Printed Name of Agent, Broker, or other Representative	

* Signature not required for direct response sales.

Dental Plan

Please complete this section if you to elected to purchase a Delta Dental Individual dental plan to supplement your Moda Health Medicare plan for an additional monthly premium on Page 2

Please note: You are not eligible to purchase Delta Dental Individual coverage if you have had Delta Dental Individual coverage within the last 12 months **unless**:

- You have continuous coverage with no more than a 90-day break (see Section 1 below)
- You lost dental coverage because your medical coverage ended and you have a qualifying event.]

Section 1: Credit towards benefit exclusion period (for new dental coverage)

For applicants age 19 and over:

Have you had dental insurance for the last 12 months with no more than a 90-day break in coverage from the end of the old policy to the expected effective date of this new policy? ☐ Yes ☐ No

If this coverage was through Delta Dental of Alaska, we'll automatically waive the exclusion period on your dental coverage. If this coverage was through a different carrier, we can credit your prior coverage toward the benefit exclusion period. Attach a letter from your prior carrier or employer documenting the start and end dates of your prior dental coverage. Was this coverage through Delta Dental of Alaska? ☐ Yes ☐ No

Section 2: Basic terms of enrollment

I understand and agree that:

1. I may receive benefits that are less than the amount billed by my provider when treatment is not received from a contracted provider.
2. This application is not an offer of coverage. Coverage does not begin until this application is received and reviewed by Delta Dental and an effective date of coverage is assigned.
3. This application becomes part of my policy.
4. I have the right to examine and return the policy within 10 days of receipt.
5. Being accepted for coverage has these requirements:
    A. I must be an Alaska "resident" to apply for and keep coverage under a Delta Dental plan. "Resident" means a person who lives in the plan's service area and intends to live in the service are permanently or indefinitely. Delta Dental may require proof of residency, including but not limited to, my street address (not a post office box).
    B. I cannot be covered by more than one Delta Dental individual dental plan at any time.
6. No benefits are available under a Delta Dental plan for services or supplies that were received before the effective date of coverage.
7. Changes to state or federal laws or rules may change the benefits or rates of the plan I chose. Changes will be effective January 1.
8. Regardless of my enrollment date, my plan premium will renew January 1.
9. I have read the Delta Dental privacy statement that is available on deltadentalor.com.

Section 3: Certification of completeness and correctness

Be sure to sign and date the application below.

I affirm that the answers given on this application are complete and correct to the best of my knowledge. I understand that if this application contains any intentional misrepresentations of material fact, Delta Dental may deny coverage, modify or cancel the contract, rescind the contract and/or take other legal action. I will promptly inform Delta Dental in writing if anything happens before my coverage takes effect that makes this application incomplete or incorrect. If approved, coverage will be in force as of the effective date determined by Delta Dental. Delta Dental may contact me to clarify answers on this application. As the applicant, I understand I have the right to inspect the information in my file. I have read and understand this application, terms, and certification and privacy statements.

Applicant (subscriber)	
Signature	Date

By providing my contact information, I am consenting to receive communications from Delta Dental of Alaska and their affiliates and business partners regarding my health plan benefits, payments and treatment. Please keep in mind that communications via email over the internet may not be secure. Although it is unlikely, there is a possibility that information included in an email could be obtained by other parties besides the person to whom it is addressed. We recommend that you do not include personal identifying information such as your birth date or personal medical information in any emails you send to us. You do not have to provide your email address or phone number as a condition to purchasing any goods or services.

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-877-605-3229 (TTY: 711) or speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-877-605-3229 (TTY: 711) o hable con su proveedor.

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số (Người khuyết tật: 1-877-605-3229 (TTY: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-877-605-3229 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-877-605-3229 (TTY: 711) или обратитесь к своему поставщику услуг.

注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-877-605-3229 (TTY: 711) までお電話ください。または、ご利用の事業者にご相談ください。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-877-605-3229 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-877-605-3229 (TTY: 711) o makipag-usap sa iyong provider.

УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-877-605-3229 (TTY: 711) або зверніться до свого постачальника».

ማሳሰቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር 1-877-605-3229 (TTY: 711) ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ።

FIIRO GAAR AH: Haddaad ku hadasho Soomaali, adeegyo kaalmada luuqadda ah oo bilaash ah ayaad heli kartaa. Qalab caawinaad iyo adeegyo oo habboon si loogu bixiyo macluumaadka qaabab la adeegsan karo ayaa sidoo kale bilaa lacag heli karaa. Wac 1-877-605-3229 (TTY: 711) ama la hadal bixiyahaaga.

ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-877-605-3229 (TTY: 711) ou parlez à votre fournisseur.

注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电（文本电话：1-877-605-3229 (TTY: 711)）或咨询您的服务提供商。

ຊຶນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ,
ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ.
ມີເຄື່ອງຊ່ວຍ ແລະ
ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບ
ແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-877-605-3229
(TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

หมายเหตุ: หากคุณใช้ภาษา ไทย
เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้
ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1-877-605-3229 (TTY: 711) หรือปรึกษาผู้ให้บริการของคุณ

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ - (1-877-605-3229 (TTY: 711 پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔"

LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau 1-877-605-3229 (TTY: 711) los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob.

सावधान: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि निःशुल्क भाषिक सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायता र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-877-605-3229 (TTY: 711) मा फोन गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।

ശ്രദ്ധിക്കുക: നിങ്ങൾ മലയാളം ഭാഷ സംസാരിക്കുമെങ്കിൽ, സൗജന്യ ഭാഷാ സഹായ സേവനങ്ങൾ നിങ്ങൾക്ക് ലഭ്യമാണ്. ആക്സസ് ചെയ്യാവുന്ന ഫോർമാറ്റുകളിൽ വിവരങ്ങൾ നൽകാനുള്ള ഉചിതമായ അനുബന്ധ സഹായങ്ങളും സേവനങ്ങളും കൂടെ സൗജന്യമായി ലഭ്യമാണ്. 1-877-605-3229 (TTY: 711) ലേക്ക് വിളിക്കുക അല്ലെങ്കിൽ നിങ്ങളുടെ ദാതാവിനോട് സംസാരിക്കുക.

PANANGIKASO: No agsasaoka iti Ilocano, magun-odmo dagiti libre a serbisio ti tulong iti pagsasao. Libre met laeng a magun-odan dagiti maitutop a katulongan ken serbisio a mangipaay iti impormasion kadagiti ma-akses a pormat. Awagan ti 1-877-605-3229 (TTY: 711) wenno makisarita iti mangipapaay kenka.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-877-605-3229 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

సావధానం: మీరు తెలుగు మాట్లాడితే, మీకు ఉచిత భాషా సహాయ సేవలు అందుబాటులో ఉంటాయి. యాక్సెస్ చేయగల ఫార్మాట్‌లలో సమాచారాన్ని అందించడానికి తగిన సహాయక సహాయాలు మరియు సేవలు కూడా ఉచితంగా అందుబాటులో ఉంటాయి. 1-877-605-3229 (TTY: 711) కి కాల్ చేయండి లేదా మీ ప్రొవైడర్‌తో మాట్లాడండి.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 877-605-3229 (TTY: 711) أو تحدث إلى مقدم الخدمة".

AKIYESI: Ti o ba sọ Yorùbá, awọn iṣẹ iranlọwọ ede ọfẹ wa fun ọ. Awọn iranlọwọ iranlọwọ ti o yẹ ati awọn iṣẹ lati pese alaye ni awọn ọna kika wiwọle tun wa laisi idiyele. Pe 1-877-605-3229 (TTY: 711) tabi sọrọ si olupese rẹ.

MAKINIKA: Ikiwa wewe huzungumza Kiswahili, msaada na huduma za lugha bila malipo unapatikana kwako. Vifaa vya usaidizi vinavyofaa na huduma bila malipo ili kutoa taarifa katika mifumo inayofikiwa pia inapatikana bila malipo. Piga simu 1-877-605-3229 (TTY: 711) au zungumza na mtoa huduma wako.

ATENÇÃO: Se você fala Português do Brasil, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-877-605-3229 (TTY: 711) ou fale com seu provedor.