

## Instructions

- If you are an existing Kaiser Permanente for Individuals and Families (KPIF) member enrolled directly into a KPIF account, you may use this form to make plan changes or account changes. Only the subscriber or parent/legal guardian of a child-only account can fill out this form.
- If you are an existing KPIF member enrolled through Nevada Health Link, all account and plan changes to your existing coverage must be requested through [nevadahealthlink.com](http://nevadahealthlink.com). If you are not sure how you are enrolled or need additional support, please call **855-WE-R-KPNV (855-937-5768)** (TTY 711).
- There are different types of plan changes and account changes you can make with this form. Please fill out your personal information in Section A. Then select what changes you'd like to make in Section B, and continue on to fill out any other sections related to those changes.
- If you are a subscriber ending coverage, your dependents' coverage automatically ends. You may choose to keep your children under 21 years of age on a child-only account. If you're ending KPIF coverage because you are newly eligible for Group coverage or Medicare, your dependents have a Special Enrollment Period to enroll in new KPIF coverage. Go to [kp.org/specialenrollment](http://kp.org/specialenrollment) or contact Member Services to learn more.
- If you're adding a dependent to your plan, any other coverage they have won't be automatically canceled unless stated in this form. To avoid paying for 2 plans or having a gap in coverage, please cancel any other coverage they have as of the day before their new coverage starts.
- Note: If you're entitled to Medicare Part A or enrolled in Medicare Part B, you're not eligible to change (KPIF) plans. If a family member is entitled to Medicare Part A or enrolled in Medicare Part B, they're not eligible to change KPIF plans or be added to your KPIF plan as a new dependent.

## A. Fill out your information

If you're making a change, please update the boxes below with your new information.

|                                            |                                                                                                   |                                 |
|--------------------------------------------|---------------------------------------------------------------------------------------------------|---------------------------------|
| First name                                 | MI                                                                                                | Date of birth (mm/dd/yyyy)      |
| <input type="text"/>                       | <input type="text"/>                                                                              | <input type="text"/>            |
| Last name                                  |                                                                                                   |                                 |
| <input type="text"/>                       |                                                                                                   |                                 |
| Medical record number (if any)             | Gender:                                                                                           | Social Security number (if any) |
| <input type="text"/>                       | <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undeclared | <input type="text"/>            |
| Home address (no P.O. boxes)               |                                                                                                   |                                 |
| <input type="text"/>                       |                                                                                                   |                                 |
| City                                       |                                                                                                   |                                 |
| <input type="text"/>                       |                                                                                                   |                                 |
| State                                      | ZIP code                                                                                          | County                          |
| <input type="text"/>                       | <input type="text"/>                                                                              | <input type="text"/>            |
| Primary phone (mobile phone, if available) |                                                                                                   |                                 |
| <input type="text"/>                       |                                                                                                   |                                 |
| Email address                              |                                                                                                   |                                 |
| <input type="text"/>                       |                                                                                                   |                                 |
| Mailing address                            | <input type="checkbox"/> Check if same as home address                                            |                                 |
| <input type="text"/>                       |                                                                                                   |                                 |
| City                                       |                                                                                                   |                                 |
| <input type="text"/>                       |                                                                                                   |                                 |
| State                                      | ZIP code                                                                                          |                                 |
| <input type="text"/>                       | <input type="text"/>                                                                              |                                 |

**Applicants 21 and older:** Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)?  
 Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

## B. What change(s) do you want to make?

Please check the boxes below for the changes you wish to make and list each family member affected. We won't make any changes for any family members you don't list.

**You can make the following changes during open enrollment or a special enrollment period.** To make a change other than listed below, you can call Member Services at **855-WE-R-KPNV (855-937-5768) (TTY 711)**.

- ☐ Change plans.
- ☐ Add medical coverage for a family member.
- ☐ Change my child-only account to a family account with myself as the subscriber.

(Restrictions apply for special enrollment periods. See [kp.org/specialenrollment](http://kp.org/specialenrollment) for more information.)

### Combine KPIF Accounts

**Accounts can be combined during open enrollment or a special enrollment period.**

- ☐ I wish to add (a) family member(s) already on a KPIF plan to my account. Doing this will end their existing plan.  
(Please indicate which family member(s) will move to your account in Section C.)

Account ending

First name

MI

Last name

Subscriber medical record number for account ending

X

Date (mm/dd/yyyy)

Subscriber or parent/legal guardian for account ending

**You can make the following changes any time during the year.** (Note: For these changes, you can skip Sections D and E.)

- ☐ End all coverage for myself and all family members.
- ☐ End all coverage for a family member.
- ☐ End my coverage and keep my child(ren) under 21 years of age on a child-only account.
- ☐ End my and my spouse's/domestic partner's coverage and keep my child(ren) under 21 years of age on a child-only account.
- ☐ Make the changes shown in Section A. (If you're changing your name, please include legal documentation of the change.)
- ☐ Someone on my account stopped using tobacco.  
(Please indicate which family member in Section C.)

Requested effective date (not guaranteed)

## C. Which family members are affected by the change? (Please list below.)

|                                         |                                                                                                                                        |                                                                                                                                                                                                                                                                                                                            |
|-----------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Spouse/<br/>Domestic<br/>partner</b> | <input type="checkbox"/> Name change<br><input type="checkbox"/> Add medical coverage<br><input type="checkbox"/> End medical coverage | <b>Applicants 21 and older:</b> Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. <input type="checkbox"/> Yes <input type="checkbox"/> No |
|-----------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

First name

MI

Choose one:

- ☐ Spouse
- ☐ Domestic partner

Last name

Date of birth (mm/dd/yyyy)

Gender

- ☐ Male
- ☐ Female
- ☐ Undeclared

Social Security number (if any)

Medical record number (if any)

Primary phone (mobile phone, if available)

Email address

C. Which family members are affected by the change? (Continued)

If you have more than 3 dependents with a change, attach a copy of this page and complete the information for those dependents. Provide phone and email for dependents aged 18 and over only.

|                                            |                                                                                                   |                                                                                                                                                                                                                                                                                                                            |                            |
|--------------------------------------------|---------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|
| <b>Dependent<br/>1</b>                     | <input type="checkbox"/> Name change                                                              | <b>Applicants 21 and older:</b> Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. <input type="checkbox"/> Yes <input type="checkbox"/> No |                            |
|                                            | <input type="checkbox"/> Add medical coverage                                                     |                                                                                                                                                                                                                                                                                                                            |                            |
|                                            | <input type="checkbox"/> End medical coverage                                                     |                                                                                                                                                                                                                                                                                                                            |                            |
|                                            | First name                                                                                        | MI                                                                                                                                                                                                                                                                                                                         | Date of birth (mm/dd/yyyy) |
|                                            | <div></div>                                                                                       |                                                                                                                                                                                                                                                                                                                            |                            |
|                                            | Last name                                                                                         |                                                                                                                                                                                                                                                                                                                            |                            |
| <div></div>                                |                                                                                                   |                                                                                                                                                                                                                                                                                                                            |                            |
| Medical record number (if any)             | Gender                                                                                            | Social Security number (if any)                                                                                                                                                                                                                                                                                            |                            |
| <div></div>                                | <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undeclared | <div></div> - <div></div> - <div></div>                                                                                                                                                                                                                                                                                    |                            |
| Primary phone (mobile phone, if available) |                                                                                                   |                                                                                                                                                                                                                                                                                                                            |                            |
| <div></div> - <div></div> - <div></div>    |                                                                                                   |                                                                                                                                                                                                                                                                                                                            |                            |
| Email address                              |                                                                                                   |                                                                                                                                                                                                                                                                                                                            |                            |
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|                                            |                                                                                                   |                                                                                                                                                                                                                                                                                                                            |                            |
|--------------------------------------------|---------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|
| <b>Dependent<br/>2</b>                     | <input type="checkbox"/> Name change                                                              | <b>Applicants 21 and older:</b> Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. <input type="checkbox"/> Yes <input type="checkbox"/> No |                            |
|                                            | <input type="checkbox"/> Add medical coverage                                                     |                                                                                                                                                                                                                                                                                                                            |                            |
|                                            | <input type="checkbox"/> End medical coverage                                                     |                                                                                                                                                                                                                                                                                                                            |                            |
|                                            | First name                                                                                        | MI                                                                                                                                                                                                                                                                                                                         | Date of birth (mm/dd/yyyy) |
|                                            | <div></div>                                                                                       |                                                                                                                                                                                                                                                                                                                            |                            |
|                                            | Last name                                                                                         |                                                                                                                                                                                                                                                                                                                            |                            |
| <div></div>                                |                                                                                                   |                                                                                                                                                                                                                                                                                                                            |                            |
| Medical record number (if any)             | Gender                                                                                            | Social Security number (if any)                                                                                                                                                                                                                                                                                            |                            |
| <div></div>                                | <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undeclared | <div></div> - <div></div> - <div></div>                                                                                                                                                                                                                                                                                    |                            |
| Primary phone (mobile phone, if available) |                                                                                                   |                                                                                                                                                                                                                                                                                                                            |                            |
| <div></div> - <div></div> - <div></div>    |                                                                                                   |                                                                                                                                                                                                                                                                                                                            |                            |
| Email address                              |                                                                                                   |                                                                                                                                                                                                                                                                                                                            |                            |
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|                                            |                                                                                                   |                                                                                                                                                                                                                                                                                                                            |                            |
|--------------------------------------------|---------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|
| <b>Dependent<br/>3</b>                     | <input type="checkbox"/> Name change                                                              | <b>Applicants 21 and older:</b> Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. <input type="checkbox"/> Yes <input type="checkbox"/> No |                            |
|                                            | <input type="checkbox"/> Add medical coverage                                                     |                                                                                                                                                                                                                                                                                                                            |                            |
|                                            | <input type="checkbox"/> End medical coverage                                                     |                                                                                                                                                                                                                                                                                                                            |                            |
|                                            | First name                                                                                        | MI                                                                                                                                                                                                                                                                                                                         | Date of birth (mm/dd/yyyy) |
|                                            | <div></div>                                                                                       |                                                                                                                                                                                                                                                                                                                            |                            |
|                                            | Last name                                                                                         |                                                                                                                                                                                                                                                                                                                            |                            |
| <div></div>                                |                                                                                                   |                                                                                                                                                                                                                                                                                                                            |                            |
| Medical record number (if any)             | Gender                                                                                            | Social Security number (if any)                                                                                                                                                                                                                                                                                            |                            |
| <div></div>                                | <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undeclared | <div></div> - <div></div> - <div></div>                                                                                                                                                                                                                                                                                    |                            |
| Primary phone (mobile phone, if available) |                                                                                                   |                                                                                                                                                                                                                                                                                                                            |                            |
| <div></div> - <div></div> - <div></div>    |                                                                                                   |                                                                                                                                                                                                                                                                                                                            |                            |
| Email address                              |                                                                                                   |                                                                                                                                                                                                                                                                                                                            |                            |
| <div></div>                                |                                                                                                   |                                                                                                                                                                                                                                                                                                                            |                            |

## D. Choose your enrollment period

Select one option: ☐ Open enrollment (**skip to Section E**) ☐ A special enrollment period (continue below)

Choose your qualifying life event. If you had more than one, review your options because effective dates vary by event. **Proof of eligibility is also required within 10 calendar days.** Visit [kp.org/specialenrollment](http://kp.org/specialenrollment) or call **855-WE-R-KPNV (855-937-5768)** (TTY **711**) for more about qualifying life events or if you do not see your qualifying life event below.

### Change in health coverage

- ☐ Loss of minimum essential health coverage (write the last full day you had coverage)
- ☐ Eligibility to purchase an individual health plan through an individual coverage health reimbursement arrangement (ICHRA) or a qualified small employer health reimbursement arrangement (QSEHRA)
- ☐ Discontinuation of employer contribution or government subsidization of COBRA premiums

### Change in household

- ☐ Gaining or becoming a dependent through marriage or domestic partnership
- ☐ Gaining or becoming a dependent through the birth of a child, adoption, or placement for adoption or foster care

**Note:** In this case, you also need to choose between 2 effective date options:

- ☐ The date of birth, adoption, foster care, or placement for adoption or foster care
- ☐ The first day of the month after the birth or placement of the child with you

- ☐ Child support order or other court order to cover a dependent  
**Note:** In this case, you also need to choose between 2 effective date options:
  - ☐ The date of the child support order or other court order to cover a dependent
  - ☐ The first day of the month after the court order date
- ☐ Domestic violence or spousal abandonment occurring within the household

### Change in residence

- ☐ Permanent relocation within the United States with access to new plans
- ☐ Permanent relocation to the United States from another country

**Note:** Please check one of the following boxes:

- ☐ U.S. citizen/permanent resident
- ☐ Non-U.S. citizen

### Other qualifying life events

- ☐ Determination by the health benefit exchange of exceptional circumstances

Please write the date when your qualifying life event occurred

/  /  (mm/dd/yyyy)

## E. Choose your health plan

If you indicated that you would like to change plans or add coverage for a family member, please select the plan you would like here. Each family member you listed in Section C will be moved to the plan you select. If you wish to enroll family members in different plans, please submit a separate form for each plan. Choosing a health plan is based on your county. See the county list below to determine which health plans are available to you. Your county may appear multiple times.

HMO plans available in the following counties: Carson City, Douglas, Lyon, Storey, Washoe

|                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                    |                                                                                                                                                    |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Bronze</b> <ul style="list-style-type: none"><li><input type="checkbox"/> KP NV Bronze 5900 HSA</li><li><input type="checkbox"/> KP NV Bronze 5500 HSA</li><li><input type="checkbox"/> KP NV Bronze 11750 HSA</li></ul> | <b>Silver</b> <ul style="list-style-type: none"><li><input type="checkbox"/> KP NV Silver 0</li><li><input type="checkbox"/> KP NV Silver 5000</li><li><input type="checkbox"/> KP NV Silver 3700 HSA</li><li><input type="checkbox"/> KP NV Silver 6500</li></ul> | <b>Gold</b> <ul style="list-style-type: none"><li><input type="checkbox"/> KP NV Gold 0</li><li><input type="checkbox"/> KP NV Gold 2400</li></ul> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|

EPO plans available in the following counties: Carson City, Douglas, Lyon, Storey, Washoe

|                                                                                                                                                                                                                                 |                                                                                                           |                                                                                                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| <b>Bronze</b> <ul style="list-style-type: none"><li><input type="checkbox"/> KP NV EPO Bronze 5900</li><li><input type="checkbox"/> KP NV EPO Bronze 5500 HSA</li><li><input type="checkbox"/> KP NV EPO Bronze 11750</li></ul> | <b>Silver</b> <ul style="list-style-type: none"><li><input type="checkbox"/> KP NV EPO Silver 0</li></ul> | <b>Gold</b> <ul style="list-style-type: none"><li><input type="checkbox"/> KP NV EPO Gold 0</li></ul> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|

HMO SENSIBLE plans available in the following county: Washoe

|                                                                                                                        |                                                                                                                                                                                   |                                                                                                               |
|------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|
| <b>Bronze</b> <ul style="list-style-type: none"><li><input type="checkbox"/> KP NV SENSIBLE Bronze 11750 HSA</li></ul> | <b>Silver</b> <ul style="list-style-type: none"><li><input type="checkbox"/> KP NV SENSIBLE Silver 3700 HSA</li><li><input type="checkbox"/> KP NV SENSIBLE Silver 6500</li></ul> | <b>Gold</b> <ul style="list-style-type: none"><li><input type="checkbox"/> KP NV SENSIBLE Gold 2400</li></ul> |
|------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|

Is the primary applicant purchasing this plan using a health reimbursement arrangement (HRA)? ☐ Yes

If Yes, what type: ☐ ICHRA ☐ QSEHRA

Under an individual coverage health reimbursement arrangement (ICHRA) or a qualified small employer health reimbursement arrangement (QSEHRA), your employer will establish and fund an account to help you pay monthly individual plan premiums and out-of-pocket expenses as an alternative to traditional group health coverage.

Using an employer's HRA to help pay premiums and out-of-pocket expenses does not change your eligibility for a Kaiser Permanente Individual and Family plan.

## F. Sign the form

- I understand that Kaiser Permanente for Individuals and Families (KPIF) will rely on the information provided in this form, and that if any information is found to be fraudulent or intentionally misrepresented, KPIF may choose to terminate my coverage back to the coverage effective date.
- I verify that no one listed on this form who is changing plans or being added as a dependent is entitled to Medicare Part A or enrolled in Medicare Part B.
- If I worked with a broker, I understand they may receive monetary payments or other compensation from Kaiser Permanente in connection with this coverage. Our standard compensation is \$26 per member per month plus a potential bonus. To learn more, visit [kp.org/brokercompensation](https://kp.org/brokercompensation).
- By providing my email address and phone number(s), I understand I may receive email and/or voice/text communications from Kaiser Permanente. For more information visit [healthy.kaiserpermanente.org/termsconditions](https://healthy.kaiserpermanente.org/termsconditions).

Note: The subscriber making a change must sign the form.

X

Date (mm/dd/yyyy)  
 /  /

Subscriber/new subscriber (parent or legal guardian for subscribers under 18)

## Contact information

|                                                                            |                                                                         |                                                                         |
|----------------------------------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------------------------------------------|
| <b>Mail to:</b> Kaiser Permanente<br>P.O. Box 23127<br>San Diego, CA 92193 | <b>Or fax to:</b><br>Membership Administration<br><b>1-855-355-5334</b> | <b>Questions? Call</b><br><b>855-WE-R-KPNV (855-937-5768) (TTY 711)</b> |
|----------------------------------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------------------------------------------|

In Nevada, HMO plans are offered and underwritten by Kaiser Foundation Health Plan of Nevada and EPO plans are offered and underwritten by Kaiser Insurance Company of Nevada, N.C.C., 10315 Professional Circle, Reno, NV 89521

## Nondiscrimination Notice

In this document, “we”, “us”, or “our” means Kaiser Permanente (Kaiser Foundation Health Plan of Nevada, Kaiser Insurance Company of Nevada, and Kaiser Permanente Medical Group of Nevada). This notice is available on our website at **kp.org**.

We do not discriminate, exclude people, or treat them differently because of age, race, color, national origin, ancestry, religion, sex, gender, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, or medical condition.

Kaiser Permanente provides the following services in a timely manner:

- No-cost aids and services to people with disabilities to help them communicate better with us, such as:
  - ◆ Qualified sign language interpreters
  - ◆ Written information in other formats (braille, large print, audio, accessible electronic formats, and other formats)
- No-cost language services to people whose primary language is not English, such as:
  - ◆ Qualified interpreters
  - ◆ Information written in other languages

If you need these services, call our Member Services department at the numbers below. The call is free. Member services is closed on major holidays.

- Medicare, including D-SNP: **1-888-775-7003 or 775-982-3112 (TTY 711)**, Monday through Friday, 7:00 a.m. to 8:00 p.m.
- All others: **1-855-937-5768 (TTY 711)**, Monday through Friday, 7:00 a.m. to 8:00 p.m.

Upon request, this document can be made available to you in braille, large print, audio, or electronic formats. To obtain a copy in one of these alternative formats, or another format, call our Member Services department and ask for the format you need.

### How to file a grievance with Kaiser Permanente

You can file a discrimination grievance with us if you believe we have failed to provide these services or discriminated against you in another way. You can file a grievance by phone, by mail, or online. You can call Member Services for more information on the options that apply to you, or for help filing a grievance. You may file a discrimination grievance in the following ways:

- **By phone:** Call our Member Services department. Phone numbers are listed above.
- **Online:** Use the online form on our website at **kp.org**

You may also contact the Kaiser Permanente Civil Rights Coordinator directly at the addresses below:

**Attn: Kaiser Permanente Civil Rights Coordinator**

Member Relations Grievance Operations

10315 Professional Circle

Reno, Nevada 89521

**How to file a grievance with the U.S. Department of Health and Human Services  
Office of Civil Rights**

You can file a discrimination complaint with the U.S. Department of Health and Human Services Office for Civil Rights. You can file your complaint in writing, by phone, or online:

- **By phone:** Call **1-800-368-1019** (TTY **711** or **1-800-537-7697**)

- **By mail:** Fill out a complaint form or send a letter to:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

Complaint forms are available at:

**<https://www.hhs.gov/ocr/office/file/index.html>**

- **Online:** Visit the Office of Civil Rights Complaint Portal at:  
**<https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>**

# Notice of Language Assistance

**English: ATTENTION.** Timely language assistance is available at no cost to you. You can ask for interpreters, including sign language, or translated materials. You can also ask for materials in alternative formats, such as braille, audio, or large print. You can request auxiliary aids and devices at our facilities. Call our Member Services department for help. Member Services is closed on major holidays.

- Medicare, including D-SNP: **1-888-775-7003 or 775-982-3112 (TTY 711)**, Monday through Friday, 7:00 a.m. to 8:00 p.m.
- All others: **1-855-937-5768 (TTY 711)**, Monday through Friday, 7:00 a.m. to 8:00 p.m.

**Arabic: تنبيه.** المساعدة اللغوية متوفرة من دون أن تتحمل أي تكلفة. يمكنك طلب توفير مترجمين شفهيين، بما يشمل لغة الإشارة أو الحصول على وثائق مترجمة. يمكنك أيضًا طلب وثائق بصيغ بديلة، مثل طريقة برايل للمكفوفين أو ملف صوتي أو الطباعة بأحرف كبيرة. يمكنك طلب وسائل مساعدة وأجهزة مساعدة في منشأتنا. اتصل بقسم خدمات الأعضاء لدينا للحصول على المساعدة. يغلق قسم خدمات الأعضاء (Member Services) أبوابه في أيام العطلات الرئيسية.

- يمكن الاتصال ببرنامج Medicare، ويشمل ذلك D-SNP: **1-888-775-7003 أو 775-982-3112** (خدمة الهاتف النصي (TTY 711))، من الاثنين إلى الجمعة، من 7:00 صباحًا إلى 8:00 مساءً
- جميع البرامج الأخرى: **1-855-937-5768 (TTY 711)**، من الاثنين إلى الجمعة، من 7:00 صباحًا إلى 8:00 مساءً

**Armenian: ՈւՆԴԱՂՐՈՒԹՅՈՒՆ:** Ժամանակին տրամադրվող լեզվական աջակցությունը հասանելի է ձեզ անվճար: Դուք կարող եք խնդրել բանավոր թարգմանության ծառայություններ, այդ թվում՝ ժեստերի լեզվի թարգմանիչներ կամ թարգմանված նյութեր: Դուք կարող եք նաև խնդրել նյութեր այլընտրանքային ձևաչափեր, ինչպիսիք են՝ բրայլը, ձայնագրությունը կամ խոշոր տառատեսակը: Դուք կարող եք դիմել օժանդակ աջակցության և սարքերի համար մեր հաստատություններում: Օգնության համար զանգահարեք մեր Անդամների սպասարկման բաժին: Անդամների սպասարկման բաժինը (Member Services) փակ է հիմնական տոն օրերին:

- Medicare, ներառյալ D-SNP **1-888-775-7003 կամ 775-982-3112 (TTY 711)**, երկուշաբթիից ուրբաթ, 7 a.m.-ից 8 p.m.-ը
- Մյուս բոլորը՝ **1-855-937-5768 (TTY 711)**, երկուշաբթիից ուրբաթ, 7 a.m.-ից 8 p.m.-ը

**Chinese: 请注意。**我们可及时提供免费语言协助。您可以要求使用口译员（包括手语翻译）或翻译资料。您还可以要求获取其他格式的资料，如盲文、音频或大字版。您可以要求使用我们设施中的语言辅助工具和设备。请联系会员服务部 (Member Services) 以获取帮助。重要节假日期间会员服务不开放。

- 联邦医疗保险计划 (Medicare), 包括 D-SNP: **1-888-775-7003或 775-982-3112 (TTY 711)**, 周一至周五, 上午7点至晚上8点
- 所有其他保险计划: **1-855-937-5768 (TTY 711)**, 周一至周五, 上午7点至晚上8点

**Farsi: توجه.** امکان بهرهمندی از مساعدت زبانی بموقع به طور رایگان برای شما وجود دارد. می‌توانید خدمات ترجمه شفاهی را درخواست کنید، از جمله مترجمان زبان اشاره، یا مطالب ترجمه شده. همچنین می‌توانید مطالب را در قالب‌های جایگزین درخواست کنید، از جمله خط بریل، فایل صوتی، یا چاپ با حروف درشت. می‌توانید امکانات و دستگاه‌های کمکی را از مراکز ما درخواست کنید. برای دریافت کمک، با خدمات اعضای (Member Services) ما تماس بگیرید. خدمات اعضاء، در تعطیلات رسمی بسته است.

- Medicare، شامل D-SNP: با شماره **1-888-775-7003** یا شماره **775-982-3112 (TTY 711)**، روزهای دوشنبه تا جمعه از 7:00 صبح تا 8:00 عصر، تماس بگیرید
- همه موارد دیگر: با شماره **1-855-937-5768 (TTY 711)**، روزهای دوشنبه تا جمعه از 7:00 صبح تا 8:00 عصر، تماس بگیرید

**French: ATTENTION.** Une assistance linguistique est disponible pour vous gratuitement. Vous pouvez demander un interprète, notamment spécialiste du langage des signes, ou des documents traduits. Vous pouvez également demander des documents dans d'autres formats, par exemple en braille, en version audio ou en gros caractères. Vous pouvez demander des appareils et des aides auxiliaires dans nos établissements. Pour toute aide, appelez notre Direction des services aux adhérents (Member Services). Les services aux adhérents sont fermés pendant les jours fériés.

- Medicare, y compris D-SNP : **1-888-775-7003 ou 775-982-3112 (TTY 711)**, du lundi au vendredi, de 7 h à 20 h.
- Tous les autres services : **1-855-937-5768 (TTY 711)**, du lundi au vendredi, de 7 h à 20 h.

**German: HINWEIS!** Wir stellen Ihnen kostenlos eine schnelle Sprachunterstützung zur Verfügung. Sie können um einen Dolmetscher bitten, darunter auch in Gebärdensprache, oder um übersetzte Dokumente. Sie können darum bitten, dass Ihnen das Material in alternativen Formaten zur Verfügung gestellt wird, darunter Brailleschrift, Audioformate oder Großdruck. In unseren Einrichtungen können Sie auch um Hilfsmittel und unterstützende Geräte bitten. Wenn Sie Hilfe benötigen, wenden Sie sich an unsere Abteilung für Mitgliederdienste (Member Services). Die Abteilung für Mitgliederdienste ist an Hauptfeiertagen geschlossen.

- Medicare, einschließlich D-SNP: **1-888-775-7003 oder 775-982-3112 (TTY 711)**, Montag bis Freitag, 7:00 bis 20:00 Uhr
- Alle anderen: **1-855-937-5768 (TTY 711)**, Montag bis Freitag 7:00 bis 20:00 Uhr

**Italian: ATTENZIONE.** Sono disponibili servizi di assistenza linguistica, forniti gratuitamente e in modo tempestivo. Può richiedere servizi di interpretariato, compreso interpretariato nella lingua dei segni, oppure materiale tradotto. Inoltre, può richiedere materiali in altri formati, come braille, audio o stampa a caratteri ingranditi. Presso le nostre strutture è possibile richiedere ausili e strumenti di supporto alla comunicazione. Per richiedere assistenza, contatti il nostro ufficio Servizi Assistiti (Member Services). L'ufficio Servizi Assistiti è chiuso nei principali giorni festivi.

- Medicare, compresi i piani D-SNP: **1-888-775-7003 oppure 775-982-3112 (TTY 711)**, dal lunedì al venerdì, dalle ore 7:00 alle ore 20:00.
- Per tutti gli altri piani: **1-855-937-5768 (TTY 711)**, dal lunedì al venerdì, dalle ore 7:00 alle ore 20:00.

**Japanese:ご注意.** タイムリーな言語サポートは無料でご利用いただけます。手話を含む通訳者や翻訳された資料をご依頼いただけます。点字、大型活字、または録音音声など、別のフォーマットの資料も求めることができます。当社の施設では、補助器具や機器をご依頼いただけます。支援が必要な方は、メンバーサービス部門 (Member Services) にお電話ください。メンバーサービス部門は主要な祝日には休業となります。

- D-SNP を含む Medicare : **1-888-775-7003**、または **775-982-3112 (TTY 711)**、月曜日から金曜日まで、午前7時から午後8時までです。
- その他 : **1-855-937-5768 (TTY 711)**、月曜日から金曜日まで、午前7時から午後8時までです。

**Korean: 참조.** 시기적절한 언어 지원이 무료로 제공됩니다. 수화를 포함한 통역사, 또는 번역 자료를 요청하실 수 있습니다. 또한, 한국어로 점자, 오디오 또는 큰 글씨와 같은 대체 형식의 자료를 요청할 수 있습니다. 저희 시설에서 보조 기구와 장치를 요청할 수 있습니다. 가입자 서비스 (Member Services) 부서에 도움을 요청하시기 바랍니다. 가입자 서비스부는 주요 공휴일에는 운영하지 않습니다.

- Medicare (D-SNP 포함): **1-888-775-7003** 또는 **775-982-3112 (TTY 711)**, 월요일~금요일, 오전 7시 ~ 오후 8시.
- 기타 모두: **1-855-937-5768 (TTY 711)**, 월요일~금요일, 오전 7시~오후 8시.

**Portuguese: ATENÇÃO.** Assistência linguística gratuita disponível para você sempre que precisar. Você pode solicitar intérpretes, incluindo de linguagem de sinais, ou materiais traduzidos. Você também pode solicitar materiais em formatos alternativos, como braille, áudio ou impressão ampliada. Você pode solicitar dispositivos e assistências alternativas em nossas instalações. Ligue para o nosso departamento de Atendimento ao Cliente (Member Services) para obter ajuda. O Atendimento ao Cliente estará fechado nos principais feriados.

- Medicare, incluindo D-SNP: **1-888-775-7003 ou 775-982-3112 (TTY 711)**, de segunda a sexta-feira, das 7h às 20h.
- Todos os outros: **1-855-937-5768 (TTY 711)**, de segunda a sexta-feira, das 7h às 20h.

**Russian: Внимание!** Вы можете своевременно получить бесплатные услуги перевода. Вы можете попросить предоставить Вам услуги переводчика, в том числе сурдопереводчика, или переведенные материалы. Вы также можете запросить материалы в альтернативных форматах, например шрифтом Брайля, крупным шрифтом или в аудиоформате. Вы также можете запросить дополнительные приспособления и вспомогательные устройства в наших учреждениях. Если Вам нужна помощь, позвоните в отдел обслуживания участников (Member Services). Отдел обслуживания участников закрыт в дни государственных праздников.

- Программа Medicare, включая D-SNP: **1-888-775-7003 или 775-982-3112 (TTY 711)**, с понедельника по пятницу, с 7:00 до 20:00.
- Для всех остальных: **1-855-937-5768 (TTY 711)**, с понедельника по пятницу, с 7:00 до 20:00.

**Spanish: ATENCIÓN.** Se ofrece ayuda oportuna en otros idiomas sin ningún costo para usted. Puede solicitar intérpretes, incluyendo intérpretes de lengua de señas, o materiales traducidos. También puede solicitar materiales en formatos alternativos, como braille, audio o letra grande. Puede solicitar ayuda adicional y dispositivos auxiliares en nuestros centros de atención. Llame al Departamento de Servicio a los Miembros (Member Services) para pedir ayuda. Servicio a los Miembros está cerrado los días festivos principales.

- Medicare, incluyendo D-SNP: **1-888-775-7003 o 775-982-3112 (TTY 711)**, de lunes a viernes, de 7:00 a. m. a 8:00 p. m.
- Todos los otros: **1-855-937-5768 (TTY 711)**, de lunes a viernes, de 7:00 a. m. a 8:00 p. m.

**Tagalog: PAUNAWA** May magagamit na napapanahong tulong sa wika na wala kang babayaran. Maaari kang humingi ng mga tagapagsalin, kasama ang sign language, o isinaling mga babasahin. Maaari ka ring humingi ng mga babasahin sa mga alternatibong format, na tulad ng braille, audio, o malalaking titik. Maaari kang humiling ng mga karagdagang tulong at kagamitan sa aming mga pasilidad. Tawagan ang aming departamento ng Mga Serbisyo sa Miyembro (Member Services) para sa tulong. Sarado ang Mga Serbisyo sa Miyembro sa mga pangunahing holiday.

- Medicare, kasama ang D-SNP: **1-888-775-7003 o 775-982-3112 (TTY 711)**, Lunes hanggang Biyernes, 7:00 a.m. hanggang 8:00 p.m.
- Lahat ng iba: **1-855-937-5768 (TTY 711)**, Lunes hanggang Biyernes, 7:00 a.m. hanggang 8:00 p.m.

**Ukrainian: УВАГА!** Своєчасні послуги перекладача надаються безкоштовно. Ви можете зробити запит на послуги усного перекладу, зокрема мовою жестів, або перекладені матеріали. Ви можете зробити запит на отримання матеріалів в альтернативних форматах, як-от надрукованим шрифтом Брайля чи великим шрифтом, а також у звуковому форматі. Ви можете зробити запит на отримання допоміжних засобів і пристроїв у закладах нашої мережі компаній. Якщо вам потрібна допомога, зателефонуйте у відділ обслуговування клієнтів (Member Services). Відділ обслуговування клієнтів зачинений у державні свята.

- Medicare, зокрема D-SNP: **1-888-775-7003 або 775-982-3112 (TTY 711)**, з понеділка по п'ятницю, з 07:00 до 20:00.
- Усі інші надавачі послуг: **1-855-937-5768 (TTY 711)**, з понеділка по п'ятницю, з 07:00 до 20:00.

**Vietnamese: CHÚ Ý.** Dịch vụ hỗ trợ ngôn ngữ được cung cấp miễn phí, kịp thời cho quý vị. Quý vị có thể yêu cầu thông dịch viên, bao gồm cả thông dịch viên ngôn ngữ ký hiệu, hoặc các tài liệu đã được dịch. Quý vị cũng có thể yêu cầu các tài liệu theo định dạng thay thế, chẳng hạn như chữ nổi Braille, băng đĩa thu âm hoặc bản in khổ chữ lớn. Quý vị có thể yêu cầu các phương tiện và công cụ hỗ trợ tại các cơ sở của chúng tôi. Gọi cho ban Dịch Vụ Hội Viên (Member Services) của chúng tôi để được trợ giúp. Ban Dịch Vụ Hội Viên không làm việc vào những ngày lễ lớn.

- Medicare, bao gồm cả D-SNP: **1-888-775-7003 hoặc 775-982-3112 (TTY 711)**, Thứ Hai đến Thứ Sáu, 7 giờ sáng đến 8 giờ tối.
- Tất cả các chương trình khác: **1-855-937-5768 (TTY 711)**, Thứ Hai đến Thứ Sáu, 7 giờ sáng đến 8 giờ tối.