Blue Shield of California
Blue Shield of California Life & Health Insurance Company
Dental plan, vision plan, and dental + vision package application

blue california

This form is to be used by applicants applying for a Blue Shield dental plan, vision plan or IFP Specialty Duo℠ dental + vision package. Please include first month's dues/premiums to avoid return of application.

You are eligible for any Individual and Family Plan (IFP) dental plan, vision plan or the Specialty Duo dental + vision package if you are a California resident at the time of enrollment. If you had any Blue Shield IFP dental or vision plan cancelled for any reason (by yourself or by Blue Shield), you must wait six months from date of cancellation before reapplying.

Part 1 – Coverage, plan, and applicant information

Reason for application: ☐ New enrollment ☐ Plan transfer ☐ Add dependent family member to existing coverage
Requested effective date: _____/_____/_____

Dental plan, vision plan or dental + vision package options:

Dental plans:

☐ Dental HMO Plan
☐ Dental Standard HMO
☐ Dental PPO Plan
☐ Enhanced Dental PPO 25/500
☐ Enhanced Dental PPO 50/1250
☐ Enhanced Dental PPO 50/2000
☐ Enhanced Dental PPO 50/2000 Lifetime Ortho 1500

Vision plans:

☐ Ultimate Vision 15/25/120*
☐ Ultimate Vision 15/25/150*

Vision + dental package:

☐ Specialty Duo (dental + vision) package*

Dental HMO applicants only – please choose a dentist from the Provider Directory at **blueshieldca.com**, or call **(888) 256-3650** for assistance.

Dental HMO provider name: _____ Dental HMO provider number: _____

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

Part 2 – Primary applicant information

Applicant's Social Security number/Tax ID number	Sex: ☐ Male ☐ Female	Date of birth (month/day/year)	Married: ☐ Yes ☐ No Domestic partnership: ☐ Yes ☐ No
___ ___ ___ -___ ___ -___ ___ ___ ___		____/____/_____	

First name	MI	Last name

Do you currently have dental coverage through Blue Shield? ☐ Yes ☐ No	If yes, please indicate plan	Dental subscriber number (if applicable)
Do you currently have medical coverage through Blue Shield? ☐ Yes ☐ No	If yes, please indicate plan	Medical subscriber number (if applicable)
Do you currently have vision coverage through Blue Shield? ☐ Yes ☐ No	If yes, please indicate plan	Vision subscriber number (if applicable)

Applicant's business number	Applicant's home number	Applicant's fax number	Applicant's cell number

I understand and agree that any phone number(s) I provide on this Application will be used by Blue Shield to contact me about my Blue Shield contract/policy. Subject to HIPAA, I understand that information may be provided in a pre-recorded telephone message with important information about my coverage, renewal options and other information Blue Shield determines is relevant to my coverage. I consent to allow Blue Shield to contact me and/or any dependents covered on my contract/policy at the phone number(s) I provided, including any number I provide that connects to a cell or mobile phone.	Initial _____

Applicant's Email address

I understand and agree that the email address I provide on this Application may be used by Blue Shield to contact me about my Blue Shield contract/policy. I understand that information sent to me by email could include important information about my coverage, renewal options, and any other information Blue Shield determines is relevant to my coverage. I consent to allow Blue Shield to contact me and/or any dependents covered on my contract/policy at the email I provide on this Application.	Initial _____

Home address (**NO** P.O. box)		Apt No.
City	State	ZIP code
Billing address (if different from home address)		Apt No.
City	State	ZIP code
Applicant's mailing address (if different from home address)		Apt No.
City	State	ZIP code

Preferred method of contact (check one): ☐ Home phone ☐ Work phone ☐ Cell phone ☐ Email ☐ Standard mail

Indicate language preference: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Korean ☐ Other _____

Part 3(a) – Spouse/domestic partner dependent applicant information

☐ Spouse ☐ Domestic partner Sex: ☐ Male ☐ Female

First name	MI	Last name

Applicant's Social Security number/Tax ID number ___ ___ ___ -___ ___ -___ ___ ___ ___	Date of birth (month/day/year) ____/____/_____

Is the spouse/domestic partner applicant's residence the same as the primary applicant? ☐ Yes ☐ No
If no, where does the applicant reside? (address, including ZIP code and state)

Part 3(b) – Child dependent applicant information

Dependent children must be under age 26. If more than eight child dependents are applying for coverage, please attach a supplemental page providing all information listed below, your signature, and date. Check here if a supplemental page is attached. ☐

1. ☐ Male ☐ Female | Relationship _____ (e.g. son/daughter)

First name | MI | Last name (if different from above)

Applicant's Social Security number/Tax ID number
___ ___ ___-___ ___-___ ___ ___ ___

Date of birth (month/day/year) ____/____/_____

Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No
If no, where does the applicant reside? (address, including ZIP code and state)

2. ☐ Male ☐ Female | Relationship _____ (e.g. son/daughter)

First name | MI | Last name (if different from above)

Applicant's Social Security number/Tax ID number
___ ___ ___-___ ___-___ ___ ___ ___

Date of birth (month/day/year) ____/____/_____

Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No
If no, where does the applicant reside? (address, including ZIP code and state)

3. ☐ Male ☐ Female | Relationship _____ (e.g. son/daughter)

First name | MI | Last name (if different from above)

Applicant's Social Security number/Tax ID number
___ ___ ___-___ ___-___ ___ ___ ___

Date of birth (month/day/year) ____/____/_____

Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No
If no, where does the applicant reside? (address, including ZIP code and state)

4. ☐ Male ☐ Female | Relationship _____ (e.g. son/daughter)

First name | MI | Last name (if different from above)

Applicant's Social Security number/Tax ID number
___ ___ ___-___ ___-___ ___ ___ ___

Date of birth (month/day/year) ____/____/_____

Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No
If no, where does the applicant reside? (address, including ZIP code and state)

5. ☐ Male ☐ Female | Relationship _____ (e.g. son/daughter)

First name | MI | Last name (if different from above)

Applicant's Social Security number/Tax ID number
___ ___ ___-___ ___-___ ___ ___ ___

Date of birth (month/day/year) ____/____/_____

Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No
If no, where does the applicant reside? (address, including ZIP code and state)

6. ☐ Male ☐ Female | Relationship _____ (e.g. son/daughter)

First name | MI | Last name (if different from above)

Applicant's Social Security number/Tax ID number
___ ___ ___-___ ___-___ ___ ___ ___

Date of birth (month/day/year) ____/____/_____

Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No
If no, where does the applicant reside? (address, including ZIP code and state)

7. ☐ Male ☐ Female | Relationship _____ (e.g. son/daughter)

First name | MI | Last name (if different from above)

Applicant's Social Security number/Tax ID number
___ ___ ___-___ ___-___ ___ ___ ___

Date of birth (month/day/year) ____/____/_____

Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No
If no, where does the applicant reside? (address, including ZIP code and state)

8. ☐ Male ☐ Female | Relationship _____ (e.g. son/daughter)

First name | MI | Last name (if different from above)

Applicant's Social Security number/Tax ID number
___ ___ ___-___ ___-___ ___ ___ ___

Date of birth (month/day/year) ____/____/_____

Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No
If no, where does the applicant reside? (address, including ZIP code and state)

Part 4 – Authorizations, terms, and conditions

Please read the following terms and conditions carefully. Each applicant age 18 and older is required to review the completed application and provide their own authorization and signature. Keep a copy of this application for your records.

1. **Application for coverage:** I understand that Blue Shield has the right to decline my application for coverage. I also understand that I must be residing in California in order to be eligible for enrollment in this plan/package. I will notify Blue Shield upon any change regarding my eligibility for the dental plan, vision plan, or Specialty Duo dental + vision package. I also agree to provide information requested by Blue Shield to verify my eligibility or continued eligibility for coverage, and understand that failure to cooperate could result in cancellation of coverage.
2. **First month's dues/premiums:** Blue Shield requires first month's dues/premiums at the time of application submission. Find your estimated monthly dues/premiums by going to **blueshieldca.com** or contact your agent. Refer to Part 6 for payment options. Failure to submit full payment of dues/premiums will result in a return of your application. Please note that processing of your payment does not constitute approval of your application with Blue Shield or Blue Shield Life. If you include a check, it will be destroyed. If you complete the payment authorization form, your credit card or checking account will not be debited.
3. **Dues/premiums:** Dues/premiums are to be paid by the due date. Coverage will be terminated for failure to pay dues/premiums in a timely manner as set forth in the *Evidence of Coverage* and health service agreement/policy as allowed by law.
4. **Effective date of coverage:** If you qualify for coverage, Blue Shield will notify you of your effective date of coverage. If Blue Shield cannot honor your requested effective date or is unable to issue coverage before the requested date, coverage will begin as soon as possible. If additional dues/premiums are owed, payment must be received before coverage becomes effective. Any charges incurred for services received prior to your effective date or after termination of coverage are not covered.
5. **Acceptance of application:** You understand that only Blue Shield can accept your application and issue coverage for an IFP plan requested on this form. Your agent or broker cannot enroll you for coverage or change any terms or conditions of coverage.
6. **Parents/guardians:** If you are the parent or legal guardian of an applicant who is a minor, please sign on behalf of the applicant at the bottom of this Part 4. As the parent or legal guardian, you are identified as the person who may make inquiries and act on behalf of the applicant regarding this coverage (as allowed by law). In addition, you are agreeing to assume all responsibility for dues/premiums payments and for following the terms and conditions for coverage. If you are not the parent of the applicant, please attach court documents that appoint you as the guardian of this minor. Mark one of the following boxes and identify the individual authorized to act on behalf of the minor (applicant):
   - ☐ Parent only _____ (include name and relationship); or
   - ☐ Legal guardian only_____ (include name and relationship); or
   - ☐ My designee _____ (include name and relationship); or
   - ☐ Qualified medical child support order designee _____ (include name and relationship).
   - ☐ Mark this box if Blue Shield is to only make changes to the contract upon written request by the person identified above.
7. **Authorization for spouse/domestic partner to make changes:** If you are an applicant whose spouse/domestic partner is also applying for coverage, please specify if you authorize your spouse/domestic partner to make changes to the contract/policy on your behalf. You may discontinue this authorization at any time by sending a written request to Blue Shield. ☐ **Yes** ☐ **No**
8. **Authorization for your agent to provide/obtain information:** Check here if you do **not** authorize your insurance agent, broker, or producer (referred to as "your agent") to access all information on this application. ☐
9. **Process to authorize Blue Shield to release personal and health information to a third party:** If you would like to authorize your spouse, domestic partner, or a third party to access your personal health information, please complete the form titled Authorization for Blue Shield to Disclose Personal & Health Information to a Third Party. To obtain this form, go to **blueshieldca.com** and click on the *Privacy* link at the bottom of the page, or call **(888) 256-3650**.
10. **Response to requested information:** You agree to cooperate with Blue Shield (or Blue Shield Life, as applicable) by providing, or by providing access to, documents and other information requested (such as court orders to provide dependent coverage, etc.) to corroborate information provided in this application for coverage. You acknowledge and agree that failure or refusal to provide these documents or the information requested may be cause to rescind or cancel your coverage.
11. **Receiving materials and communications electronically versus print:** Check here if you agree to receive required benefit plan and coverage-related materials and communications via email and/or the Blue Shield website **blueshieldca.com**, as applicable. Documents that are made available to you via **blueshieldca.com** are as follows:
    - Blue Shield Identification (ID) cards
    - Statement of Benefits (SOB)
    - Endorsements to your EOC or policy
    - *Evidence of Coverage* (EOC) and health service agreement/policy
    - Summary of Benefits and Coverage (SBC)

    Obtaining a document electronically will confirm your consent to electronic delivery. You also have the right to obtain printed, mailed materials at any time and at no expense to you.
    To receive printed materials in the mail, to opt out of email communications, or if you have questions, please call **(888) 256-3650**.

I have reviewed all responses pertaining to me in this application. I have read the summary of benefits and the terms and conditions of coverage and authorizations set forth above. With my own signature below, I represent that the information provided in this application is complete and accurate to the best of my knowledge, and I understand and agree to the terms and conditions of coverage and the authorizations I have provided. (Important: Each adult applicant must provide their own signature.) I understand that I must inform Blue Shield if anything changes or is different from what I listed on this application before my enrollment with Blue Shield begins.

Signature of applicant/parent or legal guardian	Today's date _____/_____/_____	Print name (and your relationship if applicant is a minor)
Signature of applicant/parent or legal guardian	Today's date _____/_____/_____	Print name (and your relationship if applicant is a minor)
Signature of applicant's spouse/domestic partner (if applying)	Today's date _____/_____/_____	Print name
Signature of family member age 18 or over (if applying)	Today's date _____/_____/_____	Print name
Signature of family member age 18 or over (if applying)	Today's date _____/_____/_____	Print name
Signature of family member age 18 or over (if applying)	Today's date _____/_____/_____	Print name
Signature of family member age 18 or over (if applying)	Today's date	Print name

	____/____/_____	
Signature of family member age 18 or over (if applying)	Today's date ____/____/_____	Print name
Signature of family member age 18 or over (if applying)	Today's date ____/____/_____	Print name
Signature of family member age 18 or over (if applying)	Today's date ____/____/_____	Print name
Signature of family member age 18 or over (if applying)	Today's date	Print name

Important: Return the application within 30 days of your date(s) and signature(s).

Part 5 – Producer information: To be completed by an authorized Blue Shield agent

1. Did you complete this application? ☐ Yes ☐ No

2. If yes, did you ask each question in this application exactly as set forth? ☐ Yes ☐ No

3. Are the answers recorded exactly as given to you? ☐ Yes ☐ No, attach explanation.

4. Do you want the health service agreement/policy sent directly to the subscriber? ☐ Yes ☐ No

Producer name (the entity/individual to whom commissions will be issued)

Email address jorge@bestquoteinsurance.net ☐ Update email	Producer number	
Telephone number (760)942-7684 ☐ Update phone	Fax number (760)942-0540 ☐ Update fax	
Producer address 1103 Ouail Gardens Ct ☐ Update address		
City Encinitas	State CA	ZIP code
Super producer name	Super producer number	

	____/____/_____	
Producer signature (required)	Today's date (required)	Print name

Producers: Please ensure each part of the application is complete. In the event of missing or incomplete information, Blue Shield may contact your applicant directly to obtain complete information.

Please fax or mail the completed and signed application to:

Installation and Billing
Blue Shield of California
P.O. Box 3008
Lodi, CA 95241-1912
Fax: **(888) 386-3420**

For internal use only
DSA name: _____
DSA number: _____
Producer number: _____

Part 6 – Billing and payment information

Calculate estimate monthly dues/premiums

- Go to **blueshieldca.com** to get your estimated dues/premiums or talk to your agent to get estimated dues/premiums.
- First month's dues/premiums is required at the time of application submission.
- Blue Shield will issue final dues/premium before any effective date of coverage. If the final amount differs from the estimated dues/premium and additional amounts are owed, payment must be received before coverage will take effect.

Payment options

Your first month's dues/premium can be paid by submitting a check* or money order.

* When you provide a check as payment, you authorize Blue Shield either to use information from your check to make a one-time electronic funds transfer from your account or to process the payment as a check transaction. When we use this information from your check to make an electronic funds transfer, funds will be withdrawn from your account as soon as the date we approve your application and you will not receive your check back from your financial institution.

Authorization and signature(s)

One of the following provisions will apply, depending on the payment method I selected above:

By signing below, I agree to the terms and conditions of this authorization form and I acknowledge that I have received a copy of this form. I acknowledge that all payment transactions must comply with the provisions of U.S. law.

Payments may be processed by a third-party vendor on behalf of Blue Shield.

Account holder signature

Print name

_____/_____/_____

Date

Account holder signature

Print name

_____/_____/_____

Date

Part 6 – Billing and payment information

KEEP THIS COPY FOR YOUR RECORDS

Calculate estimate monthly dues/premiums

- Go to **blueshieldca.com** to get your estimated dues/premiums or talk to your agent to get estimated dues/premiums.
- First month's dues/premiums is required at the time of application submission.
- Blue Shield will issue final dues/premium before any effective date of coverage. If the final amount differs from the estimated dues/premium and additional amounts are owed, payment must be received before coverage will take effect.

Payment options

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* When you provide a check as payment, you authorize Blue Shield either to use information from your check to make a one-time electronic funds transfer from your account or to process the payment as a check transaction. When we use this information from your check to make an electronic funds transfer, funds will be withdrawn from your account as soon as the date we approve your application and you will not receive your check back from your financial institution.

Authorization and signature(s)

By signing below, I agree to the terms and conditions of this authorization form and I acknowledge that I have received a copy of this form.
I acknowledge that all payment transactions must comply with the provisions of U.S. law.

Payments may be processed by a third-party vendor on behalf of Blue Shield.

Account holder signature

Print name

____/____/_____

Date

Account holder signature

Print name

____/____/_____

Date

Blue Shield of California

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

Blue Shield of California complies with applicable state laws and federal civil rights laws, and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability.

Blue Shield of California:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability, you can file a grievance with:

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711)
Fax: (844) 696-6070
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
(800) 368-1019; TTY: (800) 537-7697

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

Notice of the Availability of Language Assistance Services

Blue Shield of California

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For help at no cost, please call right away at the Member/Customer Service telephone number on the back of your Blue Shield ID card, or (866) 346-7198.

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda sin cargo, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Blue Shield o al (866) 346-7198. (Spanish)

Blue Shield ID / 費

(866) 346-7198 (Chinese)

QUAN TR NG: Quý v có th u không, chúng tôi có th nh i giúp quý v nh c vi t b ng ngôn ng c a quý v c h tr mi n phí, vui lòng g n Ban D ch v H i viên/Khách hàng theo s m t sau th ID Blue Shield c a quý v ho c theo s (866) 346-7198. (Vietnamese)

MAHALAGA: Nababasa mo ba ang sulat na ito? Kung hindi, maari kaming kumuha ng isang tao upang matulungan ka upang mabasa ito. Maari ka ring makakuha ng sulat na ito na nakasulat sa iyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa numerong telepono ng Miyembro/Customer Service sa likod ng iyong Blue Shield ID kard, o (866) 346-7198. (Tagalog)

Baa' ákohwiindzindooígí: Díí naaltsoosísh yííni ta'go bíníghah? Doo bíníghahgóó éí, naaltsoos nich'į' yiidóołtahígíí a' nihee hóló. Díí naaltsoos ałdó' t'áá Diné k'ehjí ádoolníił nínízingo bíighah. Doo bąąh ílínígó shíká' adoowoł nínízingó nihich'į' béésh bee hodíilnih dóó námboo éí díí Blue Shield bee néího'dílzinígí bine'déé' bikáá' éí doodagó éí (866) 346-7198 jį' hodíilnih. (Navajo)

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/ (866) 346-7198 . (Korean)

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Blue Shield ID , (866) 346-7198 (Armenian)

- (Russian)

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Blue Shield ID /

(866) 346-7198 (Japanese)

(Persian) 866) 346-7198 Blue Shield

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Blue Shield ID / , (866) 346-7198 (Punjabi)

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ន ង
/ ង Blue Shield
(866) 346-7198 (Khmer)

(Arabic).(866) 346-7198 Blue Shield

TSEEM CEEB: Koj pos tuaj yeem nyeem tau tsab ntawv no? Yog hais tias nyeem tsis tau, peb tuaj yeem nrhiav ib tug neeg los pab nyeem nws rau koj. Tej zaum koj kuj yuav tau txais muab tsab ntawv no sau ua koj hom lus. Rau kev pab txhais dawb, thov hu kiag rau tus xov tooj Kev Pab Cuam Tub Koom Xeeb/Tub Lag Luam uas nyob rau sab nraum nrob qaum ntawm koj daim npav Blue Shield ID, los yog hu rau tus xov tooj (866) 346-7198. (Hmong)

Blue Shield
(866) 346-7198 (Thai)

: ? , ส
ส : ส Blue Shield ID
/ , (866) 346-7198 (Hindi)

ລຶ້ງສຳລັບ: ? p , t .
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/ Blue Shield ,
(866) 346-7198. (Laotian)

Notice of the Availability of Language Assistance Services

Blue Shield of California Life & Health Insurance Company

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-866-346-7198. For more help call the CA Dept. of Insurance at 1-800-927-4357. English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-866-346-7198. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

免費語言服務 ф

1-866-346-7198

1-800-927-4357 Chinese

Các D ch V Tr Giúp Ngôn Ng Mi n Phí. Quý v có th c nh n d ch v thông d ch. Quý v có th c ॐष c giúp các tài li u và nh n m t s tài li u b ng ti ng Vi ष भें ष , hãy g i cho chúng tôi t i s ष n tho i ghi trên th h i viên c a quý v ho c 1-866-346- ष c tr giúp thêm, xin g i S B o Hi m California t i s 1-800-927-4357. Vietnamese

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. せ ID : 1-866-346-7198 み .

, 1-800-927-4357 み . Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-866-346-7198. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 Tagalog

(ID)

1-866-346-7198 1-800-927-4357

Armenian

.

-866-346-

-800-927-4357. Russian

無料の言語サービス

1-866-346-7198

1-800-927-4357 Japanese

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Persian. 1-800-927-4357 ( )CA Dept. of Insurance

:

(ID) ' ' 1-866-346-7198 ' '
1-800-927-4357 ' Punjabi

1-866-346-7198
1-800-927-4357 Khmer

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.1-866-346-7198
Arabic .1-800-927-4357

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-866-346-7198. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

1-866-346-7198
1-800-927-4357 Thai

ิ ภุ ถ ย รฟ ณ ุถิ ื รฟ น ร โ ณ ฟโ ๋ ณสฟ โร ุ ร โ น ุค ณี
ถ ย ท ฆา ๋ ิถ ฟ ร โ ร โ ป , ณ ป์D ช ณนิ ๋ตน ณน 1-866-346-7198 ณน ท ห น
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