moda HEALTH | DELTA DENTAL

Apply online during open enrollment by visiting shopmodaplans.com.
Questions? We're here to help. Call us at 855-718-1767.

2026 | Individual health plan application – Affinity service area

for individuals and families in all Oregon counties.

Your application can be reviewed more quickly if you apply online.

Submit your complete application no later than the 15th of the month before the date you want your coverage to start. If your application is received after the 15th, your enrollment may be delayed.

What you need to complete this enrollment form:

- **For special enrollment:** A copy of the documentation needed to show you are eligible *(see Section 1)*
- A copy of any documentation needed to show legal guardianship, if applicable
- The name of your in-network primary care provider *(PCP)* for all family members enrolling
- Your health insurance agent's information *(if an agent helped you)*
- Your first month's premium payment *(needed before your policy effective date)*

You are eligible to enroll if you meet the following requirements.

You must confirm you meet eligibility requirements by checking the boxes below.

I confirm that:

Medical plans

- ☐ I currently live, and have a fixed, permanent home address, in the service area
- ☐ I spend at least 6 months of the year living in the service area
- ☐ Children living outside the service area are in school or covered under a qualified medical childsupport order (QMCSO)
- ☐ I and any dependents enrolling are not enrolled in Medicare or living in the service area to get healthcoverage or for another temporary reason such as getting treatment.

Note: *Living in a residential care facility to receive treatment does not meet the residency requirement*

Dental plans

- ☐ I have a permanent home address in Oregon, and live in Oregon at least 6 months out of the year

If you had Delta Dental individual dental coverage that ended during the past 12 months:

- ☐ I have a special enrollment qualifying event or have had continuous group coverage since leaving Delta Dental

Section 1 > Why I am applying

- ☐ New policy/subscriber
- ☐ Changing my current coverage

Current subscriber name
Current subscriber ID#

- ☐ Add dependent to existing plan
- ☐ Plan change only

If you are not enrolling during Open Enrollment, you must have a special enrollment event to make changes or enroll in a new medical policy.

Date of special enrollment qualifying event

_____/_____/_____

No more than 60 days after the date of your special enrollment event, we must receive:

- > your application
- > proof of the life event that made you eligible

Mark your qualifying event and the document you are providing in the table below (not applicable to dental).

Qualifying Events	Required Proof
☐ Gained or became a dependent due to: ☐ Marriage or registered domestic partnership (RDP) ☐ Birth, adoption or placement for adoption ☐ Placement of foster child	☐ Marriage certificate or domestic partnership documentation AND proof of prior coverage for at least 1 spouse/partner ☐ Birth certificate or adoption papers ☐ Child support or other court order
☐ Loss of coverage because I turned 26	☐ Letter from employer or other carrier confirming loss of coverage due to age
☐ Loss of coverage due to end of marriage or RDP	☐ Divorce or other government documentation showing end of marriage or partnership
☐ Loss of eligibility for group coverage	☐ Coverage cancellation notice AND letter from employer confirming loss of eligibility for coverage. Include coverage start and end dates.
☐ COBRA ended due to expiration of coverage or end of employer contributions or government subsidy	☐ Coverage cancellation notice. Include coverage start and end dates.
☐ Loss of Medicaid coverage	☐ Notice of loss of coverage from state program
☐ Other _____	Contact us

Letters must be on official letterhead.

A more detailed list of required proof is at modahealth.com/shop/special-enrollment.

Section 2 › Choose a plan

IMPORTANT: *No out-of-network coverage. You must use in-network providers for services to be covered by these medical plans or by the dental EPO plan.*

I want my coverage to start on: _____/_____/_____

I choose this medical and/or dental plan:

Medical plans

- ☐ Standard Gold (Affinity)
- ☐ Standard Silver (Affinity)
- ☐ Standard Bronze (Affinity)
- ☐ Gold 250[1]
- ☐ Gold 1000[1]
- ☐ Gold 1500
- ☐ Silver 2900 Direct[1]
- ☐ Silver 3000[1]
- ☐ Silver 3400
- ☐ Silver 3500 Direct
- ☐ Silver 3650 Direct
- ☐ Silver 4400 Direct
- ☐ Silver 4500
- ☐ Silver 6000
- ☐ Bronze 8000
- ☐ Bronze 9000
- ☐ Bronze HDHP 7500
- ☐ No medical coverage

1 Includes pediatric dental coverage that meets the requirements of the Affordable Care Act

Dental plans

- ☐ Delta Dental PPO
- ☐ Delta Dental EPO
- ☐ Delta Dental PPO MAC
- ☐ Delta Dental Premier 1000[2]
- ☐ Willamette EPO[2]
- ☐ Delta Dental PPO Bright Smiles
- ☐ No dental coverage

2 Non-certified plan. Does not meet the requirement for pediatric dental coverage under the Affordable Care Act.

If you are changing from one Delta Dental individual plan to another because of a special enrollment qualifying event, any amount applied to your annual maximum plan payment limit will be transferred to your new plan.

Section 3 › Credit toward 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?

☐ No ☐ Yes If this coverage was through Delta Dental Plan of Oregon, 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.

Section 4 › Other insurance

Will you have other medical and/or dental insurance?

☐ Yes, Medical ☐ Yes, Dental ☐ Yes, both Medical and Dental ☐ No other coverage

Enrolling

List all family members you want to cover *(sections 5-6)*.

Only your legal spouse, registered domestic partner and children under age 26 are eligible. Children who are full-time students in schools away from home or with a QMCSO may be covered outside of the service area. Attach the QMCSO or documentation of the child's enrollment in an out-of-area school.

You must name an in-network PCP group for each applicant. Go to Find Care on modahealth.com to see if your PCP is in-network. We may assign one for you if you do not select one yourself. You may switch to a different Affinity PCP group at any time.

We are committed to understanding and valuing diversity among our members. We ask for gender identity and race/ethnicity information so we can refer to and communicate with you appropriately and respectfully. This information is optional.

Use these codes to fill out the information for each member:

***Gender identity**

M-male
F-female
T-transgender
C-cisgender
GN-gender nonconforming
NB-nonbinary
TG-third gender
Q-questioning
O-other
P-prefer not to answer

****Race/ethnicity**

AI-American Indian/Alaska Native
A-Asian
B-Black/African American
C-Caucasian
H-Hispanic/Latino
PI-Native Hawaiian/ other Pacific Islander
O-other _____

Attach additional pages if need to include more than 3 children. I have attached _____ pages.

Section 5 › Subscriber information

This section must be completed with subscriber information.

Is this application for a child- or children-only policy? No Yes

If yes, list the youngest child as the subscriber. Children age 26 or older must be on their own policy.

Name *(Last, First, MI)*				
Date of birth *(mm/dd/yyyy)*			Social Security number	
Home address				
City	State	ZIP	County	
Phone number	Email address			
Mailing address *(if different)*				
City	State	ZIP	Tobacco user[1] No Yes	
In-network PCP name				
Gender M F	Gender identity*	Race/ethnicity**	Primary language	

1 You are a tobacco user if you have lawfully used tobacco in any form (other than religious or ceremonial) an average of 4 or more times per week in the past 6 months.

Section 6 › Dependent Information — spouse or registered domestic partner (RDP)

Name *(Last, First, MI)*			
Date of birth *(mm/dd/yyyy)*		Social Security number	
In-network PCP name		Tobacco user[1] _ No _ Yes	
Gender M F	Gender identity*	Race/ethnicity**	Primary language

Section 7 > Dependent Information — eligible children

Name *(Last, First, MI)*			
Date of birth *(mm/dd/yyyy)*		Social Security number	
In-network PCP name		Tobacco user[1] No Yes	
Gender M F	Gender identity*	Race/ethnicity**	Primary language

Name *(Last, First, MI)*			
Date of birth *(mm/dd/yyyy)*		Social Security number	
In-network PCP name		Tobacco user[1] No Yes	
Gender M F	Gender identity*	Race/ethnicity**	Primary language

Name *(Last, First, MI)*			
Date of birth *(mm/dd/yyyy)*		Social Security number	
In-network PCP name		Tobacco user[1] No Yes	
Gender M F	Gender identity*	Race/ethnicity**	Primary language

Name *(Last, First, MI)*			
Date of birth *(mm/dd/yyyy)*		Social Security number	
In-network PCP name		Tobacco user[1] No Yes	
Gender M F	Gender identity*	Race/ethnicity**	Primary language

Section 8 › Billing and payment method

If you choose eBill or EFT, your premium invoice is paperless and located in the eBill section of your Member Dashboard. Otherwise, you will receive paper invoices in the mail. You may change your billing preference in the eBill section of your Member Dashboard.

Choose your payment option:

Automatic eBill payment through your Member Dashboard.

Electronic fund transfer (EFT), see authorization agreement below.

Personal check, money order or cashier's check.

Is your employer or your spouse's employer paying for or reimbursing any portion of your premium for this policy?

No Yes Yes, my spouse's employer

If yes, what type of benefit plan is it? ICHRA QSEHRA Unknown

For monthly automatic premium deductions from your bank (EFT) you must sign below and:

> Attach a photocopy of a voided personal check from the account, or

> Provide the bank routing and account numbers below

Bank name	Account type Checking Savings
Routing number	Account number

I authorize Moda Health or Delta Dental to charge my 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 X	Date
Account holder name (print)	

EFT initiates around the 5th of the month and usually takes one or two days to post to your account. Your first payment may be later if your enrollment is processed after the 5th of the month.

Billing address *(if different than mailing address)*:		
City	State	ZIP

Section 9 > Basic terms of enrollment

By signing Section 10, I understand and agree that:

- This application is not an offer of coverage. Coverage does not begin until this application is received and reviewed by Moda Health and/or Delta Dental and an effective date of coverage is assigned.
- This application becomes part of my policy.
- I have the right to examine and return the policy within 10 days of receipt.
- Being accepted for coverage has these requirements:
  - A. Subscriber must be an Oregon "resident" to apply for and keep coverage under a Moda Health or Delta Dental plan. "Resident" means a person who lives in the plan's service area and intends to live in the service area permanently or indefinitely. Moda Health/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 Moda Health and/or Delta Dental individual medical and dental plan at any time.
  - C. No one listed on this application is enrolled in Medicare on the date coverage would begin.
- If I chose a Moda Health or Delta Dental plan that does not include pediatric dental benefits, I attest that I and my dependents on the application have obtained or will obtain a pediatric dental plan certified by the Health Insurance Marketplace.
- **Medical:** I must use in-network providers. There is no out-of-network coverage except for emergency services, retail pharmacy services and services at an in-network facility when I do not have the opportunity to choose an in-network provider, or for children living out of state but in the U.S. with a QMCSO or who are full-time students.
- **Dental:** My benefits may be less than the amount billed by my provider when I do not get treatment from a contracted provider.
- No benefits are available under a Moda Health or Delta Dental plan for services or supplies, including those related to an inpatient stay, that were received before the effective date of coverage.
- 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.
- Regardless of my enrollment date, my plan premium will renew January 1.
- I have read the Moda Health/Delta Dental privacy statement that is available on modahealth.com and deltadentalor.com.

Section 10 > Certification of completion and correctness

Be sure to sign and date the application below. Your spouse, registered domestic partner and any children over age 18 are also required to sign the application.

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, Moda Health/Delta Dental may deny coverage, modify or cancel the contract and/or take other legal action. I will promptly inform Moda Health/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 Moda Health/Delta Dental. Moda Health/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 (We) have read and understand this application, terms, and certification and privacy statements.

Applicant *(subscriber)* or parent/guardian *(for child-only policy)*:

Printed name of ☐ Parent ☐ Guardian[1] ☐ Applicant	
Applicant holder signature X	Date

If enrolling:

Spouse/domestic partner	Date
Child age 18 or older	Date
Child age 18 or older	Date

1 If not a parent, please attach legal documentation if you are the legal guardian or holder of Power of Attorney.

By providing my contact information, I am consenting to receive communications from Moda Health Plan, Inc., Delta Dental Plan of Oregon, 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.

Go to Section 12 for information on how to submit your application.

Section 11 › Agent of Record *(to be completed by agent only)*

I *(the agent of record)* 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 or Delta Dental. I have informed the applicant that the effective date of coverage is assigned only by Moda Health or Delta Dental.

To become the agent of record, you must be actively appointed with Moda Health/Delta Dental of Oregon.

Agent name	Agency name	NPN
Phone	Address	
City	State	Zip

I certify that the information supplied to me by the subscriber has been truly and accurately recorded.

Agent signature *(required)* X	Date

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

Moda Health pays a commission to appointed brokers *(agents)* for the work they do on your behalf. Our current commission schedule is located at modahealth.com/oregon/broker-commission.

Section 12 › Ready to submit?

- Have you filled out the application completely, and signed it?
- Have you attached required documentation *(for special enrollment, guardianship, etc.)*?
- Have you included your first month's premium payment? Payment does not have to be included with the application, but coverage will not start until we have received your first payment.

Send your signed, completed application and attachments to us:

Email: Scan and send to individualapp@modahealth.com

Fax: 503-219-3696

Mail: Moda Health *(medical)* or Delta Dental *(dental)*, Membership Accounting
601 SW Second Ave., Portland, OR 97204-3156

Go paperless!

New to Moda Health/Delta Dental? After your application is approved, you will receive a welcome letter with your member ID number. With this ID number, simply set up your Member Dashboard account by visiting modahealth.com or deltadentalor.com. Log in to your Member Dashboard to:

- View your Member Handbook
- See how your claims were paid by opting to receive electronic explanations of benefits (EOBs)
- Go paperless - you'll receive an email when your first bill is ready

Questions?

Contact Moda Health/Delta Dental at 855-718-1767.

modahealth.com | deltadentalor.com

To view the summary of benefits and coverage (SBC) for the medical plans, please visit shopmodaplans.com. A uniform glossary to help you understand the most common healthcare terms is at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf. For free print copies of the SBC or uniform glossary, contact Moda Health at 855-718-1767.

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。

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

หมายเหตุ: หากคุณใช้ภาษา ไทย
เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้
ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึง
ได้โดยไม่เสียค่าใช้จ่าย 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.