APPLICATION FOR DENTAL INSURANCE
UNITEDHEALTHCARE INSURANCE COMPANY
HARTFORD, CONNECTICUT 06103-0450

Applicant(s) Information

Gender	Name (Last, First, M.I.)	Birth Date
☐ Male ☐ Female	Primary (You)	____/____/_____
☐ Male ☐ Female	Spouse/Registered Domestic Partner	____/____/_____

Permanent Home Address (PO Box/PMB is not allowed)

Street (Include Apt.)	City	State	ZIP Code

Mailing Address (if different from permanent home address)

Street (Include Apt.)	City	State	ZIP Code

Contact Information

Phone Number	Optional Email
( )	

Plan Selection

Plan Start Date
Your Plan will start on the first day of the month following receipt and approval of this Application Form and receipt of your first month's payment. If you would like your Plan to start on a later date (the first day of a future month), please indicate the date: ____/_01_/_____

Plans *(Choose One)*	☐ DVH 500	☐ DVH 1000	☐ DVH 2000	☐ DVH 3000
	☐ DVH 500 PLUS	☐ DVH 1000 PLUS	☐ DVH 2000 PLUS	☐ DVH 3000 PLUS

Initial Payment

Estimated Monthly Premium **$** _____

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.

Statement of Understanding

I have read this application and represent that the information shown on it is true and complete to the best of my knowledge and belief.
I understand and agree that:

(1) No insurance will become effective unless my application is approved and the appropriate premium is actually received by UnitedHealthcare Insurance Company (UHIC) with this application.

(2) The primary applicant must be age 64 and 11 months or older on the plan effective date to be eligible for coverage.

(3) The information provided in this application may result in claim denial or voidance of coverage if it constitutes fraud or intentional misrepresentation of material fact. However, there may be no cancellation, limitation of policy provisions, or premium increases due to inaccuracies in the application form, whether willful or not, after 24 months following issuance of the policy.

(4) The information provided in this application, and any supplement or amendments to it, will be made a part of any policy or policies that may be issued.

(5) If an application is approved, insurance will be effective:
   (a) The first day of the month following receipt and approval of this application and receipt of your first month's payment; or
   (b) The first day of a future month requested by you.

(6) The agent is only authorized to submit the application and initial premium and may not change or waive any right or requirement.

(7) If UHIC rejects this application, under no circumstances will any benefits be payable. Receipt of payment by UHIC does not constitute approval of my application or create UHIC coverage.

(8) I have received a Notice of Privacy Practices and a Conditional Receipt or Conditions Prior to Coverage.

(9) I acknowledge that applicant has access to/has received a Guide to Health Insurance for People with Medicare. The Guide to Health Insurance for People with Medicare is available at: https://stage.uhone.com/api/supplysystem/?Filename=Medicare-Medigap-guide.pdf

(10) **THIS IS NOT A MEDICARE SUPPLEMENT POLICY.**

For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Signature Information

	Signature	Date Signed
Primary Applicant		

CALIFORNIA ATTESTATION FORM

1. To the best of my knowledge, the information on the application is complete and accurate.
2. I have explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and attest that the applicant understood the explanation.
3. I understand that if I willfully state as true any material fact I know to be false, in addition to any applicable penalties or remedies available under current law, I may be subject to a civil penalty of up to $10,000.

X _____ Signature of Agent/Broker (required)

X _____ Date

X _____ Type or Print Agent/Broker Name

X _____ Individual Producer Number

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IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- Any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- Other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare,* available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

45574-X-0918

Payment Method - Select one below.

☐ **EFT** – Complete EFT Authorization below

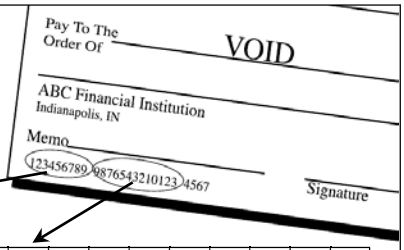
☐ **Credit Card** – Complete Credit Card Authorization below

Electronic Funds Transfer (EFT) and Credit Card payments will be collected at the time of application. Premium will be verified and may be adjusted up or down during the processing of your application.

☐ **ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION – ONLY IF PAYING BY EFT:**

I (we) hereby authorize UnitedHealthcare Insurance Company to initiate debit entries to the account indicated below. I also authorize the named financial institution to debit the same to such account.

I agree this authorization will remain in effect until you actually receive written notification of its termination from me.



Type of Account: ☐ Checking ☐ Savings

Nine-digit Routing No. _____ Account No. _____

Financial Institution's Name _____

Address _____

City, State, ZIP _____

Draft On _____ _____
Day Date Signed

Only select a draft date between the 1st and 28th of the month.

In Tennessee and Texas, drafts may only be scheduled on 1) the premium due date; or 2) up to 10 days after the due date.

X _____
Authorized Account Signature

☐ **CREDIT CARD AUTHORIZATION – ONLY IF PAYING BY CREDIT CARD:**

I authorize UnitedHealthcare Insurance Company to bill my MasterCard/Visa/American Express/Discover account.

Type of Card: ☐MasterCard ☐Visa ☐American Express ☐Discover Exp Date _____ _____
Month Year

Billing ZIP Code: _____ Card Number: _____

X _____
Signature of Authorized User

Charge On _____
Day

Only select a charge date between the 1st and 28th of the month.

NOTE: Some card issuers/financial institutions charge cash advance fees on insurance payments.

ELECTRONIC DELIVERY TERMS AND CONDITIONS

You will receive your Required Plan Communications electronically instead of receiving paper copies through the U.S. Mail. We will send you an email when a document is ready to view online.

Not all communications require permission before sending electronically. This Notice only applies when permission is required. Communications are based on the Plan(s) you have. You will get new types of communications as they become electronic. If there is not an electronic version, we will send by mail. Occasionally, in addition to electronic delivery, you may also receive a hard copy document.

You can request a free paper copy of documents that we are required to provide you by calling the phone number on your insurance ID card.

Your consent remains in effect until you withdraw it. You may withdraw your consent at any time and choose to begin receiving paper mailings by changing your delivery preferences on the member website or by calling the phone number on your insurance ID card. Changes may take up to seven business days to process.

It is your responsibility to notify us of any changes to your email address and your failure to do so may cause delayed communications. If attempts are made to deliver information to any email address you provide and the message is returned as undeliverable after several attempts and that email address is not updated by you, we will assume that you have withdrawn consent for electronic delivery and will begin sending the information to you in paper format. To ensure that you continue to receive emails from us, add the email "from" address to your email address book or safe list. To update your email address, go to your member website or you can call the phone number on your insurance ID card.

If you change plans or add a benefit, program, product or service, we will use the same contact information, when possible, to electronically deliver Required Plan Communications related to those services.

Requirements to access and retain information – in order to receive and retain electronic communications, you must have access to a computer or other device that is capable of mobile or internet access and complete your registration for the member website. This page contains documents in PDF format. PDF (Portable Document Format) files can be viewed with Adobe® Reader®. If you don't already have this viewer on your computer, download it free from the Adobe website (http://get.adobe.com/reader/).

☐ I hereby consent to receive Communications and Transaction Documents electronically, as per the aforementioned conditions. All of the Communications between the time you submit your consent and withdraw your consent will remain valid and binding on both you and us notwithstanding your withdrawal.

☐ I hereby DO NOT consent to receive Communications and Transaction Documents electronically, as per the aforementioned conditions. If you do not consent, we will conduct all future business with you in paper form.

X _____
Primary Applicant *(You)*

X _____
Parent/Guardian *(if you are a minor)* Relationship

_____
Primary Applicant's *(Your)* Email Address

_____
Parent/Guardian's *(if you are a minor)* Email Address

_____
Date

_____
Policy Number

NOTICE OF NONDISCRIMINATION
and
NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES AND ALTERNATE FORMATS

UnitedHealthcare complies with applicable civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, age, disability, sex (including pregnancy, sexual orientation, gender, and gender identity), or marital status. UnitedHealthcare does not exclude, deny Covered Health Care Benefits to, or otherwise discriminate against any Member for participation in, or receipt of the Covered Health Care Services under, any of its health plans, whether carried out by UnitedHealthcare directly or through a Network provider or any other entity with which UnitedHealthcare arranges to carry out Covered Health Care Services under any of its health plans. We do not exclude people or treat them less favorably because of race, color, national origin, ancestry, religion, age, disability, sex or marital status.

We provide free auxiliary aids and services to help you communicate with us or your doctor. You can ask for interpreters and/or for communications in other languages or formats such as large print. We also provide reasonable modifications for persons with disabilities.

If you need these services, call the toll-free number 1-800-657-8205. (TTY 711).

If you believe that we failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can send a complaint to the Civil Rights Coordinator:

Civil Rights Coordinator
UnitedHealthcare Civil Rights
Grievance P.O. Box 30608
Salt Lake City, UTAH 84130
UHC_Civil_Rights@uhc.com

If you need help filing a complaint, call the toll-free number 1-800-657-8205. (TTY 711).

If your complaint is not resolved, you can file a grievance with the *Department of Managed Health Care ("DMHC")*. Contact the *DMHC* Help Center at the toll-free telephone number (1-888-466-2219) or submit an inquiry in writing to the *DMHC*, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725 or through the website:
http://www.dmhc.ca.gov. The hearing and speech impaired may use the California Relay Service's toll-free telephone number 1-877-688-9891 (TTY).

If your complaint is not resolved, you can file a grievance with the California Department of Insurance (“CDI”). Contact the CDI at the toll-free telephone number 1-800-927-HELP (1-800-927-4357) or submit an inquiry in writing to the California Department of Insurance, Consumer Communications Bureau, 300 South Spring Street, South Tower,
Los Angeles, CA 90013 or through the website: www.insurance.ca.gov. The hearing and speech impaired may use the toll-free telephone number 1-800-482-4833 (TTY).

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

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Phone: 1-800-368-1019, 800-537-7697 (TDD)
Mail: 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 http://www.hhs.gov/ocr/office/file/index.html.

This notice is available at: https://www.uhc.com/legal/required-state-notices/california/nondiscrimination-notice.

ATTENTION: You can get an interpreter to talk to your doctor at the time of your appointment or with us. If you speak English, free language assistance services and free communications in other formats, such as large print, are available to you. Call 1-800-657-8205. (TTY: 711). If you need more help, call DMHC Help Line at 1-888-466-2219 or call the Department of Insurance Hotline at 1-800-927-4357.

ENGLISH

ATTENTION: You can get an interpreter to talk to your doctor at the time of your appointment or with us. If you speak English, free language assistance services and free communications in other formats, such as large print, are available to you. Call 1-800-657-8205. (TTY: 711). If you need more help, call DMHC Help Line at 1-888-466-2219 or call the Department of Insurance Hotline at 1-800-927-4357.

AMHARIC

ትኩረት፦ በቀጠሮዎ ጊዜ ወይም ከእኛ ጋር ሲሆኑ ከሐኪምዎ ጋር ለመነጋገር አስተርጓሚ ማግኘት ይችላሉ። አማርኛ የሚናገሩ ከሆነ፣ ነፃ የቋንቋ ድጋፍ አገልግሎቶች እና ነፃ ግንኙነቶች እንደ ትልቅ ሁነጦት ባሉ ሌሎች ቅርጸቶች ለእርስዎ ይገኛሉ። ወደ 1-800-657-8205 ይደውሉ። (TTY: 711)። ተጨማሪ እርዳታ ከፈለጉ፣ ለDMHC የእርዳታ መስመር በ 1-888-466-2219 ይደውሉ ወይም ለኢንሹራንስ መምሪያ ስልክ 1-800-927-4357 ላይ ይደውሉ።

ARABIC

يرجى الانتباه: يمكنك الحصول على مترجم فوري لمساعدتك في التحدث مع طبيبك خلال الموعد أو معنا. إذا كنت تتحدث العربية، يمكنك الاستفادة من خدمات المساعدة اللغوية المجانية. بالإضافة إلى وسائل اتصال مجانية بتنسيقات أخرى، مثل الطباعة كبيرة الحجم. اتصل على الرقم (TTY:711). 1-800-657-8205. لمزيد من المساعدة، اتصل بخط المساعدة التابع لإدارة الرعاية الصحية المُدارة (DMHC) على الرقم 1-888-466-2219 أو بالخط الساخن التابع لإدارة التأمين على الرقم 1-800-927-4357.

ARMENIAN

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Դուք կարող եք օգտվել բանավոր թարգմանչի ծառայություններից, որպեսզի խոսեք Ձեր բժշկի հետ Ձեր ժամադրության պահին կամ մեզ հետ: Եթե խոսում եք հայերեն, Ձեզ հասանելի են անվճար լեզվական աջակցության ծառայություններ և անվճար հաղորդակցություններ այլ ձևաչափերով, օրինակ՝ մեծատառով: Զանգահարեք 1-800-657-8205 հեռախոսահամարով: (TTY: 711): Եթե լրացուցիչ օգնության կարիք ունեք, զանգահարեք DMHC-ի օգնության գիծ՝ 1-888-466-2219 հեռախոսահամարով կամ Ապահովագրության բաժնի թեժ գիծ՝ 1-800-927-4357 հեռախոսահամարով:

CAMBODIAN-MON-KHMER

ចំណាំ៖ អ្នកអាចមានអ្នកបកប្រែ ដើម្បីនិយាយជាមួយគ្រូពេទ្យរបស់អ្នក នៅពេលណាត់ជួប ឬនិយាយជាមួយយើងខ្ញុំ។ ប្រសិនបើអ្នកនិយាយភាសាខ្មែ សេវាជំនួយភាសាឥតគិតថ្លៃ និងការទំនាក់ទំនងឥតគិតថ្លៃជាទម្រង់ផ្សេងទៀត ជូនជាអក្សរធំ មានសម្រាប់អ្នក។ ហៅទូរសព្ទទៅលេខ 1-800-657-8205។ (TTY: 711)។ ប្រសិនបើអ្នកត្រូវការជំនួយបន្ថែម សូមហៅទូរសព្ទទៅគាន់ខ្ញែទូរសព្ទជំនួយ សម្រាប់ក្រសួងគ្រប់គ្រងការថែទាំសុខភាព (DMHC) តាមរយៈលេខ 1-888-466-2219 ឬហៅទូរសព្ទទៅគាន់ខ្ញែទូរសព្ទរយការណ៍បន្ទាន់នៃនាយកដ្ឋានធានារ៉ាប់រងតាមរយៈលេខ 1-800-927-4357។

CAROLINIAN

PÒLÒ: Na'ishte na' kayot tekyo chon wahu a chòta / kòta kisyon wo wahu chon. Si you lekon Senkirei, atu'ung assistensia lengua, si atu'ung komunikasion i difere' formatos, hao large print, ma'loyo hao. Kama' 1-800-657-8205. (TTY: 711). Si nu' iñao' ayuda, kama' DMHC Help Line 1-888-466-2219 o kama' Department of Insurance Hotline 1-800-927-4357.

CHAMORRO

ATENSION: Sina ha un konne' taotao para u interpiti i finn' i doktu gi tiempo mu yan hami pat duranten i machek mu. Kumu un tungo fumino' CHamoru, guaha dibatde na setbision asistementon lengguahi, yan dibatde na otru siha na fotmat komunikasion, tatkumo dangkulo na letra. Agang 1-800-657-8205. (TTY: 711). Yanggen un nisisita mas ayudu, agang i DMHC Telefon Ayudu gi 1-888-466-2219 pat agang i Depattamenton i Sigurida: telefon gi 1-800-927-4357.

CHINESE (TRADITIONAL)

請注意：您可以獲得一位口譯員，在您看診時與您的醫生溝通或平常與我們溝通。如果您說中文，我們可為您提供免費的語言協助服務和免費的其他溝通格式，例如大字版文件。請致電 1-800-657-8205。聽力語言殘障服務專線 (TTY: 711)。若您需要更多協助，請致電健康照護管理局 (DMHC) 協助專線 1-888-466-2219 或保險局熱線 1-800-927-4357。

FARSI

توجه: شما می‌توانید یک مترجم برای صحبت با پزشک خود در زمان ویزیت یا برای گفتگو با ما، درخواست کنید. اگر فارسی صحبت می‌کنید، خدمات رایگان کمک زبانی و خدمات رایگان ارتباطاتی در سایر قالب‌ها، مانند چاپ با حروف درشت، در دسترس شما هستند. با 1-800-657-8205 تماس بگیرید. (TTY: 711). اگر به کمک بیشتری نیاز دارید، با خط تلفن راهنمای DMHC به شماره 1-888-466-2219 یا با خط تلفن رایگان وزارت بیمه به شماره 1-800-927-4357 تماس بگیرید.

HINDI

ध्यान दें: आप अपनी अपॉइंटमेंट के समय या हमारे साथ अपने डॉक्टर से बात करने के लिए एक दुभाषिया प्राप्त कर सकते हैं। यदि आप हिंदी बोलते हैं, तो मुफ्त भाषा सहायता सेवाएँ और बड़े प्रिंट जैसे अन्य प्रारूपों में मुफ्त संचार सेवा आपके लिए उपलब्ध हैं। 1-800-657-8205 पर कॉल करें। (TTY: 711)। यदि आपको अधिक सहायता की आवश्यकता है, तो DMHC हेल्पलाइन पर 1-888-466-2219 पर कॉल करें या बीमा विभाग की हॉटलाइन पर 1-800-927-4357 पर कॉल करें।

HMONG

CEEB TOOM: Koj tuaj yeem tau txais ib tug neeg txhais lus tham nrog koj tus kws kho mob thaum lub sijhawm kev teem caij los sis thaum tham nrog peb. Yog tias koj hais lus Hmoob, muaj cov kev pab cuam txhais lus pub dawb thiab kev pab cuam luam ua lwm hom qauv ntawv, xws li luam ua tus ntawv loj rau koj siv. Hu rau 1-800-657-8205. (TTY: 711). Yog tias koj xav tau kev pab ntxiv, hu rau DMHC Tus Xov Tooj Pab Cuam ntawm 1-888-466-2219 los sis hu rau Lub Tuam Tsev Saib Xyuas Kev Tuav Pov Hwm Tus Xov Tooj ntawm 1-800-927-4357.

ILOCANO

ATENSION: Makaalaka iti interpreter a makisarita kadakami wenno iti doktormo iti oras ti appointment-mo. No makasaoka iti Ilocano, makaalaka iti libre a tulong iti lengguahe ken libre a pannakikomunikar iti sabali a format, kas iti dadakkel a letra. Tawagan ti 1-800-657-8205. (TTY: 711). No kasapulam iti ad-adu pay a tulong, tawagam ti DMHC Help Line iti 1-888-466-2219 wenno tawagam ti Department of Insurance Hotline iti 1-800-927-4357.

JAPANESE

ご注意：ご予約にお越しの際またはご来院の際、医師とお話になるための通訳者を手配することが可能です。あなたが日本語をお話になる場合、無料の言語支援サービスおよび大きい活字など他の形式による無料のコミュニケーションをご利用になれます。1-800-657-8205 までお電話ください。(TTY: 711)。その他お困りのことがありましたら、DMHC ヘルプライン (1-888-466-2219) もしくは保険部門ホットライン (1-800-927-4357) までお電話ください。

KOREAN

주의: 진료 시 의사와 상담하거나 저희와의 소통을 위해 통역사 서비스를 받으실 수 있습니다. 한국어를 하시는 경우, 무료 언어 지원 서비스와 큰 활자체와 같은 다른 형식의 커뮤니케이션을 무료로 이용하실 수 있습니다. 1-800-657-8205 로 전화하십시오. (TTY: 711). 도움이 더 필요하시면 DMHC 헬프라인에 1-888-466-2219번으로 전화하거나 보험부 핫라인에 1-800-927-4357번으로 문의하십시오.

NAVAJO

SHOOH: Diné ata' hane'í ne'azee' íił'íní bił yah aninááh bee náhoo'a' góne' doodago nihí nihich'į' yáłti'go biighah. Bilagáana bizaad bee yáníłti'to, t'áá jiik'eh saad bee áka'e'eyeed bee áka'anída'ow'í dóó t'áá jíík'eh nááná łahgo át'éego bee hada'dilyaaígíí bee ahił hane', díí nitsaago bik'e'ashchíní, ná dahólǫ. 1-800-657-8205 bee hodíilnih. (TTY: 711). Áka'e'eyeed la' nááníndzingo, DMHC Áka'e'eyeed Bee Hane'í kohjį' 1-888-466-2219 hodíilnih **doodago** Béeso Ách'ąąh Naa'nil Bił Haz'ání T'áá Jiik'ah Bee Hane'í kohjį' 1-800-927-4357 bee hodíilnih.

PENNSYLVANIA DUTCH

WICHDICH: Du kannscht en Interpreter griege fer schwetze mit dei Dockter an dei Appointment odder mit uns. Wann du Deitsch schwetzschtun brauchscht Hilf fer communicat-e kenne mer dich helfe unni as es dich ennich eppes koschde zellt. Mir kenne differnti Sadde Schprooch-Hilf beigriege aa fer nix. Ruf 1-800-657-8205 uff. (TTY: 711). Wann du meh Hilf brauchscht, ruf fi DMHC Help Line uff an 1-888-466-2219 odder ruf die Department of Insurance Hotline an 1-800-927-4357.

PUNJABI

ਧਿਆਨ ਦਿਓ: ਤੁਸੀਂ ਆਪਣੀ ਅਪਾਇੰਟਮੈਂਟ ਦੇ ਸਮੇਂ ਆਪਣੇ ਡਾਕਟਰ ਨਾਲ ਜਾਂ ਸਾਡੇ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ ਇੱਕ ਦੁਭਾਸ਼ੀਆ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਜੇਕਰ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਹੋਰ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਮੁਫ਼ਤ ਸੰਚਾਰ, ਜਿਵੇਂ ਕਿ ਵੱਡਾ ਪ੍ਰਿੰਟ, ਤੁਹਾਡੇ ਲਈ ਉਪਲਬਧ ਹਨ। 1-800-657-8205 'ਤੇ ਕਾਲ ਕਰੋ। (TTY: 711)। ਜੇਕਰ ਤੁਹਾਨੂੰ ਹੋਰ ਮਦਦ ਦੀ ਲੋੜ ਹੈ, ਤਾਂ DMHC ਹੈਲਪ ਲਾਈਨ ਨੂੰ 1-888-466-2219 'ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ ਬੀਮਾ ਵਿਭਾਗ ਦੀ ਹੌਟਲਾਈਨ ਨੂੰ 1-800-927-4357 'ਤੇ ਕਾਲ ਕਰੋ।

RUSSIAN

ВНИМАНИЕ. Вы можете воспользоваться услугами устного переводчика для общения с вашим врачом во время приема или через наши услуги. Если вы говорите по-русски, вам предоставляются услуги языковой помощи и сообщения в других форматах бесплатно, например, с использованием крупного шрифта. Позвоните по номеру 1-800-657-8205. (Линия TTY: 711). За дополнительной помощью обращайтесь в справочную службу DMHC по телефону 1-888-466-2219 или на горячую линию Департамента страхования по телефону 1-800-927-4357.

SAMOAN

FAASILASILAGA: E mafai ona e maua se faamatala'upu e talanoa i lau foma'i poo matou i le taimi o lau siaki faatulagaina. Afai e te tautala i le gagana Samoa, o loo avanoa mo oe 'au'aunaga fesoasoani mo gagana, e pei o lomiga lapopo'a ma fesoota'iga e leai se totogi i isi faiga. Vala'au le 1-800-657-8205. (TTY: 711). Afai e te mana'omia atili se fesoasoani, valaau le Laina Fesoasoani a le DMHC i le 1-888-466-2219 **pe** valaau le Laina a le Matagaluega o Inisiua (Department of Insurance Hotline) i le 1-800-927-4357.

SPANISH

ATENCIÓN: Puede conseguir un intérprete para hablar con su médico en el momento de la cita o con nosotros. Si habla español, usted dispone de servicios gratuitos de asistencia en otros idiomas y comunicaciones gratuitas en otros formatos, como letra grande. Llame al 1-800-657-8205. (TTY: 711). Si necesita más ayuda, llame a la línea de ayuda del Departamento de Atención Médica Administrada (DMHC) al 1-888-466-2219 o llame a la línea directa del Departamento de Seguros al 1-800-927-4357.

TAGALOG

PAUNAWA: Maaari kang makakuha ng interpreter upang makausap ang iyong doktor sa panahon ng iyong appointment o sa pakikipag-usap sa amin. Kung nagsasalita ka ng Tagalog, maaari kang makakuha ng libreng mga serbisyo sa tulong sa wika at libreng pakikipag-ugnayan sa ibang mga anyo o pamamaraan, tulad ng malalaking titik. Tumawag sa 1-800-657-8205. (TTY: 711). Kung kailangan mo ng karagdagan pang tulong, tawagan ang DMHC Help Line sa 1-888-466-2219 o tawagan ang Hotline ng Departamento ng Insurance sa 1-800-927-4357.

THAI

หมายเหตุ: คุณสามารถขอล่ามมาพูดคุยกับแพทย์ของคุณได้ในเวลาที่คุณนัดหมายหรือกับเรา หากคุณพูดภาษาไทย เรายินดีให้บริการช่วยเหลือด้านภาษาฟรีและการสื่อสารฟรีในรูปแบบอื่นๆ เช่น ตัวอักษรขนาดใหญ่ โทร 1-800-657-8205. (TTY: 711). หากคุณต้องการความช่วยเหลือเพิ่มเติม โปรดติดต่อสายด่วน DMHC ที่หมายเลข 1-888-466-2219 **หรือ** โทรไปที่สายด่วนกรมการประกันภัยที่หมายเลข 1-800-927-4357.

UKRAINIAN

ЗВЕРНІТЬ УВАГУ! Під час прийому у лікаря або розмови з нами ви маєте змогу скористатися послугами усного перекладача. Якщо ви розмовляєте українською, ви можете безоплатно скористатися послугами мовної підтримки, а також безоплатно отримувати інформаційні матеріали в інших форматах, як-от набрані великим шрифтом. Телефонуйте на номер 1-800-657-8205. (лінія TTY: 711). Якщо вам потрібна допомога, зателефонуйте на гарячу лінію Департаменту керованого медичного обслуговування (DMHC) за номером 1-888-466-2219 або на гарячу лінію Департаменту страхування (Department of Insurance) за номером 1-800-927-4357.

VIETNAMESE

LƯU Ý: Quý vị có thể có một thông dịch viên miễn phí để nói chuyện với bác sĩ thời điểm hẹn khám của mình hoặc nói chuyện với chúng tôi. Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí và thông tin liên lạc miễn phí ở các định dạng khác, chẳng hạn như bản in cỡ chữ lớn, sẽ được cung cấp cho quý vị. Gọi 1-800-657-8205. (TTY: 711). Nếu quý vị cần trợ giúp thêm, hãy gọi cho Đường dây trợ giúp DMHC theo số 1-888-466-2219 **hoặc** gọi cho Đường dây nóng của Sở Bảo hiểm theo số 1-800-927-4357.