California Small Group Employee Enrollment/Change Form (1 - 100 employees)

TO COMPLY WITH CALIFORNIA LAW, WHEREVER THE TERM "SPOUSE" APPEARS IT SHALL BE CONSTRUED TO INCLUDE DOMESTIC PARTNER.

The following entities provide coverage: Aetna Health of California Inc. for HMO, Aetna Dental of California Inc. for Dental (DMO® only) and Aetna Life Insurance Company for all other coverages. For Vision coverage, First American Administrators, Inc. provides certain claims administration services. EyeMed Vision Care LLC ("EyeMed") provides certain network administration services.

PSUID or account number (if available)
Aetna member ID number (if available)

Company name	**INSTRUCTIONS:** You, the employee, must complete this enrollment form in full. If you do not, we will return it to you or your employer, and that can delay its processing. You alone are responsible for its accuracy and completeness. **If you are enrolling, please be sure to sign and date Employee signature on page 6. If you are declining coverage, you must complete section F on page 6.** Please use only black ink to complete this form.

Effective date **Date of hire**	☐ New hire ☐ Rehire/reinstatement ☐ New group enrollment ☐ Late enrollment ☐ Open enrollment ☐ Waiver	☐ Add spouse/dependent child ☐ Change of coverage ☐ Name change ☐ Other _____	☐ Employee termination ☐ Remove spouse/dependent child ☐ Cancel coverage

☐ **COBRA** ☐ **Cal-COBRA** for: ☐ Employee ☐ Dependent Length of Continuation: ☐ 18 months ☐ 36 months ☐ Other _____

Qualifying event _____ Original qualifying event date _____ Loss of coverage date _____

A. Employee information – *You must complete this section.*

Member Social Security number or tax ID number*	Last name, first name, middle initial		
Home address (PO box not acceptable)	Apt. number	City, state	ZIP code
Work address (PO box not acceptable)		City, state	ZIP code

Home telephone ( ) -	Work telephone ( ) -	Primary language spoken (optional)	Number of dependents enrolling for medical coverage including spouse
Number of hours worked a week	Check one: ☐ Full time ☐ 1099 ☐ Seasonal ☐ Union ☐ Part time ☐ Retiree ☐ Temporary		Job title

*Social Security number is optional; tax identification number is acceptable.

B. Coverage selection – ***Please print clearly.***

1. Medical coverage selection: Select a medical plan by checking the appropriate box below. (The plan must be offered by your employer.)				
HMO	☐ Full HMO ☐ HMO Deductible ☐ HMO Aetna Value Network ☐ HMO Basic ☐ HMO AWH Southern CA			
OAMC/EPO/PPO	☐ OA Managed Choice POS ☐ AWH Southern CA OA Managed Choice POS ☐ AWH Southern CA OA Elect Choice EPO	☐ Savings Plus OA Managed Choice POS ☐ OA Elect Choice EPO ☐ Open Choice PPO		
Metal Tier	☐ Platinum	☐ Gold	☐ Silver	☐ Bronze
Plan Name: _____				

Control/Group number	**Suffix**	**Account**	**Plan number**

2. Dental – *Check one (if applicable).*

Non-voluntary plans: ☐ Aetna Dental® Plan - Plan option _____ For *FOC, choose:* ☐ DMO® or ☐ PPO

Voluntary plans: ☐ Aetna Dental® Plan - Plan option _____ For *FOC, choose:* ☐ DMO® or ☐ PPO

Before today, were you covered under this employer's dental plan? ☐ **Yes** ☐ **No**

Creditable coverage is allowed for new members enrolling in voluntary takeover groups. New hires please see below if applicable:

New Hire selecting a Voluntary plan **and your Aetna plan is a takeover group**: Were you covered for 12 months **under** a dental plan within the last 90 days that included both Preventive and Basic coverage? Discount dental and preventive only plans do not apply. ☐ Yes ☐ No

Employees in AZ, CA, GA, MA, MD, MO, NC, NJ and TX must either live or work within the approved DMO® service area to be eligible to enroll in the DMO®.

Control number	**Suffix**	**Account**	**Plan number**

3. Aetna Vision℠ Preferred ☐ **Yes** ☐ **No** *To enroll, check "yes" and enter the plan option elected below. Please print clearly.*

Plan option/name _____

You may only select a vision plan if your employer offers vision coverage.

C. Individuals Covered – ***List individuals for whom you are enrolling or adding/changing/removing coverage. Add more sheets if needed. For dependents with different last names or living at another address, complete Section D below.*** **NOTE FOR MEDICAL COVERAGE:** While the Affordable Care Act mandates coverage of dependent children up to age 26, your plan may allow coverage beyond age 26. Disabled children may be covered if they are over age 26. Please refer to your plan documents or contact your benefits administrator.

1	**Employee name** (last, first, middle initial)			Sex (M/F)	Birthdate (MM/DD/YYYY) / /	
Status ☐ Single ☐ Married ☐ Divorced ☐ Legally separated ☐ Domestic partnership	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision	Primary care physician (PCP) provider office ID number	Current patient ☐ Yes	Dental office ID number (if applicable)	Current patient ☐ Yes	

Continued on next page

C. Individuals Covered *(Continued)*

2	**Spouse name** (last, first, middle initial)		Sex (M/F)	Social Security number		Birthdate (MM/DD/YYYY) / /	
Relationship ☐ Spouse ☐ Domestic partner ☐ Other _____	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision		PCP provider office ID number	Current patient ☐ Yes	Dental office ID number (if applicable)	Current patient ☐ Yes	
3	**Child name** (last, first, middle initial)		Sex (M/F)	Social Security number		Birthdate (MM/DD/YYYY) / /	
Relationship ☐ Child ☐ Stepchild ☐ Other _____	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision		PCP provider office ID number	Current patient ☐ Yes	Dental office ID number (if applicable)	Current patient ☐ Yes	
4	**Child name** (last, first, middle initial)		Sex (M/F)	Social Security number		Birthdate (MM/DD/YYYY) / /	
Relationship ☐ Child ☐ Stepchild ☐ Other _____	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision		PCP provider office ID number	Current patient ☐ Yes	Dental office ID number (if applicable)	Current patient ☐ Yes	
5	**Child name** (last, first, middle initial)		Sex (M/F)	Social Security number		Birthdate (MM/DD/YYYY) / /	
Relationship ☐ Child ☐ Stepchild ☐ Other _____	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision		PCP provider office ID number	Current patient ☐ Yes	Dental office ID number (if applicable)	Current patient ☐ Yes	
6	**Child name** (last, first, middle initial)		Sex (M/F)	Social Security number		Birthdate (MM/DD/YYYY) / /	
Relationship ☐ Child ☐ Stepchild ☐ Other _____	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision		PCP provider office ID number	Current patient ☐ Yes	Dental office ID number (if applicable)	Current patient ☐ Yes	
7	**Child name** (last, first, middle initial)		Sex (M/F)	Social Security number		Birthdate (MM/DD/YYYY) / /	
Relationship ☐ Child ☐ Stepchild ☐ Other _____	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision		PCP provider office ID number	Current patient ☐ Yes	Dental office ID number (if applicable)	Current patient ☐ Yes	

D. Dependent information

List any dependent in section **C** with a different last name or living at another address.

Name	Address

E. Coordination of benefits

Will you have other health insurance at the same time as this coverage? ☐ Yes ☐ No

If **yes**, will the Aetna coverage you're applying for replace the coverage you have now? ☐ Yes ☐ No

Name of person	Carrier name	Name of person	Carrier name

Conditions of enrollment

NOTICE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

I understand that the following legal entities (collectively referred to as "Aetna") underwrite the plans I apply for:

- Aetna Health of California Inc. underwrites HMO plans.
- Aetna Life Insurance Company underwrites Aetna Vision plans, Elect Choice EPO plans, and Managed Choice POS plans.
- Aetna Dental of California Inc. and Aetna Life Insurance Company underwrite Aetna Dental plans.

1. My employer's application determines coverage. I don't have coverage until Aetna approves my employee enrollment form and the employer application. Even if Aetna approves the employer application, any fraud, intentional misstatement or omissions of material facts may result in denial of future claims and Aetna may rescind or reevaluate my coverage under the policy, as of the effective date, for eligibility and rating purposes. If Aetna voids or rescinds coverage, I may be entitled to a refund of any paid premiums from the effective date of coverage. Aetna will give at least 30 days prior notice by certified mail to any covered person affected by the proposed rescission. However, after 24 months following the issuance of the policy, Aetna will not rescind the policy for any reason and will not cancel the policy, limit the policy, or raise premiums due on the policy due to misrepresentation or inaccuracies in this form, whether willful or not. Aetna does not base its eligibility rules for medical, dental or vision on any of the following factors:
   A. Health status
   B. Medical condition, including physical and mental illnesses
   C. Claims experience
   D. Receipt of health care
   E. Medical history
   F. Genetic information
   G. Evidence of insurability, including conditions arising out of acts of domestic violence
   H. Any other health status-related factor as determined by any federal regulations, rules, or guidance issued pursuant to Section 2705 of the federal Public Safety Act
2. The Group Agreement/Group Policy determines the rights and responsibilities of members and will govern in the event they conflict with any:
   – Benefits comparison
   – Summary
   – Other description of the plan
3. Participating physicians, hospitals and other health care providers are independent contractors. They are not Aetna agents or employees. We cannot guarantee the availability of any particular provider. Any provider network is subject to change. We will provide a notice of the change in accordance with applicable state law.
4. I understand that, with certain exceptions described in the plan documents, HMO and DMO© plans only provide coverage for network covered benefits. The plan documents also describe if I need a referral for certain procedures, and who can provide care. Covered services must be performed by:
   - Participating primary care physicians
   - Participating primary care dentists
   - Participating specialists
   - Participating hospitals
   - Participating pharmacies
   - Participating dentists
   - Other participating providers as authorized by a referral from a participating primary care physician

Continued on next page

Conditions of enrollment *(Continued)*

To the best of my knowledge, I represent that all information supplied in this form is true and complete. I have read and agree to the conditions of enrollment on this enrollment/change form. I understand in the event I fail to sign and return this form within 31 days of my eligibility date or Aetna does not receive the request within a reasonable time, my eligibility may be affected. I am employed by the employer shown on page 1. I am working full time at least 30 hours a week (or 20-29 hours a week if elected by my employer) for this employer at the regular place of business. I authorize deductions from my earnings for any contributions required for coverage. I agree to make any necessary payments as required for coverage.

To receive documents online, please visit your secure member account at aetna.com.

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

Please sign here ONLY if you are enrolling in coverage for yourself and/or dependents.	***Employee email***	***Date (Month/Day/Year)***
☐ **I AM ENROLLING FOR COVERAGE:** ***Employee signature*** **X**		

F. Declining coverage – ***Check all that apply.***

I understand I am eligible to apply for this coverage through my employer. However, I am declining the coverage I checked below.

☐ **Employee:**
☐ Medical ☐ Dental ☐ Vision

☐ **Spouse:**
☐ Medical ☐ Dental ☐ Vision

☐ **Children:**
☐ Medical ☐ Dental ☐ Vision

Reason for declining coverage

☐ Spouse group coverage
☐ Parental group coverage
☐ Medicare
☐ Medi-Cal
☐ Retiree coverage
☐ Another group plan provided by my employer
☐ COBRA coverage
☐ Insurance through another job
☐ TRICARE Military coverage
☐ Individual coverage – On Exchange
☐ Individual coverage – Off Exchange
☐ I have no other coverage
☐ Do not want
☐ Other _____

I certify I have been given the right to apply for this coverage. However, I am declining coverage as noted above. By declining this group coverage, I acknowledge that I and/or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage.

Please sign here ONLY if you are declining coverage for yourself and/or dependents.	***Date (Month/Day/Year)***
X I AM DECLINING COVERAGE: **Employee signature**	

Non-Discrimination

Aetna complies with applicable California and Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, ancestry, religion, sex, marital status, age, gender, gender identity, sexual orientation or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on race, color, national origin, ancestry, religion, sex, marital status, age, gender, gender identity, sexual orientation or disability, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator
P.O. Box 24030, Fresno, CA 93779
1-800-648-7817, TTY: 711, Fax: 860-262-7705
CRCoordinator@aetna.com.

You can file a grievance to Aetna at **www.aetna.com**, PO Box 24030, Fresno, CA 93779, or the number on your ID card once enrolled. After completing the grievance process or participating in the process for at least 30 days, you can file a grievance with the California Department of Managed Health Care at **www.dmhc.ca.gov**, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, or 1-888-466-2219, TDD 1-877-688-9891.

You can also file a complaint with the California Department of Insurance at **www.insurance.ca.gov**, or at: Consumer Services Division, 300 Spring Street South Tower, Los Angeles CA 90013, or at 1-800-927-HELP (4357), TDD: 1-800-482-4TDD (4833).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights if there is a concern of discrimination based on the federal protected classes which include race, color, national origin, age, disability, or sex. You can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at:
U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

DMHC written notice of availability of language assistance

HMO and DMO-based plans - **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 free help, please call right away at 1-877-287-0117.

Planes basados en DMO y HMO - **IMPORTANTE:** ¿Puede leer esta carta? En caso de no poder leerla, le brindamos nuestra ayuda. También puede obtener esta carta escrita en su idioma. Para obtener ayuda gratuita, por favor llame de inmediato al 1-877-287-0117.

Traditional plans:

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 1-877-287-0117. 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 1-877-287-0117. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

免費語言服務。您可獲得口譯員服務，用中文把文件唸給您聽。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打 1-877-287-0117 與我們聯絡。欲取得其他協助，請致電1-800-927-4357 與加州保險部聯絡。Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch và được người khác đọc giúp các tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-877-287-0117 . Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese.

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-877-287-0117번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. 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 1-877-287-0117. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-877-287-0117 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-877-287-0117. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または1-877-287-0117までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Japanese

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره 1-877-287-0117 تماس بگیرید. برای دریافت کمک بیشتر، به اداره بیمه کالیفرنیا (CA Dept. of Insurance) به شماره 1-800-927-4357 تلفن کنید. Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-877-287-0117 'ਤ ਸਾਨ ਫ਼ਨ ਕਰੋ। ਵਧੇਰ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

េសវាកម្មភាសាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមាន បង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-877-287-0117 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-877-287-0117 . للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357.Arabic

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 1-877-287-0117. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

CDI Notice of Language Assistance-Trad

TTY: 711

To access language services at no cost to you, call 1-888-238-6201.

Para acceder a los servicios de idiomas sin costo, llame al 1-888-238-6201. (Spanish)

如欲使用免費語言服務，請致電 1-888-238-6201。(Chinese)

Afin d'accéder aux services langagiers sans frais, composez le 1-888-238-6201. (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-888-238-6201. (Tagalog)

T'áá ni nizaad k'ehjí bee níká a'doowoł doo bą́ą́h ílínígóó kojį' hólne' 1-888-238-6201. (Navajo)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-888-238-6201 an. (German)

Për shërbime përkthimi falas për ju, telefononi 1-888-238-6201. (Albanian)

የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-888-238-6201 ይደውሉ። (Amharic)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-888-238-6201. (Arabic)

Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-888-238-6201 հեռախոսահամարով: (Armenian)

Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-888-238-6201 (Bantu)

আপনাকে বিনামূল্যে ভাষা পরিষেবা পেতে হলে এই নম্বরে টেলিফোন করুন: 1-888-238-6201। (Bengali)

Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-888-238-6201. (Bisayan-Visayan)

သင့်အနေဖြင့် အခကြေးငွေ မပေးရပဲ ဘာသာစကားပန်ဆောင်မှုများ ရရှိနိုင်ရန် 1-888-238-6201 သို့ ဖုန်းခေါ်ဆိုပါ။ (Burmese)

Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-888-238-6201. (Catalan)

Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-888-238-6201. (Chamorro)

ᏀᎩᏯᏗ ᏚᎾᏂᏍᏯᏗ ᎤᏩᏫᏓᏁᏗ Ꮭ ᎪᎢᏯᏗ ᏗᏀᎬᏩᏁᏗ ᎯᎩ, ᏫᏥᏍᏂᎳᏫᏓ 1-888-238-6201. (Cherokee)

Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-888-238-6201. (Choctaw)

Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-888-238-6201. (Cushite-Oromo)

Voor gratis toegang tot taaldiensten, bell 1-888-238-6201. (Dutch)

Pou jwenn sèvis lang gratis, rele 1-888-238-6201. (French Creole-Haitian)

Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-888-238-6201. (Greek)

તમારે કોઇ જાતના ખર્ચ વિના ભાષાની સેવાઓની પહોંચ માટે, કોલ કરો 1-888-238-6201. (Gujarati)

No ka wala‘au ‘ana me ka lawelawe ‘ōlelo e kahea aku i kēia helu kelepona 1-888-238-6201. Kāki ‘ole ‘ia kēia kōkua nei. (Hawaiian)

आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, 1-888-238-6201 पर कॉल करें। (Hindi)

Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-888-238-6201. (Hmong)

Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 1-888-238-6201. (Ibo)

Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-888-238-6201. (Ilocano)

Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-888-238-6201. (Indonesian)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-888-238-6201 (Italian)

言語サービスを無料でご利用いただくには、1-888-238-6201 までお電話ください。(Japanese)

လၢတၢ်ကမၤန့ၢ်ကျိဉ်အတၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖဉ်လၢတအိဉ်ဒီးအပှၤလၢကဘဉ်ဟ့ဉ်အီၤအဂီၢ်ဘဉ်နှဉ် ကိး 1-888-238-6201 တက့ၢ်. (Karen)

무료 언어 서비스를 이용하려면 1-888-238-6201 번으로 전화해 주십시오. (Korean)

Ǹ dyi wuɖu-dù kà kò ɖò ɓě dyi mɔ́uń nì Pídyi ní, nìí, ɖá nɔ̀ɓà nìà kɛ: 1-888-238-6201. (Kru-Bassa)

بۆ دەستپێڕاگەیشتن بە خزمەتگوزاری زمان بەبێ تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارەی 1-888-238-6201. (Kurdish)

ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-888-238-6201. (Laotian)

कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-888-238-6201 वर फोन करा. (Marathi)

Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-888-238-6201. (Marshallese)

Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-888-238-6201. (Micronesian-Pohnpeian)

ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-888-238-6201។ (Mon-Khmer, Cambodian)

निःशुल्क भाषा सेवा प्राप्त गर्न 1-888-238-6201 मा टेलिफोन गर्नुहोस् । (Nepali)

Të kɔɔr yïn wëër de thokic ke cïn wëu kɔr keek tënɔŋ yïn. Ke cɔl kɔc ye kɔc kuɔny ne nɔmba 1-888-238-6201. (Nilotic-Dinka)

For tilgang til kostnadsfri språktjenester, ring 1-888-238-6201. (Norwegian)

Um Schprooch Services zu griege mitaus Koscht, ruff 1-888-238-6201. (Pennsylvania Dutch)

برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-888-238-6201 تماس بگیرید. (Persian-Farsi)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-888-238-6201 (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para 1-888-238-6201. (Portuguese)

ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-888-238-6201 'ਤੇ ਫ਼ੋਨ ਕਰੋ। (Punjabi)

Pentru a accesa gratuit serviciile de limbă, apelați 1-888-238-6201. (Romanian)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-888-238-6201. (Russian)

Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-888-238-6201. (Samoan)

Za besplatne prevodilačke usluge pozovite 1-888-238-6201. (Serbo-Croatian)

Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-888-238-6201. (Sudanic-Fulfulde)

Kupata huduma za lugha bila malipo kwako, piga 1-888-238-6201. (Swahili)

ܐܢ ܣܢܝܩܐ ܝܘܬܘܢ ܠ ܝܠܦܬܐ ܕܬܘܪܓܡܐ ܒܠܫܢܐ ܡܓܢܐܝܬ، ܡܢܝܢܐ:
(Syriac-Assyrian) 1-888-238-6201

మీరు భాష సేవలను ఉచితంగా అందుకునేందుకు, 1-888-238-6201 కు కాల్ చేయండి. (Telugu)

หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-888-238-6201 (Thai)

Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-888-238-6201. (Tongan)

Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-888-238-6201. (Trukese)

Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-888-238-6201 numarayı arayın. (Turkish)

Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-888-238-6201. (Ukrainian)

بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-888-238-6201. پر بات کریں۔ (Urdu)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-888-238-6201. (Vietnamese)

צו צוטריט שפּראַך באַדינונגען אין קיין פּרייַז צו איר, רופן 1-888-238-6201. (Yiddish)

Lati wọnú awọn isẹ èdè l'ọfẹ fun ọ, pe 1-888-238-6201. (Yoruba)