

Colorado Bridge Program Account Change Form

What is this form for?

Use this form if you need to make changes to your Kaiser Permanente Colorado Bridge Program account, which provides help in paying your health plan premiums and out-of-pocket costs. This form is not for applying for coverage in Kaiser Permanente's CO Gold 0/20 plan.

Do I need to use this form?

Not all changes to your account need to be made using this form. Some changes you can also request by phone.

Please see the guidelines below for which changes must be made using this form, and what parts you need to fill out. To make changes by phone, please call the Member Service Contact Center at (Denver/Boulder) **303-338-3800**, (Mountain Colorado) **844-837-6884**, (Northern Colorado) **844-201-5824**, (Southern Colorado) **888-681-7878**, 8 a.m. to 6 p.m. Mountain time (MT), Monday through Friday. TTY users, call **711**.

Type of change	How you can request the change	If you use the form, fill out these parts:
Update my contact information	By phone or by using this form	A, B, G
Change a name	Using this form, plus supporting documentation	A, C, G
Remove a dependent from my account	By phone or by using this form	A, D, G
Cancel membership for everyone on account	By phone or by using this form	A, E, G
Add a dependent to my account	Using this form, plus supporting documentation	A, F, G Proof of triggering event form (if making request outside of open enrollment)

How do I fill out this form?

- Complete all sections of this form that apply to your change, using black or blue ink.
- Please keep a copy of this form for your records.

Where do I send the form?

Return completed forms, and any required supporting documentation, to:

California Service Center
 Attn: CHC
 P.O. Box 939095
 San Diego, CA 92193

You may also fax this form, and any required supporting documentation, to:

866-242-0994

Questions?

We're here to help. If you have any questions about completing this form, please call the Member Service Contact Center at (Denver/Boulder) **303-338-3800**, (Mountain Colorado) **844-837-6884**, (Northern Colorado) **844-201-5824**, (Southern Colorado) **888-681-7878**, 8 a.m. to 6 p.m. Mountain time (MT), Monday through Friday. TTY users, call **711**.



Account Change Form Colorado

A. Fill out your information

Please select one: I'm the primary member (must be over 18) parent/guardian (if primary member is under 18)

First name MI

Last name

Health record number (if any) Date of birth (mm/dd/yyyy) / / Gender: Male Female

B. Update contact information

Fill out any information that's changed.

Mailing address

City State ZIP code

Home address, if different from mailing address (no P.O. boxes, please)

City State ZIP code

Email Phone - -

Written language preference Spoken language preference

C. Change a name

Whose name is changing? Child Spouse/domestic partner Primary member

Old name

First name MI

Last name

New name

First name MI

Last name

Enter primary applicant's name

D. Remove a dependent from my account

If you're removing more than 2 dependents, make a copy of this page before filling it out and attach it with the form.

Dependent 1

First name

MI

Last name

Health record number

Date of birth (mm/dd/yyyy)

What month do you want this change to start? The earliest a change can start is the first of the month after we receive your request.

(mm/yyyy)

Dependent 2

First name

MI

Last name

Health record number

Date of birth (mm/dd/yyyy)

What month do you want this change to start? The earliest a change can start is the first of the month after we receive your request.

(mm/yyyy)

E. Cancel membership for everyone on account

Please cancel membership in the Kaiser Permanente Colorado Bridge Program for everyone on this account. I understand that this will cancel enrollment in the Kaiser Permanente CO Gold 0/20 plan for everyone on this account.

What month do you want this change to start? The earliest a change can start is the first of the month after we receive your request. (mm/yyyy)

F. Add a dependent

The Colorado Bridge Program includes financial help from Kaiser Permanente. To qualify for this help, any dependent you add must meet these requirements:

- Live in the Kaiser Foundation Health Plan of Colorado service area.
- Are under 35 years of age at the time of the effective date of the Kaiser Permanente plan.
- Live in a household with incomes up to 300% of the federal poverty level (for example, \$36,180 for an individual or \$73,800 for a family of 4 per 2017 guidelines).
- Are not eligible for financial assistance through Connect for Health Colorado and do not have access to any other public or private health coverage, including, but not limited to, Health First Colorado (Colorado's Medicaid Program), Medicare, Child Health Plan Plus (CHP+) or a job-based health plan.

If you want to add a dependent outside of the open enrollment period:

- You must have had a triggering or qualifying life event. For a list of qualifying events, see the proof of triggering event form at the end of this form.
- **You must complete and send in the proof of triggering event form on pages 7-13 and proof of your event.**

For more information, please call the Member Service Contact Center at (Denver/Boulder) **303-338-3800**, (Mountain Colorado) **844-837-6884**, (Northern Colorado) **844-201-5824**, (Southern Colorado) **888-681-7878**, 8 a.m. to 6 p.m.

Mountain time (MT), Monday through Friday. TTY users, call **711**.

- Please complete the information below for each dependent you want to add to your plan.
- If you want to add more than 2 dependents, make a copy of this page before filling it out and attach it to the form.

Enter primary applicant's name

F. Add a dependent *(continued)*

Dependent 1

First name

MI

Last name

Health record number (if any)

Date of birth (mm/dd/yyyy)

Gender:

Male Female

Social Security number (optional)

Relationship to primary member:

Child Spouse/domestic partner Other _____

Is Dependent 1 ...

A U.S. citizen?

Yes No

A legal permanent resident?

Yes No

If yes, how many years has the primary applicant been a legal permanent resident? _____

Eligible for health coverage through public programs such as Health First Colorado (Colorado's Medicaid Program), Medicare, or Child Health Plan Plus?

Yes No

Eligible for financial assistance through Connect for Health Colorado?

Yes No

Currently covered through or able to be covered through a job-based health plan or another health plan?

Yes No

What month do you want Dependent 1's coverage to start? The earliest a change can start is the first of the month after we receive your request.

(mm/yyyy)

Enter primary applicant's name

F. Add a dependent *(continued)*

Dependent 2

First name

MI

Last name

Health record number (if any)

Date of birth (mm/dd/yyyy)

 / /

Gender:

Male Female

Social Security number (optional)

 - -

Relationship to primary member:

Child Spouse/domestic partner Other _____

Is Dependent 1 ...

A U.S. citizen?

Yes No

A legal permanent resident?

Yes No

If yes, how many years has the primary applicant been a legal permanent resident? _____

Eligible for health coverage through public programs such as Health First Colorado (Colorado's Medicaid Program), Medicare, or Child Health Plan Plus?

Yes No

Eligible for financial assistance through Connect for Health Colorado?

Yes No

Currently covered through or able to be covered through a job-based health plan or another health plan?

Yes No

What month do you want Dependent 1's coverage to start? The earliest a change can start is the first of the month after we receive your request.

(mm/yyyy) /

Enter primary applicant's name

G. Signature

By signing this form, I'm saying that the information I gave is true and complete.

If I give any false or incomplete information on this form or in any other communication about this form, my Kaiser Permanente Colorado Bridge Program account may be ended. I understand it's a crime to knowingly give false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company, and my coverage under the Kaiser Permanente Colorado Bridge Program may be ended. Penalties may include fines, denial of insurance benefits, and imprisonment.

The primary member (if over 18) or the primary member's parent or guardian (if the primary member is under 18) must sign below. If you're adding any new dependents 18 or older, they must also sign below.

X

Date (mm/dd/yyyy)

/ /

Signature of primary member (if 18 or older)

X

Date (mm/dd/yyyy)

/ /

Signature of parent or legal guardian (if primary member is under 18)

X

Date (mm/dd/yyyy)

/ /

Signature of new adult dependent (18 or older)

Enter primary applicant's name

Proof of triggering event form

Who should use this form?

Use this form only if you're adding a dependent outside of open enrollment. Ignore pages 7-13 if you're not adding a dependent to the Colorado Bridge Program.

When do I have to send in this form?

You must submit this form and any supporting documentation to us within 60 days of your event. If we don't get your documents within 60 days of your event, you may need to wait until the next open enrollment period to add a dependent to your account.

How do I fill it out?

STEP 1: Fill out the primary applicant information.

STEP 2: Check 1 box for your triggering event and 1 box for the proof you're sending in (unless otherwise noted). Make sure the triggering event and the type of proof apply to your state.

- You only need to send in 1 type of proof, unless otherwise noted.
- Send copies of official documents, not originals.
- Write this information about the primary applicant on the first page of your proof or on an attached page:
 - First and last name
 - Home address (no P.O. boxes)
 - Health/medical record number (if you have one)
 - Date of birth

Questions?

If you need help filling out this form, please call the Member Service Contact Center at (Denver/Boulder) **303-338-3800**, (Mountain Colorado) **844-837-6884**, (Northern Colorado) **844-201-5824**, (Southern Colorado) **888-681-7878**, 8 a.m. to 6 p.m. Mountain time (MT), Monday through Friday. TTY users, call **711**.

Enter primary applicant's name

STEP 1: Primary applicant information

Who is the primary applicant?

- In an individual plan, the primary applicant is the person who'll be covered by the health plan.
- If the application or Colorado Bridge Program Account Change Form is only for a child under 18, the child is the primary applicant.

First name

Social Security number (if any)

Last name

Phone

MI Application ID number (if you applied online)

Gender:

Male Female

Date of birth (mm/dd/yyyy)

Health record number (if any)

Home address (no P.O. boxes)

City

State

ZIP code

Parent/legal guardian (if primary applicant is under 18)

First name

Last name

Agent/broker/producer/KPIF representative (if any)

First name

Last name

Enter primary applicant's name

STEP 2: Proof of your triggering event

Instructions:

- Check 1 box for your triggering event and 1 box for the proof you're sending in (unless otherwise noted). Make sure the triggering event and the type of proof apply to your state.
- You only need to send in 1 type of proof, unless otherwise noted.
- Send copies of official documents, not originals.
- Write this information about the primary applicant on the first page of your proof or on an attached page:
 - First and last name
 - Home address (no P.O. boxes)
 - Health/medical record number (if you have one)
 - Date of birth

Triggering event	Type of proof
<input type="checkbox"/> 1. Loss of health care coverage California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington Keep in mind, this event does NOT qualify as a triggering event if: <ul style="list-style-type: none">• You're losing coverage because you didn't pay your premiums.• Your plan was rescinded.• You had Medicare Part B coverage and do not have any other coverage.• You voluntarily ended your coverage.	Letter from your employer <ul style="list-style-type: none"><input type="checkbox"/> Letter or other document from your employer stating that the employer dropped or will drop coverage or benefits for you, your spouse, or dependent family member and the date when this coverage ended or will end.<input type="checkbox"/> Letter or document from your employer stating that the employer stopped or will stop contributing to the cost of coverage and the date when this contribution ended or will end.<input type="checkbox"/> Letter showing your employer's offer of COBRA coverage or stating when your COBRA coverage ended or will end. <hr/> Letter from your insurer or Medicaid, Medi-Cal, Medicare, or other government programs <ul style="list-style-type: none"><input type="checkbox"/> Letter from your health insurance company showing a coverage end date, including a COBRA coverage end date.<input type="checkbox"/> Letter from school stating when student health coverage ended or will end.<input type="checkbox"/> Letter or notice from Medicaid, Medi-Cal, or the Children's Health Insurance Program (CHIP) stating when Medicaid, Medi-Cal, or CHIP coverage ended or will end.<input type="checkbox"/> Letter or notice from a government program, like TRICARE, Peace Corps, AmeriCorps, or Medicare, stating when that coverage ended or will end.

Enter primary applicant's name

STEP 2: Proof of your triggering event *(continued)*

Triggering event	Type of proof
1. Loss of health care coverage <i>(continued)</i>	Other <ul style="list-style-type: none"><input type="checkbox"/> Dated military discharge papers or Certificate of Release, including the date that coverage ended or will end, if you're losing coverage because you're no longer on active military duty.<input type="checkbox"/> Dated and signed written verification from an agent/broker/producer or dated letter from the insurer, if you are or were enrolled in a non-calendar year plan that's ending, including the date the plan ended.<input type="checkbox"/> Pay stubs of both current and previous hours if a reduction in work hours caused you to lose coverage.
<input type="checkbox"/> 2. Gaining or becoming a dependent through marriage (or domestic partnership/civil union) California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington	Provide this: <ul style="list-style-type: none"><input type="checkbox"/> Marriage certificate/license showing the date of the marriage.<input type="checkbox"/> Official government record of the marriage, including a foreign record of marriage showing the date of the marriage.
California, Colorado, Hawaii	<input type="checkbox"/> Official government record, including date of domestic partnership or civil union registration.
<input type="checkbox"/> 3. Gaining or becoming a dependent through the birth of a child, adoption, or placement for adoption or foster care California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington	Birth of a child <ul style="list-style-type: none"><input type="checkbox"/> Birth certificate or application for a birth certificate for the child.<input type="checkbox"/> Record from a clinic, hospital, doctor, midwife, institution, or other provider stating the child's date of birth.<input type="checkbox"/> Military record showing the child's birth date and place of birth.<input type="checkbox"/> Official government record of a foreign birth certificate showing the child's birth date and place of birth.<input type="checkbox"/> Religious record showing the child's birth date and place of birth.<input type="checkbox"/> Letter or other document from the health insurance company, like an Explanation of Benefits, showing that services related to birth or after-birth care were given to the child, the mother, or both, including the dates of service. Adoption or foster care <ul style="list-style-type: none"><input type="checkbox"/> Adoption letter or record showing date of adoption, dated and signed by a court official.<input type="checkbox"/> Court order showing when the order started. It must have a filing date stamp.<input type="checkbox"/> U.S. Department of Homeland Security immigration document for foreign adoptions, including the date of the adoptions.<input type="checkbox"/> Medical support court order. It must have a filing date stamp.<input type="checkbox"/> Foster care papers dated and signed by a court official.

Enter primary applicant's name

STEP 2: Proof of your triggering event *(continued)*

Triggering event	Type of proof
<p><input type="checkbox"/> 4. Child support order or other court order to cover a child</p> <p>Georgia, Hawaii, Maryland, Oregon, Virginia, Washington</p> <p>Child support order or other court order to cover a dependent</p> <p>Only California, Colorado</p>	<p><input type="checkbox"/> Signed court order with court filing date stamp.</p>
<p><input type="checkbox"/> 5. Permanent relocation</p> <p>California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington</p> <p>In this instance, you move from a non-Kaiser Permanente service area to a Kaiser Permanente service area, or you move from a foreign country or a United States territory.</p>	<p>Provide this:</p> <p><input type="checkbox"/> Proof of minimum essential coverage from your old insurer for at least 1 full day in the last 60 days (applicants moving within the U.S. only).</p> <p>And provide any of these: 1 with your old residential address and 1 with your new residential address (no P.O. boxes):</p> <ul style="list-style-type: none"><input type="checkbox"/> Lease or rental agreement.<input type="checkbox"/> Insurance documents, like homeowner's, renter's, or life insurance policy or statement.<input type="checkbox"/> Mortgage deed, if it states that the owner uses the property as the primary residence.<input type="checkbox"/> Mortgage or rental payment receipt.<input type="checkbox"/> Mail from the Department of Motor Vehicles, like a valid driver's license, vehicle registration, or change of address card.<input type="checkbox"/> Mail from a government agency to your address, like a Social Security statement, or a notice from Temporary Assistance for Needy Families or Supplemental Nutrition Assistance Program.<input type="checkbox"/> Your valid state ID.<input type="checkbox"/> Internet, cable, or other utility bill (including any public utility like a gas or water bill) or other confirmation of service (including a utility hookup or work order).<input type="checkbox"/> Telephone bill showing your address (cellphone or wireless bills are OK).<input type="checkbox"/> Mail from a financial institution, like a bank statement.<input type="checkbox"/> U.S. Postal Service change of address confirmation letter.<input type="checkbox"/> Pay stub showing your address.<input type="checkbox"/> Voter registration card showing your name and address.<input type="checkbox"/> Documents from the Department of Corrections, jail, or prison showing recent release or parole, including a dated order of parole, dated order of release, or an address certification.<input type="checkbox"/> Naturalization papers signed and dated within the last 60 days or green card, Education Certificate, or visa (if you moved to the U.S. from another country).

Enter primary applicant's name

STEP 2: Proof of your triggering event *(continued)*

Triggering event	Type of proof
<input type="checkbox"/> 6. Release from incarceration Marketplace and off-marketplace: California Marketplace only: Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington	<input type="checkbox"/> Documents from the Department of Corrections, jail, or prison showing recent release or parole, including a dated order of parole, dated order of release, or an address certification.
<input type="checkbox"/> 7. Determination by the health insurance marketplace California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington	<input type="checkbox"/> Letter or notice from the marketplace stating you're eligible for a special enrollment period and showing determination date.
<input type="checkbox"/> 8. Contract violation Colorado	<input type="checkbox"/> Written confirmation, with date, from the Division of Insurance that the health plan in which you're enrolled has substantially violated a material provision of your contract.
<input type="checkbox"/> 9. Misinformation about coverage California	<input type="checkbox"/> Notice from the marketplace stating you're eligible for a special enrollment period and showing determination date.
<input type="checkbox"/> 10. Provider network changes California	<input type="checkbox"/> Notice from provider stating you're eligible for a special enrollment period and showing determination date.
<input type="checkbox"/> 11. Losing a dependent through divorce or legal separation Marketplace and off-marketplace: California, Maryland At the option of the marketplace: Colorado, District of Columbia, Georgia, Hawaii, Oregon, Virginia, Washington	<input type="checkbox"/> Divorce decree, dissolution agreement, or separation agreement with court filing date stamp.

Enter primary applicant's name

STEP 2: Proof of your triggering event *(continued)*

Triggering event	Type of proof
<input type="checkbox"/> 12. Death of the subscriber or dependent Marketplace and off-marketplace: California, Maryland At the option of the marketplace: Colorado, District of Columbia, Georgia, Hawaii, Oregon, Virginia, Washington	<input type="checkbox"/> Death certificate.
<input type="checkbox"/> 13. Change in eligibility for federal financial assistance through the health insurance marketplace California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington	<input type="checkbox"/> Most recent eligibility determination from the marketplace showing determination date.
<input type="checkbox"/> 14. Change in eligibility for employer health coverage California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington	<input type="checkbox"/> Letter from employer stating change in minimum essential health coverage and showing determination date. <input type="checkbox"/> Letter or other document from your employer stating that the employer changed or will change coverage or benefits for you or for your spouse or dependent family member, so it's no longer considered qualifying health coverage, and the date when this coverage or benefits changed or will change.

By submitting a signed application or Account Change Form and proof of your triggering event, you're saying that the triggering event happened. It's important that we get proof of your triggering event. We will rely on your signature and proof to decide if you can enroll during a special enrollment period. If we decide that the triggering event didn't happen, we may take legal action. The legal action may include cancelling your coverage retroactively to the day it started. You may also be responsible for the cost of any services that you got.

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Colorado (Kaiser Health Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

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

If you need these services, call **1-800-632-9700** (TTY: **711**)

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail at: Customer Experience Department, Attn: Kaiser Permanente Civil Rights Coordinator, 2500 South Havana, Aurora, CO 80014, or by phone at Member Services: 1-800-632-9700.

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, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-632-9700** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ **1-800-632-9700** (TTY: **711**)።

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-632-9700** (TTY: **711**).

Bàsòò Wùdù (Bassa) Dè dɛ nià kɛ dyédé gbo: ɔ jũ ké ñ Bàsòò-wùdù-po-nyò jũ ní, níí, à wudù kà kò dò po-poò béin ñ gbo kpáa. Đá **1-800-632-9700** (TTY: **711**)

中文 (Chinese) 注意: 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-632-9700** (TTY: **711**)。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-632-9700** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-632-9700** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-632-9700** (TTY: **711**).

Igbo (Igbo) NRUBAMA: O bụrụ na i na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dijiri gi. Kpọọ **1-800-632-9700** (TTY: **711**).

日本語 (Japanese) 注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。 **1-800-632-9700** (TTY: **711**) まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-632-9700** (TTY: **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éi ná hóló, koji' hódíílnih **1-800-632-9700** (TTY: **711**).

नेपाली (Nepali) ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । **1-800-632-9700** (TTY: **711**) फोन गर्नुहोस् ।

Afaan Oromoo (Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-632-9700** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-632-9700** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-632-9700** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-800-632-9700** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-632-9700** (TTY: **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-632-9700** (TTY: **711**).