HIGHMARK

AGENT & OFFICE USE ONLY	
Date Received:	Effective Date:
Agent Name:	Agent NPN:

In which channel was this application received?

❑ Face to Face Consultation ❑ Medicare Options Seminar
❑ Highmark Direct Store ❑ Member Benefits Forum
❑ Pre-set Home Visit ❑ Other

APPLICATION FOR HIGHMARK MEDIGAP BLUE MEDICARE SUPPLEMENT INSURANCE PLANS

IMPORTANT: IF YOU ARE NOT ELIGIBLE FOR MEDICARE PART A AND ENROLLED IN MEDICARE PART B, YOU ARE NOT ELIGIBLE TO ENROLL IN MEDIGAP BLUE. DO NOT COMPLETE THIS APPLICATION.

SECTION I: APPLICANT INFORMATION

First Name	Middle Initial	Last Name			Suffix
Permanent Address	Apt#	City	State	Zip	County of Residence
Mailing Address (if different)	Apt#	City	State	Zip	
Birthdate MM/DD/YYYY	Social Security Number			Gender ❑ Male ❑ Female	
Preferred Telephone Number ❑ Home ❑ Mobile	Email Address				

Please provide your Medicare information below as shown on your red, white and blue Medicare Health Insurance card.

Medicare Number	Part A (Hospital) Effective Date	Part B (Medical) Effective Date
	/ /	/ /

Have you used any form of tobacco in the last 12 months? ❑ Yes ❑ No

If you are under age 65, did you enroll in Medicare due to End Stage Renal Disease? ❑ Yes ❑ No

SECTION II: PLAN SELECTION AND BILLING OPTIONS

Check the one plan for which you are enrolling. Rates subject to change. Enrollment subject to approval.
Please reference the enclosed Medigap Blue Outline of Coverage for the monthly premium based on your age and/or eligibility. If you have any questions or would like to speak with a licensed Medicare Advisor, call 1-888-692-5830. You may also reach out to your agent with questions.

Please indicate your plan choice below:

❑ Plan A
❑ Plan B
❑ Plan D
❑ Plan G
❑ Plan G High Deductible
❑ Plan N

Additional plan options available **ONLY if first Medicare Eligible before 2020:**

❑ Plan C
❑ Plan F
❑ High Deductible Plan F

For an additional monthly subscription fee, would you like to enroll in the optional Whole Health Balance Program, which provides optional coverage for hearing, vision, dental and fitness? (See Whole Health Balance Program description for details.) ❑ Yes ❑ No

Requested Coverage Effective Date: / 01 /

In the future bill me*: ❑ Quarterly (every 3 months) ❑ Bimonthly (every 2 months) ❑ Monthly

**If electronic funds transfer (EFT) is desired, please complete and return a separate EFT application which is included.*

SECTION III: GUARANTEED ACCEPTANCE / OPEN ENROLLMENT DETERMINATION

Please answer all questions as instructed. Applications with incomplete answers to this section will not be accepted.

1. Are you guaranteed acceptance into certain Medicare Supplement plans based on the conditions listed in the "Important Information about Your Rights to Guaranteed Issue of Medicare Supplement Insurance" that you received with this application? ❑ Yes ❑ No
2. Have you lost or are you losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you have certain rights to buy such a policy? ❑ Yes ❑ No

If you answered "Yes" to Question 1 or Question 2, you may be eligible for Guaranteed Acceptance in one or more of our Medicare Supplement Plans. Please attach proof of eligibility, such as notice from a prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy and skip to Section VII.

3. If you are applying during an Open Enrollment Period:
   - A) Are you within 6 months of your Medicare Part B effective date? ❑ Yes ❑ No
   - B) Will you be age 65 or older, or within 6 months of turning age 65, on the date of your requested coverage effective date? ❑ Yes ❑ No

If you answered "Yes" to Question 3A, skip to Section VII.

SECTION IV: HEALTH QUESTIONS TO DETERMINE ELIGIBILITY

If you were not advised to skip to Section VII after completing Section III of the application, complete this section in its entirety to determine if you are eligible for this coverage. If you are unsure how to respond, please consult your medical provider. Prior to approving your application for enrollment, Highmark reserves the right to review previous and current applications for coverage as well as claims history.

1. Were you enrolled in Medicare prior to age 65 due to a disability? ❑ Yes ❑ No

2. Are you now or have you been advised in the next year to be any of the following? ❑ Yes ❑ No
   - Admitted as an inpatient to a hospital
   - Confined to a nursing facility for other than short term rehabilitation
   - Paralyzed, bedridden or confined to a wheelchair
   - Receiving dialysis

3. Within the past 2 years, have you been diagnosed or treated (including prescription drugs) for any of the following conditions? Do not include any genetic information, such as family medical history or any information related to genetic testing, services or counseling. ❑ Yes ❑ No
   - Cancer (other than skin cancer), Leukemia or Lymphoma, Melanoma
   - Heart, Coronary, or Carotid Artery Disease (not including high blood pressure), Heart attack, Aneurysm, Congestive Heart Failure or any other type of Heart Failure, Enlarged Heart, Stroke, Transient Ischemic Attacks (TIA), or Hemophilia
   - Diabetes (using insulin)
   - Bone marrow or other organ transplant
   - ALS (Lou Gherig's Disease), Multiple Sclerosis (MS), Parkinson's, Systemic Lupus Erythematosus (SLE), Alzheimer's or Dementia
   - AIDS, AIDS Related Complex (ARC), or tested positive for HIV
   - Chronic Renal Disease such as ESRD
   - Cirrhosis of the Liver, Hepatitis C
   - Chronic Obstructive Pulmonary Disease (COPD), Emphysema
   - Alcohol Abuse or Alcoholism, Drug Abuse or use of illegal drugs
   - Bipolar or Manic Depressive, Schizophrenia, Psychological illness requiring hospitalization

4. Have you been advised to have a joint replacement in the next year, or have you received a joint replacement within the past 6 months? ❑ Yes ❑ No

If you answered YES to any of the questions in Section IV , you are not eligible for these plans.

SECTION V: HEALTH QUESTIONS TO DETERMINE RATE

If you were not advised to skip to Section VII after completing Section III of the application, complete this section in its entirety. If you are unsure how to respond, please consult your medical provider.

1. Have you been diagnosed, received treatment (including prescription drugs), or had any of the following conditions?

Heart Conditions

A. Heart Rhythm Disorders ❑ Yes ❑ No

Musculoskeletal Conditions

B. Amputation due to disease ❑ Yes ❑ No
C. Rheumatoid Arthritis ❑ Yes ❑ No
D. Spinal Stenosis ❑ Yes ❑ No
E. Degenerative Disc or Herniated Disc ❑ Yes ❑ No
F. Osteoporosis ❑ Yes ❑ No

Gastrointestinal Conditions

G. Chronic Pancreatitis ❑ Yes ❑ No
H. Esophageal Varices ❑ Yes ❑ No
I. Ulcerative Colitis ❑ Yes ❑ No

2. Within the past 2 years, have you been hospitalized or had inpatient surgery? ❑ Yes ❑ No

SECTION VI: OTHER HEALTH INFORMATION

If you were not advised to skip to Section VII after completing Section III of the application, complete this section in its entirety to provide additional health information which is subject to underwriting review.

1. Enter your Height and Weight. Body Mass Index (BMI) values greater or equal to 40 may result in a higher rate or denial.

   Height _____ ft. _____ inches Weight (lbs.) _____

2. List all prescription drugs you are currently taking or have been medically advised to take: (If none, write in "None." If additional space is needed, attach a separate page and sign and date that page.)

MEDICATION	AMOUNT	CONDITION FOR WHICH PRESCRIBED	CURRENTLY TAKING
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No

SECTION VII. ADDITIONAL INFORMATION

1. Are you covered for Medical Assistance through the state Medicaid program? ❑ Yes ❑ No

   (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question).

   If yes,

   A. Will Medicaid pay your premiums for this Medicare supplement policy? ❑ Yes ❑ No

   B. Do you receive any benefits from Medicaid OTHER THAN payments towards your Medicare Part B premium? ❑ Yes ❑ No

2. If you had coverage from any Medicare plan other than the original Medicare within the last 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

   START / / END / /

3. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? ❑ Yes ❑ No

4. Was this your first time in this type of Medicare plan? ❑ Yes ❑ No

5. Did you drop a Medicare supplement policy to enroll in the Medicare plan? ❑ Yes ❑ No

6. Do you have another Medicare supplement policy in force? ❑ Yes ❑ No

   If yes,

   A. With what company _____

   B. Letter Plan of existing policy _____

   C. Current Rate Tier (Choose one of the following)

   ❑ Preferred ❑ Standard | ❑ Tobacco ❑ Non-tobacco | ❑ Other (Please specify) _____

   D. Current Monthly Premium Amount _____

   E. Do you intend to replace your current Medicare supplement policy with this policy? ❑ Yes ❑ No

7. Have you had coverage under any other health insurance within the past 63 days? ❑ Yes ❑ No

   (For example, an employer, union, or individual plan)

   A. If so, with what company and what kind of policy? _____

   B. What are your dates of coverage under the policy? (If you are still covered under the other policy, leave "END" blank.) ❑ Yes ❑ No

   START / / END / /

8. Do you have coverage under a Medicare Prescription Drug Program through Highmark or another company? ❑ Yes ❑ No

   If Highmark, please list the identification number on the front of your ID card: _____

SECTION VIII. APPLICATION STATEMENTS FOR MEDICARE SUPPLEMENT PROGRAM

- You **do not need** more than one Medicare supplement policy
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy or, if the Medicare supplement policy is no longer available, a substantially equivalent policy will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

- If you are eligible for and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan.

  If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). Call ELDERinfo at 800-336-9500.

IMPORTANT: For the purposes of the sections that follow below, **"Creditable Health Care Coverage" includes, but is not limited to**, any Highmark group or individual health care program; another insurance company's individual, group, or Medicare Supplement program; certain Medicare health plans, for example, a Medicare health care maintenance organization (HMO) or preferred provider organization (PPO); a Program of All-Inclusive Care for the Elderly; or other government health plans such as Medicare, Medicaid, a state risk pool or FEHBP.

If you are currently enrolled in Creditable Health Care Coverage and your new Medigap Blue coverage will replace this Creditable Health Care Coverage without interruption - you are eligible for all Medigap Blue plan benefits as soon as your new coverage becomes effective. There is no waiting period for any pre-existing conditions you may have.

If you were previously, but are not currently, enrolled in some form of Creditable Health Care Coverage, you may be eligible for a waiver or reduction of your pre-existing condition exclusion if you satisfy **all** of the following requirements:

- Your prior Creditable Health Care Coverage was for a period of at least six (6) consecutive months; **and**
- You submit your completed application for Medigap Blue coverage to Highmark within sixty-three (63) days from the date that your most recent prior Creditable Health Care Coverage ended (or in certain instances, the date on which you were notified that your coverage will end); and
- You attach a copy of your "Certificate of Prior Creditable Coverage" to your application for Medigap Blue coverage or provide other proof of your Creditable Health Care Coverage prior coverage.

If you were not enrolled in any type of Creditable Health Care Coverage within the last sixty-three (63) day period prior to your application for Medigap Blue coverage, the following pre-existing exclusion clause will apply:

These Highmark Medigap Blue plans will not provide benefits during the first six (6) months of your coverage for any disease or physical condition for which you received treatment or advice from a physician during the six (6) month period before your new coverage became effective.

Notice: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The accuracy and validity of the information that you provide in the Application, including your responses to the health questionnaire, is subject to review by the Plan. The Plan reserves the right to take appropriate action in the event the information is not true or accurate.

The Plan shall terminate the Agreement if the Subscriber obtained or attempted to obtain benefits or payment for benefits as a result of a material misrepresentation. If benefits were provided due to a material misrepresentation, the Subscriber agrees to reimburse the Plan for such benefits.

I understand and agree that the terms and conditions of my coverage will be controlled by the written agreement with Highmark and that they may adopt reasonable policies, procedures, rules and interpretations to administer the program. I recognize that my coverage will only apply to services or supplies that are provided on or after the effective date of my coverage. To the best of my knowledge, the information provided on this application is true and correct.

I acknowledge and agree that certain personally identifiable information about me (collectively, "Personal Information") is subject to various statutory privacy standards, including, but not limited to, state insurance regulations implementing Title V of the Gramm-Leach-Bliley Act and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations adopted thereunder by the Department of Health and Human Services (45 CFR Parts 160, 162, 164). In accordance with those standards, Highmark may use and disclose Personal Information as permitted or required by law, and to facilitate payment, treatment and health care operations as described in its Notice of Privacy Practices ("NPP"). I understand that a copy of Highmark's current NPP is available on Highmark's Web site, or from the Highmark Privacy Department.

I hereby apply for coverage under the Highmark Medigap Blue Agreement. I understand this application is subject to approval by Highmark and the provisions of the Agreement.

I further understand that any approval of this application by Highmark is conditioned upon my being enrolled in Parts A and B of Medicare. If for any reason I am not enrolled in Medicare Part A or B, Highmark has the right to deny my application for Medigap Blue. If for any reason I become ineligible for Medicare A and B at some future date, I agree to notify Highmark immediately.

I understand that when I purchase this coverage, any other direct pay Highmark coverage I may have in effect will be cancelled as of the effective date of the Medigap Blue coverage.

I hereby authorize the Centers for Medicare and Medicaid Services (CMS) to furnish Highmark medical or other information acquired by it under the Title VII program (Medicare) to the extent necessary to process any claim under the Highmark Medigap Blue Agreement in effect with Highmark.

I understand the insurance producer cannot approve coverage. This Application does not guarantee that coverage will be provided. I further understand coverage, if provided, will not take effect until issued by Highmark and that the actual subscription rate will not be determined until coverage is issued. I understand the person discussing Medigap Blue plan options with me is either employed by or contracted with Highmark and may be entitled to receive compensation based on my enrollment in a plan.

To the best of my knowledge and belief, the information provided on this application is true and correct.

SIGNATURE

I hereby acknowledge and agree that I have received an Outline of Medicare Supplement Coverage and the Guide to Health Insurance for People with Medicare. My signature below verifies that I have read, understand and agree to all items contained in Section VIII ("Application Statements for Medicare Supplement Program") of this form:

_____ _____ Phone #: ( )

Signature Date

EMERGENCY CONTACT

_____ Phone #: ( )

Print Name

POWER OF ATTORNEY

_____ _____

Signature Date

THIS SECTION TO BE COMPLETED BY INSURANCE BROKER OR AGENT ONLY

A. List any other health insurance policies you have sold to this applicant which are still in force: _____

_____

B. List any other health insurance policies you have sold to this applicant in the past five years which are no longer in force:

_____

Signature of Agent or Broker _____ Date _____

Print Name and NPN _____

Agency Name and Number _____

Phone #: ( ) _____

FOR OFFICE USE:

_____

_____

_____

_____

INSTRUCTIONS FOR MAILING IN APPLICATION

Please review this checklist before you mail your application:

- ❑ Have you completed all required sections of the application form?
- ❑ Are your name and address written correctly on the application form?
- ❑ Have you attached your Certificate of Prior Creditable Coverage or your previous plan's letter of termination? (if applicable)
- ❑ Have you signed and dated your application?
- ❑ Have you attached the applicant's Power of Attorney or documentation of Legal Guardianship? (if applicable)

Return your completed application to us.

Use the envelope provided or mail to:

Highmark Blue Cross Blue Shield
P.O. Box 535049
Pittsburgh, PA 15253-9801

Benefits and/or benefit administration may be provided by or through Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield, which serves the state of Delaware and is an independent licensee of the Blue Cross Blue Shield Association.

All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

HIGHMARK.

An Independent Licensee of the Blue Cross and Blue Shield Association

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Plan will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Plan will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with:

Civil Rights Coordinator
P.O. Box 22492
Pittsburgh, PA 15222
Phone: 1-866-286-8295 (TTY: 711), Fax: 412-544-2475
Email: CivilRightsCoordinator@highmarkhealth.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office of Civil Rights Complaint Portal, available at 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, D.C. 20201
Phone: 1-800-368-1019, 800-537-7697 (TDD)

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

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ATTENTION: If you speak English, free language translation and interpretation services are available to you. Appropriate auxiliary aids and services (such as large print, audio, and Braille) to provide information in accessible formats are also available free of charge. Call the number on the back of your ID card (TTY: 711) for help.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de traducción e interpretación de idiomas. También hay disponibles ayudas y servicios auxiliares adecuados (como letra grande, audio y Braille) para proporcionar información en formatos accesibles sin cargo. Llame al número que figura al dorso de su tarjeta de identificación (TTY: 711) si necesita ayuda.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Übersetzungs- und Dolmetscherdienste zur Verfügung. Außerdem sind kostenlos entsprechende Hilfsmittel und Dienstleistungen (wie Großdruck, Audio und Blindenschrift) zur Bereitstellung von Informationen in barrierefreien Formaten erhältlich. Wählen Sie hierfür bitte die Nummer auf der Rückseite Ihrer Ausweiskarte (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis tradiksyon ak entèpretasyon aladispozisyon w gratis nan lang ou pale a. Èd ak sèvis siplemantè apwopriye (tèlke gwo lèt, odyo, Braille) pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nimewo ki sou do Kat ID w lan (TTY: 711) pou jwenn èd.

ВНИМАНИЕ: Если Вы говорите на русском языке, Вам доступны бесплатные услуги перевода на другой язык. Также предоставляется дополнительная бесплатная помощь и услуги отображения информации в доступных форматах (например, крупным шрифтом, шрифтом Брайля или в виде аудиозаписи). Для получения помощи позвоните по номеру, указанному на обратной стороне вашей идентификационной карты (TTY: 711).

ATTENZIONE: se parla italiano, sono disponibili servizi gratuiti di traduzione e interpretariato. Sono inoltre disponibili gratuitamente adeguati supporti e servizi ausiliari (ad esempio caratteri grandi, audio e Braille) per fornire informazioni in formati accessibili. Per assistenza, chiami il numero riportato sul retro della Sua tessera di identificazione (TTY: 711).

ATTENTION : si vous parlez français, des services de traduction et d'interprétation gratuits sont à votre disposition. Vous pouvez aussi bénéficier gratuitement de l'accès à des outils et services auxiliaires appropriés (affichage en gros caractères, audio et le braille) dans des formats accessibles. Veuillez appeler le numéro qui se trouve au verso de votre carte d'identification (TTY : 711) pour obtenir de l'aide.

ÀKÍYÈSÍ: Tí o bá nsọ èdè Yorùbá, àwọn iṣẹ ìtumọ ati òǵbufọ èdè wà ní àrọwọtó lọ́fẹ̀ẹ́ fún ọ. Awọn iṣẹ ìtọ́jú ati ìrànlọ́wọ́ tó yẹ (bíi titẹwé nla, gbigbọ ohùn, ati ìwé afọ́jú) lati pèsè iwifúnni ni awọn ọna ìrááyè si wà pẹlu lọ́fẹ̀ẹ́. Pe nọmba tó wà lẹhin kaádì ìdánimọ rẹ (TTY: 711) fún iranlọwọ.

אכטונג: אויב איר רעדט אידיש, קענט איר באקומען שפראך איבערזעצונג און דאלמעטשונג סערוויסעס פריי פון אפצאל. געהעריגע הילפסמיטלען און סערוויסעס (אזויווי גרויסע דרוק, אודיא און ברעיל) צו צושטעלן אינפארמאציע אין צוגענגליכע פארמאטן זענען אויך דא צו באקומען פריי פון אפצאל. רופט דעם נומער אויף די אנדערע זייט פון אייער אידענטיטעט קארטל (TTY: 711) פאר הילף.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات الترجمة التحريرية والترجمة الفورية مجانًا. تتوفر أيضًا الوسائل والخدمات المساعدة المناسبة (مثل الطباعة الكبيرة، والوسائل الصوتية، وطريقة برايل) لتقديم المعلومات بتنسيقاتٍ يمكن الوصول إليها من دون أي تكلفة. اتصل على الرقم المدوّن على ظهر بطاقة هويتك (TTY: 711) للحصول على المساعدة.

注意：如果您说中文，我们将为您提供免费的语言翻译和口译服务。此外，我们还免费提供相应的辅助工具和服务（如大字体、音频和盲文），以便您获取无障碍格式的信息。如需帮助，请拨打您的 ID 卡背面的号码（听障人士专用号码： 711）。

ધ્યાન આપશો: જો તમે ગુજરાતી બોલતા હોવ, તો તમારા માટે નિઃશુલ્ક ભાષા અનુવાદ અને ઇન્ટરપ્રિટેશન સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પૂરી પાડવા માટે યોગ્ય સહાયક સાધનસામગ્રી અને સેવાઓ (જેમ કે મોટી પ્રિન્ટ, ઓડિયો અને બ્રેઇલ) પણ નિઃશુલ્ક ઉપલબ્ધ છે. મદદ માટે તમારા આઇડી કાર્ડની પાછળ આપેલા નંબર (TTY: 711) પર કૉલ કરો.

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có dịch vụ biên dịch và phiên dịch ngôn ngữ miễn phí dành cho quý vị. Chúng tôi cũng cung cấp miễn phí các dịch vụ và hỗ trợ bổ sung thích hợp (như chữ in lớn, tệp âm thanh và chữ nổi) để cung cấp thông tin ở các định dạng dễ tiếp cận. Vui lòng gọi số điện thoại trên mặt sau của thẻ nhận dạng của quý vị (TTY: 711) để được trợ giúp.

ध्यान दिनुहोस्: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंलाई निःशुल्क भाषा अनुवाद र दोभासे सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक प्रविधि र सेवाहरू (जस्तै ठूलो प्रिन्ट, अडियो र ब्रेल) पनि निःशुल्क उपलब्ध छन्। मद्दतको लागि तपाईंको ID कार्डको पछाडिको नम्बरमा कल गर्नुहोस् (TTY: 711)।

कृपया ध्यान दें: यदि आप हिंदी भाषा बोलते हैं, तो आपके लिए मुफ़्त भाषा अनुवाद और व्याख्या संबंधी सेवाएं उपलब्ध हैं। एक्सेस करने योग्य फ़ॉर्मेट में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक सामग्री और सेवाएं (जैसे बड़े प्रिंट, ऑडियो और ब्रेल) भी निःशुल्क उपलब्ध हैं। सहायता के लिए अपने पहचान कार्ड के पीछे लिखे नंबर (TTY: 711) पर कॉल करें।

주의: 한국어를 사용하는 경우 무료 언어 번역 및 통역 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공받을 수 있는 적절한 보조 수단 및 서비스(예: 큰 활자, 오디오, 점자)도 무료로 이용할 수 있습니다. 도움이 필요하시면 ID 카드 뒷면에 있는 번호로 전화하십시오(TTY: 711).