Proof of qualifying life event form

Who should use this form?

- A qualifying life event is a change in your life that lets you apply for health care coverage outside the annual open enrollment period. This is called a special enrollment period. Examples include getting married, moving to a Kaiser Permanente service area with access to new health plans, or losing coverage because you lost your job.
- Use this Proof of Qualifying Life Event Form to submit your proof when applying directly to Kaiser Permanente if you or a dependent had a qualifying life event. You may also use this form to submit your proof when applying to your state's health benefit exchange in Colorado or Washington (except Clark, Cowlitz, and certain other counties*). For all other exchange applications, check your state's exchange for information on how to submit proof for exchange plans. It can help you figure out which type of proof you'll need to provide for your qualifying life event.
  - **Kaiser Permanente for Individuals and Families (KPIF) plan members** should submit their proof along with the Account Change Form.
  - **People who aren't Kaiser Permanente for Individuals and Families (KPIF) plan members** should submit their proof along with their Application for Health Care Coverage.

Who should not use this form?

- If you or any dependent you're applying for are entitled to Medicare Part A or are enrolled in Medicare Part B, that applicant is not eligible to apply for new KPIF coverage. Visit **kp.org/medicare** to learn more about your Medicare plan options or to apply for Medicare coverage.

How to use this form

California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington*

- Fill out Steps 1, 2, and 3.
- Submit this form and proof of your qualifying life event with your application or Account Change Form (if applicable). See "Submitting your proof" on page 15 for details.

When to submit your proof

California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington*

You have a limited period of time to submit your proof. Visit **kp.org/specialenrollment** for details and deadlines.

If we don't get your proof in time, we'll have to cancel your application or account change request. You may apply again if your special enrollment period is still in effect.

For applications submitted on **buykp.org**, submit your proof online.

Need help?

Visit **kp.org/specialenrollment** for more information. You can also call us at **1-800-494-5314** (TTY **711**), or contact your broker/producer or Kaiser Permanente representative.

*In Washington, go to **kp.org/specialenrollment** to see if Kaiser Permanente is collecting proof for exchange qualifying life events in your county.

Primary applicant name

6 9 5 1 3 0 9 3 2 4

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.
- In a family plan, the primary applicant is the family member on the health plan who's authorized to make changes to the account.
- In a child-only plan (where offered) for a child under 18, the child is the primary applicant.

Please note: This isn't an application for health care coverage. To get health care coverage, you need to submit an application or Account Change Form.

First name

MI

Date of birth (mm/dd/yyyy)

Last name

Phone

Application ID number (if you applied online)

Social Security number (if any)

Health/medical 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

Broker/producer or Kaiser Permanente representative (if any)

First name

Last name

Primary applicant name

STEP 2: Qualifying life event information

Qualifying life event number from Step 3

Date of qualifying event (mm/dd/yyyy)

For loss of minimum essential health coverage, the date of the qualifying event is the last full day you were covered under your prior plan.

STEP 3: Proof of your qualifying life event

- Check one box for your qualifying life event and one box for the proof you're sending (unless otherwise noted). Make sure the qualifying event and the type of proof apply to your state.
- Send one 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
  - Health/medical record number (if any)
  - Home address (no P.O. boxes)
  - Date of birth

Qualifying life event	Type of proof
☐ **1. Loss of minimum essential health coverage** California, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington*	**From your employer** ☐ Letter or other document from your employer stating the employer dropped or will drop coverage or benefits for you, your spouse, or dependent family member and the date this coverage ended or will end. ☐ Letter or document from your employer stating the employer stopped or will stop contributing to the cost of coverage and the date this contribution ended or will end. ☐ Letter showing your employer's offer of COBRA coverage, including the effective date, or stating when your COBRA coverage ended or will end. ☐ Pay stubs of current and previous hours if you lost coverage because of a reduction in work hours. ☐ Proof of age and evidence of loss of coverage when a dependent child turns 26 and is no longer eligible to be covered under a parent's health plan. **From your carrier or Medicaid, Medi-Cal, Medicare, or other government programs** ☐ Letter from your carrier showing a coverage end date, including a COBRA coverage end date. ☐ Letter from your student health plan indicating when student health coverage ended or will end. ☐ 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. ☐ Letter or notice from a government program, like TRICARE, Peace Corps, AmeriCorps, or Medicare, stating when that coverage ended or will end. **Other** ☐ Dated military discharge papers or Certificate of Release, including the date coverage ended or will end, if you're losing coverage because you're no longer on active military duty. ☐ Dated and signed written verification from a broker/producer or Kaiser Permanente representative, or dated letter from the carrier, if you are or were enrolled in a non-calendar-year plan that's ending, including the date the plan ended.

Important: This is NOT a qualifying life event if:

- You're losing coverage because you didn't pay your premiums.
- Your plan was rescinded.
- You had Medicare Part B coverage and don't have any other coverage.
- You voluntarily ended your coverage.
- You had temporary or short-term coverage like traveler's insurance.

*In Washington, go to **kp.org/specialenrollment** to see if Kaiser Permanente is collecting proof for exchange qualifying life events in your county.

Primary applicant name

STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
Loss of minimum essential health coverage *(continued)* Colorado† Important: This is NOT a qualifying life event if: • You're losing coverage because you didn't pay your premiums. • Your plan was rescinded. • You had Medicare Part B coverage and don't have any other coverage. • You voluntarily ended your coverage.	**From your employer** ☐ Letter or other document from your employer stating the employer dropped or will drop coverage or benefits for you, your spouse, or dependent family member and the date this coverage ended or will end. ☐ Letter or document from your employer stating the employer stopped or will stop contributing to the cost of coverage and the date this contribution ended or will end. ☐ Letter showing your employer's offer of COBRA coverage, including the start date, or stating when your COBRA coverage ended or will end. ☐ Proof of age and evidence of loss of coverage when a dependent child turns 26 and is no longer eligible to be covered under a parent's health plan. **From your carrier or Medicaid, Medi-Cal, Medicare, or other government programs** ☐ Letter from your carrier showing a coverage end date, including COBRA coverage end date. ☐ Letter from the Division of Insurance confirming your loss of minimum essential health coverage.
2. Gaining, becoming, or losing a dependent, or death of a subscriber or a dependent ☐ **2a. Gaining or becoming a dependent through marriage** **Check 2 boxes total.** District of Columbia, Virginia This event requires proof of prior coverage. Visit **kp.org/specialenrollment** for more information.	**Provide one of these:** Proof of minimum essential coverage for one spouse for at least one full day in the last 60 days from your prior carrier (applicants within the U.S. only): ☐ Paid premium invoice proving coverage within the last 60 days. ☐ Employer benefit record proving coverage within the last 60 days. **And provide one of these:** ☐ Marriage certificate/license showing the date of the marriage. ☐ Official government record of the marriage, including a foreign record of marriage showing the date of the marriage.

†In Colorado, proof for qualifying life events is collected by Kaiser Permanente for health plans purchased on the exchange.

Primary applicant name

STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
☐ **2b. Gaining or becoming a dependent through marriage or domestic partnership registration** **Check 2 boxes total.** California, Georgia, Hawaii, Maryland, Oregon, Washington* This event requires proof of prior coverage. Visit **kp.org/specialenrollment** for more information.	**Provide one of these:** Proof of minimum essential coverage for one spouse for at least one full day in the last 60 days from your prior carrier (applicants within the U.S. only): ☐ Paid premium invoice proving coverage within the last 60 days. ☐ Employer benefit record proving coverage within the last 60 days. **And provide:** ☐ Marriage certificate/license showing the date of the marriage. ☐ Official government record of the marriage, including a foreign record of marriage showing the date of the marriage. ☐ Official government record, including date of domestic partnership registration.
☐ **2c. Gaining or becoming a dependent through marriage or civil union partnership** **Check 2 boxes total.** Colorado† This event requires proof of prior coverage. Visit **kp.org/specialenrollment** for more information.	**Provide one of these:** Proof of minimum essential coverage for one spouse for at least one full day in the last 60 days from your prior carrier (applicants within the U.S. only): ☐ Paid premium invoice proving coverage within the last 60 days. ☐ Employer benefit record proving coverage within the last 60 days. **If you can't provide proof of minimum essential coverage, you may send in one of the following:** ☐ Official documentation showing that you are an American Indian or Native Alaskan. ☐ Proof that you lived for one or more days during the 60 days before your life event or during your most recent open enrollment period in a service area where no qualified health plan was available through your state's health benefit exchange. You can provide a screenshot from the exchange website or other proof from the exchange. ☐ Proof that you lived outside of the United States or in a United States territory for one or more days during the 60 days before the date of the qualifying life event. **And provide one of these:** ☐ Marriage certificate/license/other documentation showing the date of the marriage. ☐ Official government record, including date of civil union.

*In Washington, go to **kp.org/specialenrollment** to see if Kaiser Permanente is collecting proof for exchange qualifying life events in your county.

†In Colorado, proof for qualifying life events is collected by Kaiser Permanente for health plans purchased on the exchange.

STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
☐ **2d. Gaining or becoming a dependent through the birth of a child, adoption, or placement for adoption or foster care** California, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington*	**Birth of a child** ☐ Birth certificate or application for a birth certificate for the child. ☐ Record from a clinic, hospital, doctor, midwife, institution, or other provider stating the child's date of birth. ☐ Military record showing the child's birth date and place of birth. ☐ Official government record of a foreign birth certificate showing the child's birth date and place of birth. ☐ Religious record showing the child's birth date and place of birth. ☐ Letter or other document from the carrier, 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** ☐ Adoption letter or record showing date of adoption, dated and signed by a court official. ☐ Court order showing when the order started. It must have a filing date stamp. ☐ Official government record of a domestic adoption, or placement for adoption or foster care, showing the child's birth date and place of birth. ☐ U.S. Department of Homeland Security immigration document for foreign adoptions, including the date of the adoptions. ☐ Medical support court order. It must have a court filing date stamp. ☐ Foster care papers dated and signed by a court official.
Colorado†	**Birth of a child** ☐ Birth certificate or application for a birth certificate for the child. **Adoption or foster care** ☐ Adoption letter or record showing date of adoption, dated and signed by a court official. ☐ Court order showing when the order started. It must have a court filing date stamp. ☐ Official government record of a domestic adoption, or placement for adoption or foster care, showing the child's birth date and place of birth. ☐ U.S. Department of Homeland Security immigration document for foreign adoptions, including the date of the adoptions. ☐ Medical support court order. It must have a court filing date stamp. ☐ Foster care papers dated and signed by a court official.

*In Washington, go to **kp.org/specialenrollment** to see if Kaiser Permanente is collecting proof for exchange qualifying life events in your county.

†In Colorado, proof for qualifying life events is collected by Kaiser Permanente for health plans purchased on the exchange.

Primary applicant name

STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
☐ **2e. Losing a dependent through divorce, dissolution of domestic partnership, or legal separation** California, Maryland	☐ Divorce decree, dissolution agreement, or separation agreement with court filing date stamp.
☐ **2f. Losing a dependent through divorce, dissolution of a civil union partnership, or legal separation** Colorado†	☐ Divorce decree, dissolution agreement, or separation agreement with court filing date stamp.
☐ **2g. Death of the subscriber or a dependent** California, Maryland	☐ Death certificate.
Colorado†	☐ Death certificate or obituary.
☐ **3. Child support order or other court order to cover a dependent** California, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington*	☐ Signed court order with court filing date stamp.
Colorado†	☐ Signed court order with court filing date stamp or dated Designated Beneficiary Agreement.

*In Washington, go to **kp.org/specialenrollment** to see if Kaiser Permanente is collecting proof for exchange qualifying life events in your county.

†In Colorado, proof for qualifying life events is collected by Kaiser Permanente for health plans purchased on the exchange.

Primary applicant name

STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
☐ **4. Permanent relocation with access to new plans** California, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington* Choose **Permanent relocation with access to new plans**, if one of the following applies to you: • You moved from a non–Kaiser Permanente area to a Kaiser Permanente area. • You moved to a new state. • You moved from a foreign country or a United States territory. • You moved from a county that did not offer a qualified health plan. This event requires proof of prior coverage. Visit **kp.org/specialenrollment** for more information.	**Provide one of these:** Proof of minimum essential coverage for all applicants from your prior carrier for at least one full day in the last 60 days (applicants moving within the U.S. only). ☐ Paid premium invoice proving coverage within the last 60 days. ☐ Employer benefit record proving coverage within the last 60 days. **And, within 60 days of your move, provide any of these – one with your prior residential address and one with your new residential address (no P.O. boxes):** ☐ Lease or rental agreement. ☐ Insurance documents, like homeowner's, renter's, or life insurance policy or statement. ☐ Mortgage deed, if it states the owner uses the property as the primary residence. ☐ Mortgage or rental payment receipt. ☐ Mail from the Department of Motor Vehicles, like a valid driver's license, vehicle registration, or change of address card. ☐ 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. ☐ Your valid state ID. ☐ 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). ☐ Telephone bill showing your address (cellphone or wireless bills are OK). ☐ Mail from a financial institution, like a bank statement. ☐ U.S. Postal Service change of address confirmation letter. ☐ Pay stub showing your address. ☐ Voter registration card showing your name and address. ☐ 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. ☐ 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).

*In Washington, go to **kp.org/specialenrollment** to see if Kaiser Permanente is collecting proof for exchange qualifying life events in your county.

STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
Permanent relocation with access to new plans *(continued)* Colorado† Choose **Permanent relocation with access to new plans**, if one of the following applies to you: • You moved from a non–Kaiser Permanente area to a Kaiser Permanente area. • You moved to a new residence within our Kaiser Permanente service area where your current health plan is not available or you have additional health plan options. • You moved to a new state. • You moved from a foreign country or a United States territory. • You moved from a county that did not offer a qualified health plan. This event requires proof of prior coverage. Visit **kp.org/specialenrollment** for more information.	**Provide one of these:** Proof of minimum essential coverage for all applicants from your prior carrier for at least one full day in the last 60 days (applicants moving within the U.S. only). ☐ Paid premium invoice proving coverage within the last 60 days. ☐ Employer benefit record proving coverage within the last 60 days. **And, within 60 days of your move, provide any of these – one with your prior residential address and one with your new residential address (no P.O. boxes):** ☐ Lease or rental agreement. ☐ Mortgage deed, if it states the owner uses the property as the primary residence. ☐ Valid driver's license from the Department of Motor Vehicles. ☐ 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). ☐ Telephone bill showing your address (cellphone or wireless bills are OK). ☐ U.S. Postal Service change of address confirmation letter.

†In Colorado, proof for qualifying life events is collected by Kaiser Permanente for health plans purchased on the exchange.

Primary applicant name

STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
☐ **5. Changes in employer health coverage making you eligible for a premium tax credit** You must apply through your health benefits exchange for the following states: California, Georgia, Hawaii, and Oregon. You can apply either through your health benefit exchange or directly with Kaiser Permanente for the following states/ jurisdictions: Colorado†, District of Columbia, Maryland, Virginia, Washington*. **You're now eligible for a premium tax credit because your coverage through your employer has changed.**	☐ Letter from employer stating change in minimum essential health coverage and showing determination date. ☐ Letter or other document from your employer stating 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 this coverage or benefits changed or will change.
☐ **6. Determination by your state's health benefit exchange of exceptional circumstances** California, Colorado†, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington*	☐ Letter or notice from your state's health benefit exchange stating you're eligible for a special enrollment period and showing determination date.

*In Washington, go to **kp.org/specialenrollment** to see if Kaiser Permanente is collecting proof for exchange qualifying life events in your county.

†In Colorado, proof for qualifying life events is collected by Kaiser Permanente for health plans purchased on the exchange.

Primary applicant name

STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
☐ **7. Eligibility to purchase an individual health plan through an individual coverage health reimbursement arrangement (ICHRA) or a qualified small employer health reimbursement arrangement (QSEHRA)** California, Colorado†, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington*	☐ Letter or other documentation stating you are now eligible to purchase an individual health plan through an individual coverage health reimbursement arrangement (ICHRA) or a qualified small employer health reimbursement arrangement (QSEHRA) including the date showing when you are first eligible for the ICHRA or QSEHRA.
☐ **8. Domestic violence or spousal abandonment occurring within the household** California, Colorado†, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington*	☐ Attestation stating you're a victim of domestic abuse or spousal abandonment.
☐ **9. Loss of COBRA health coverage due to discontinuation of employer contribution** California, Colorado†, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington*	☐ Proof from your employer or COBRA administrator showing subsidies had been provided and the date they will end.

*In Washington, go to **kp.org/specialenrollment** to see if Kaiser Permanente is collecting proof for exchange qualifying life events in your county.

†In Colorado, proof for qualifying life events is collected by Kaiser Permanente for health plans purchased on the exchange.

Primary applicant name

STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
☐ **10. Release from incarceration** California, Colorado†	☐ 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.
☐ **11. Misinformation about your enrollment in minimum essential coverage** California	☐ Notice from your state's health benefit exchange or the Department of Managed Health Care stating you're eligible for a special enrollment period and showing determination date.
☐ **12. Provider network changes** California	☐ Notice that the provider is no longer participating in the health benefit plan and showing determination date.
☐ **13. Contract violation** California	☐ Written confirmation, with date, from the Department of Managed Health Care that the health plan in which you're enrolled has substantially violated a material provision of your contract.
Colorado†	☐ 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.
☐ **14. Eligibility for app-based transportation or delivery network company health care stipend** California	☐ A copy or a screen shot of your quarterly hours driven.
☐ **15. Determination by the Department of Insurance Commissioner of exceptional circumstances** Colorado†	☐ Letter or notice from the Department of Insurance Commissioner stating you're eligible for a special enrollment period and showing determination date.
☐ **16. Loss of Short Term Health Coverage** Colorado†	☐ Dated and signed proof providing evidence of the termination of a short-term policy with an expiration date on or after April 1, 2019, that indicates that the carrier has ceased all short-term policy sales in the state, or that the carrier has exited the market, which includes, but is not limited to, written communication from the carrier or from a broker or Kaiser Permanente representative.
☐ **17. Initial confirmation of pregnancy by a health care practitioner** District of Columbia, Maryland	☐ A document from your health care practitioner dated within the last 90 days confirming your initial pregnancy.

†In Colorado, proof for qualifying life events is collected by Kaiser Permanente for health plans purchased on the exchange.

STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
☐ **18. Change in employer health coverage making you ineligible for a premium tax credit or change in eligibility for cost share reductions** Maryland	☐ Letter from employer stating change in minimum essential health coverage and showing determination date. ☐ Letter or other document from your employer stating 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 this coverage or benefits changed or will change.
☐ **19. Tax Season Easy Enrollment** Maryland You must apply through your state's health benefit exchange	☐ Your financial information has been validated by the Comptroller, and you don't need to send additional proof.
☐ **20. Change in immigration status** California, Colorado†, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington* You must apply through your state's health benefit exchange	☐ Official documentation of a change in citizenship or immigration status.
☐ **21. Coverage as American Indian/Native Alaskan** California, Colorado†, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington* You must apply through your state's health benefit exchange	☐ Official documentation showing your status.

*In Washington, go to **kp.org/specialenrollment** to see if Kaiser Permanente is collecting proof for exchange qualifying life events in your county.

†In Colorado, proof for qualifying life events is collected by Kaiser Permanente for health plans purchased on the exchange.

Primary applicant name

STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
☐ **22. Change in income changing your eligibility for federal financial assistance through the health benefit exchange** California, Colorado†, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington* You must apply through your state's health benefit exchange. The exchange may require you to submit proof of change in income directly to the exchange.	**Provide one of these:** Proof of minimum essential coverage for all applicants from your prior carrier for at least one full day in the last 60 days. ☐ Paid premium invoice proving coverage within the last 60 days. ☐ Employer benefit record proving coverage within the last 60 days. **And provide:** ☐ Most recent eligibility determination from your state's health benefit exchange showing determination date.

By submitting a signed application or Account Change Form and proof of your qualifying life event, you're saying that the qualifying life event happened. It's important that we get proof of your qualifying life event. We will rely on your signature and proof to decide if you can enroll during a special enrollment period. If we determine that the qualifying life event didn't happen, or we learn of any other inaccuracy in the information that is included in the application, Account Change Form or any other information that you submit, we may take legal action. The legal action may include but is not limited to canceling your coverage retroactively to the day it started. You may also be responsible for the full charges of any services that you received.

*In Washington, go to **kp.org/specialenrollment** to see if Kaiser Permanente is collecting proof for exchange qualifying life events in your county.

†In Colorado, proof for qualifying life events is collected by Kaiser Permanente for health plans purchased on the exchange.

Submitting your proof

How are you applying?

- **If you're applying online:** Sign in at **buykp.org** and upload your proof. You don't need to upload this form.
- **In Washington (except Clark, Cowlitz, and certain other counties):**
  - If you're applying online through Washington Healthplanfinder: Sign in to **kp.org/wa/if-exchange** and upload your proof. You don't need to upload this form with your proof.
  - If you're applying online directly through Kaiser Permanente: Sign in to **kp.org/wa/if-myaccount** and upload this form with your proof.
- **If you're applying by mail or fax:** Use the information on this page to send your proof and this form to the address or fax number below.

Send application or Account Change Form and proof along with this form:

By mail

Kaiser Permanente for Individuals and Families
P.O. Box 23127
San Diego, CA 92193-9921

By fax

1-855-355-5334

To download an Account Change Form, visit kp.org/specialenrollment.

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KAISER PERMANENTE®

Nondiscrimination Notice

Kaiser Permanente does not discriminate on the basis of age, race, ethnicity, color, national origin, cultural background, ancestry, religion, sex, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, source of payment, genetic information, citizenship, primary language, or immigration status.

Language assistance services are available from our Member Service Contact Center 24 hours a day, 7 days a week (except closed holidays). Interpreter services, including sign language, are available at no cost to you during all hours of operation. Auxiliary aids and services for individuals with disabilities are available at no cost to you during all hours of operation. We can also provide you, your family, and friends with any special assistance needed to access our facilities and services. You may request materials translated in your language at no cost to you. You may also request these materials in large text or in other formats to accommodate your needs at no cost to you. For more information, call **1-800-464-4000** (TTY **711**).

A grievance is any expression of dissatisfaction expressed by you or your authorized representative through the grievance process. For example, if you believe that we have discriminated against you, you can file a grievance. Please refer to your *Evidence of Coverage or Certificate of Insurance* or speak with a Member Services representative for the dispute-resolution options that apply to you.

You may submit a grievance in the following ways:

- **By phone:** Call member services at **1-800-464-4000** (TTY **711**) 24 hours a day, 7 days a week (except closed holidays).
- **By mail:** Call us at **1-800-464-4000** (TTY **711**) and ask to have a form sent to you.
- **In person:** Fill out a Complaint or Benefit Claim/Request form at a member services office located at a Plan Facility (go to your provider directory at **kp.org/facilities** for addresses)
- **Online:** Use the online form on our website at **kp.org**

Please call our Member Service Contact Center if you need help submitting a grievance.

The Kaiser Permanente Civil Rights Coordinator will be notified of all grievances related to discrimination on the basis of race, color, national origin, sex, age, or disability. You may also contact the Kaiser Permanente Civil Rights Coordinator directly at:

Northern California
Civil Rights/ADA Coordinator
1800 Harrison St.
16th Floor
Oakland, CA 94612

Southern California
Civil Rights/ADA Coordinator
SCAL Compliance and Privacy
393 East Walnut St.,
Pasadena, CA 91188

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 *ocrportal.hhs.gov/ocr/portal/lobby.jsf* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TTY). Complaint forms are available at *hhs.gov/ocr/office/file/index.html*.

Aviso de no discriminación

Kaiser Permanente no discrimina a ninguna persona por su edad, raza, etnia, color, país de origen, antecedentes culturales, ascendencia, religión, sexo, identidad de género, expresión de género, orientación sexual, estado civil, discapacidad física o mental, fuente de pago, información genética, ciudadanía, lengua materna o estado migratorio.

La Central de Llamadas de Servicio a los Miembros brinda servicios de asistencia con el idioma las 24 horas del día, los 7 días de la semana (excepto los días festivos). Se ofrecen servicios de interpretación sin costo alguno para usted durante el horario de atención, incluido el lenguaje de señas. Se ofrecen aparatos y servicios auxiliares para personas con discapacidades sin costo alguno durante el horario de atención. También podemos ofrecerle a usted, a sus familiares y amigos cualquier ayuda especial que necesiten para acceder a nuestros centros de atención y servicios. Puede solicitar los materiales traducidos a su idioma sin costo para usted. También los puede solicitar con letra grande o en otros formatos que se adapten a sus necesidades sin costo para usted. Para obtener más información, llame al **1-800-788-0616** (TTY **711**).

Una queja es una expresión de inconformidad que manifiesta usted o su representante autorizado a través del proceso de quejas. Por ejemplo, si usted cree que ha sufrido discriminación de nuestra parte, puede presentar una queja. Consulte su *Evidencia de Cobertura (Evidence of Coverage)* o *Certificado de Seguro (Certificate of Insurance)*, o comuníquese con un representante de Servicio a los Miembros para conocer las opciones de resolución de disputas que le corresponden.

Puede presentar una queja de las siguientes maneras:

- **Por teléfono:** Llame a servicio a los miembros al **1-800-788-0616** (TTY **711**) las 24 horas del día, los 7 días de la semana (excepto los días festivos).
- **Por correo postal:** Llámenos al **1-800-788-0616** (TTY **711**) y pida que se le envíe un formulario.
- **En persona:** Llene un formulario de Queja Formal o Reclamo/Solicitud de Beneficios en una oficina de servicio a los miembros ubicada en un Centro de Atención del Plan (consulte su directorio de proveedores en **kp.org/facilities** [haga clic en "Español"] para obtener las direcciones).
- **En línea:** Use el formulario en línea en nuestro sitio web en **kp.org/espanol**.

Llame a nuestra Central de Llamadas de Servicio a los Miembros si necesita ayuda para presentar una queja.

Se le informará al Coordinador de Derechos Civiles de Kaiser Permanente (Civil Rights Coordinator) de todas las quejas relacionadas con la discriminación por motivos de raza, color, país de origen, género, edad o discapacidad. También puede comunicarse directamente con el coordinador de derechos civiles de Kaiser Permanente en:

Northern California
Civil Rights/ADA Coordinator
1800 Harrison St.
16th Floor
Oakland, CA 94612

Southern California
Civil Rights/ADA Coordinator
SCAL Compliance and Privacy
393 East Walnut St.,
Pasadena, CA 91188

También puede presentar una queja formal de derechos civiles de forma electrónica ante la Oficina de Derechos Civiles (Office for Civil Rights) en el Departamento de Salud y Servicios Humanos de los Estados Unidos (U.S. Department of Health and Human Services) mediante el Portal de Quejas Formales de la Oficina de Derechos Civiles (Office for Civil Rights Complaint Portal), en *ocrportal.hhs.gov/ocr/portal/lobby.jsf* (en inglés) o por correo postal o por teléfono a: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TTY). Los formularios de queja formal están disponibles en *hhs.gov/ocr/office/file/index.html* (en inglés).

無歧視公告

Kaiser Permanente禁止以年齡、人種、族裔、膚色、原國籍、文化背景、血統、宗教、性別、性別認同、性別表達、性取向、婚姻狀況、生理或心理殘障、付款來源、遺傳資訊、公民身份、主要語言或移民身份為由而歧視任何人。

會員服務聯絡中心每週7天每天24小時提供語言協助服務（節假日除外）。本機構在全部營業時間內免費為您提供口譯服務，包括手語服務，以及殘障人士輔助器材和服務。我們還可為您和您的親友提供使用本機構設施與服務所需要的任何特別協助。您可免費索取翻譯成您的語言的資料。您還可免費索取符合您需求的大號字體或其他格式的版本。若需更多資訊，請致電**1-800-757-7585**（TTY **711**）。

申訴指任何您或您的授權代表透過申訴程序來表達不滿的做法。例如，如果您認為自己受到歧視，即可提出申訴。若需瞭解適用於自己的爭議解決選項，請參閱《承保範圍說明書》*(Evidence of Coverage)* 或《保險證明書》*(Certificate of Insurance)*，或諮詢會員服務代表。

您可透過以下方式提出申訴：

- **透過電話：**請致電**1-800-757-7585**（TTY **711**）與會員服務部聯絡，服務時間為每週7天，每天24小時（節假日除外）。
- **透過郵件：**請致電**1-800-757-7585**（TTY **711**）與我們聯絡並請我們將表格寄給您。
- **親自遞交：**在計劃設施的會員服務辦事處填寫投訴或福利理索賠／申請表（請參閱**kp.org/facilities**上的保健業者名錄以查看地址）
- **線上：**使用我們網站上的線上表格，網址為**kp.org**

如果您在提交申訴時需要協助，請致電我們的會員服務聯絡中心。

涉及人種、膚色、原國籍、性別、年齡或殘障歧視的一切申訴都將通知Kaiser Permanente的民權事務協調員 (Civil Rights Coordinator)。您也可與Kaiser Permanente的民權事務協調員直接聯絡，地址：

Northern California
Civil Rights/ADA Coordinator
1800 Harrison St.
16th Floor
Oakland, CA 94612

Southern California
Civil Rights/ADA Coordinator
SCAL Compliance and Privacy
393 East Walnut St.,
Pasadena, CA 91188

您還可以電子方式透過民權辦公室的投訴入口網站 (Office for Civil Rights Complaint Portal) 向美國衛生與民眾服務部 (U.S. Department of Health and Human Services) 民權辦公室 (Office for Civil Rights) 提出民權投訴，網址是 *ocrportal.hhs.gov/ocr/portal/lobby.jsf* 或者按照如下資訊採用郵寄或電話方式聯絡：U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TTY)。投訴表可從網站 *hhs.gov/ocr/office/file/index.html* 下載。

Thông Báo Không Kỳ Thị

Kaiser Permanente không phân biệt đối xử dựa trên tuổi tác, chủng tộc, sắc tộc, màu da, nguyên quán, hoàn cảnh văn hóa, tổ tiên, tôn giáo, giới tính, nhận dạng giới tính, cách thể hiện giới tính, khuynh hướng tình dục, gia cảnh, khuyết tật về thể chất hoặc tinh thần, nguồn tiền thanh toán, thông tin di truyền, quốc tịch, ngôn ngữ chính, hay tình trạng di trú.

Các dịch vụ trợ giúp ngôn ngữ hiện có từ Trung Tâm Liên Lạc ban Dịch Vụ Hội Viên của chúng tôi 24 giờ trong ngày, 7 ngày trong tuần (ngoại trừ ngày lễ). Dịch vụ thông dịch, kể cả ngôn ngữ ký hiệu, được cung cấp miễn phí cho quý vị trong giờ làm việc. Các phương tiện trợ giúp và dịch vụ bổ sung cho những người khuyết tật được cung cấp miễn phí cho quý vị trong giờ làm việc. Chúng tôi cũng có thể cung cấp cho quý vị, gia đình và bạn bè quý vị mọi hỗ trợ đặc biệt cần thiết để sử dụng cơ sở và dịch vụ của chúng tôi. Quý vị có thể yêu cầu miễn phí tài liệu được dịch ra ngôn ngữ của quý vị. Quý vị cũng có thể yêu cầu miễn phí các tài liệu này dưới dạng chữ lớn hoặc dưới các dạng khác để đáp ứng nhu cầu của quý vị. Để biết thêm thông tin, gọi **1-800-464-4000** (TTY **711**).

Một phàn nàn là bất cứ thể hiện bất mãn nào được quý vị hay vị đại diện được ủy quyền của quý vị trình bày qua thủ tục phàn nàn. Ví dụ, nếu quý vị tin rằng chúng tôi đã kỳ phân biệt đối xử với vị, quý vị có thể đệ đơn phàn nàn. Vui lòng tham khảo Chứng *Từ Bảo Hiểm (Evidence of Insurance)* hay *Chứng Nhận Bảo Hiểm (Certificate of Insurance)*, hoặc nói chuyện với một nhân viên ban Dịch Vụ Hội Viên để biết các lựa chọn giải quyết tranh chấp có thể áp dụng cho quý vị.

Quý vị có thể nộp đơn phàn nàn bằng các hình thức sau đây:

- **Qua điện thoại**: Gọi cho ban dịch vụ hội viên theo số **1-800-464-4000** (TTY **711**) 24 giờ trong ngày, 7 ngày trong tuần (ngoại trừ đóng cửa ngày lễ).
- **Qua bưu điện:** Gọi cho chúng tôi theo số **1-800-464-4000** (TTY **711**) và yêu cầu được gửi một mẫu đơn.
- **Trực tiếp:** Điền một mẫu đơn Than Phiền hay Yêu Cầu Quyền Lợi/Yêu Cầu tại một văn phòng ban dịch vụ hội viên tại một Cơ Sở Thuộc Chương Trình (xem danh mục nhà cung cấp của quý vị tại **kp.org/facilities** để biết địa chỉ)
- **Trực tuyến:** Sử dụng mẫu đơn trực tuyến trên trang mạng của chúng tôi tại **kp.org**

Xin gọi Trung Tâm Liên Lạc ban Dịch Vụ Hội Viên của chúng tôi nếu quý vị cần trợ giúp nộp đơn phàn nàn.

Điều Phối Viên Dân Quyền (Civil Rights Coordinator) Kaiser Permanente sẽ được thông báo về tất cả phàn nàn liên quan tới việc kỳ thị trên cơ sở chủng tộc, màu da, nguyên quán, giới tính, tuổi tác, hay tình trạng khuyết tật. Quý vị cũng có thể liên lạc trực tiếp với Điều Phối Viên Dân Quyền Kaiser Permanente tại:

Northern California
Civil Rights/ADA Coordinator
1800 Harrison St.
16th Floor
Oakland, CA 94612

Southern California
Civil Rights/ADA Coordinator
SCAL Compliance and Privacy
393 East Walnut St.,
Pasadena, CA 91188

Quý vị cũng có thể đệ đơn than phiền về dân quyền với Bộ Y Tế và Nhân Sinh Hoa Kỳ (U.S. Department of Health and Human Services), Phòng Dân Quyền (Office of Civil Rights) bằng đường điện tử thông qua Cổng Thông Tin Phòng Phụ Trách Khiếu Nại về Dân Quyền (Office for Civil Rights Complaint Portal), hiện có tại *ocrportal.hhs.gov/ocr/portal/lobby.jsf*, hay bằng đường bưu điện hoặc điện thoại tại: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TTY). Mẫu đơn than phiền hiện có tại *hhs.gov/ocr/office/file/index.html.*

Language Assistance Services

English: Language assistance is available at no cost to you, 24 hours a day, 7 days a week. You can request interpreter services, materials translated into your language, or in alternative formats. Just call us at **1-800-464-4000**, 24 hours a day, 7 days a week (closed holidays). TTY users call **711**.

Arabic: خدمات الترجمة الفورية متوفرة لك مجانًا على مدار الساعة كافة أيام الأسبوع. بإمكانك طلب خدمة الترجمة الفورية أو ترجمة وثائق للغتك أو لصيغ أخرى. ما عليك سوى الاتصال بنا على الرقم **1-800-464-4000** على مدار الساعة كافة أيام الأسبوع (مغلق أيام العطلات). لمستخدمي خدمة الهاتف النصي يرجي الاتصال على الرقم (**711**).

Armenian: Ձեզ կարող է անվճար օգնություն տրամադրվել լեզվի հարցում՝ օրը 24 ժամ, շաբաթը 7 օր: Դուք կարող եք պահանջել բանավոր թարգմանչի ծառայություններ, Ձեր լեզվով թարգմանված կամ այլընտրանքային ձևաչափով պատրաստված նյութեր: Պարզապես զանգահարեք մեզ՝ **1-800-464-4000** հեռախոսահամարով՝ օրը 24 ժամ՝ շաբաթը 7 օր (տոն օրերին փակ է): TTY-ից օգտվողները պետք է զանգահարեն **711**:

Chinese: 您每週 7 天，每天 24 小時均可獲得免費語言協助。您可以申請口譯服務、要求將資料翻譯成您所用語言或轉換為其他格式。我們每週 7 天，每天 24 小時均歡迎您打電話 **1-800-757-7585** 前來聯絡（節假日 休息）。聽障及語障專線 (TTY) 使用者請撥 **711**。

Farsi: خدمات زبانی در 24 ساعت شبانروز و 7 روز هفته بدون اخذ هزینه در اختیار شما است. شما می توانید برای خدمات مترجم شفاهی، ترجمه جزوات به زبان شما و یا به صورتهای دیگر درخواست کنید. کافیست در 24 ساعت شبانروز و 7 روز هفته (به استثنای روزهای تعطیل) با ما به شماره **1-800-464-4000** تماس بگیرید. کاربران TTY با شماره **711** تماس بگیرند.

Hindi: बिना किसी लागत के दुभाषिया सेवाएँ, दिन के 24 घंटे, सप्ताह के सातों दिन उपलब्ध हैं। आप एक दुभाषिये की सेवाओं के लिए, बिना किसी लागत के सामग्रियों को अपनी भाषा में अनुवाद करवाने के लिए, या वैकल्पिक प्रारूपों के लिए अनुरोध कर सकते हैं। बस केवल हमें **1-800-464-4000** पर, दिन के 24 घंटे, सप्ताह के सातों दिन (छुट्टियों वाले दिन बंद रहता है) कॉल करें। TTY उपयोगकर्ता **711** पर कॉल करें।

Hmong: Muajkwc pab txhais lus pub dawb rau koj, 24 teev ib hnub twg, 7 hnub ib lim tiam twg. Koj thov tau cov kev pab txhais lus, muab cov ntaub ntawv txhais ua koj hom lus, los yog ua lwm hom.Tsuas hu rau **1-800-464-4000**, 24 teev ib hnub twg, 7 hnub ib lim tiam twg (cov hnub caiv kaw). Cov neeg siv TTY hu **711**.

Japanese: 当院では、言語支援を無料で、年中無休、終日ご利用いただけます。通訳サービス、日本語に翻訳された資料、あるいは資料を別の書式でも依頼できます。お気軽に **1-800-464-4000** までお電話ください（祭日を除き年中無休）。TTY ユーザーは **711** にお電話ください。

Khmer: ជំនួយភាសា គឺមានឥតអស់ថ្លៃដល់អ្នកទ្បើយ 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ។ អ្នកអាចស្នើសុំសេវាអ្នកបកប្រែឬ សំភារៈដែលបានបកប្រែទៅជាភាសាខ្មែរ ឬជាទំរង់ផ្សេងទៀត។ឬ គ្រាន់តែទូរស័ព្ទមកយើង តាមលេខ **1-800-464-4000** បាន 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ (បិទថ្ងៃបុណ្យ)។ អ្នកប្រើ TTY ហៅលេខ **711**។ឡ

Korean: 요일 및 시간에 관계없이 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하는 통역 서비스, 귀하의 언어로 번역된 자료 또는 대체 형식의 자료를 요청할 수 있습니다. 요일 및 시간에 관계없이 **1-800-464-4000** 번으로 전화하십시오 (공휴일 휴무). TTY 사용자 번호 **711**.

Laotian: ການຊ່ວຍເຫືອດ້ານພາສາມີໃຫ້ໂດຍບ່ເສັງຄ່າ ແກ່ທ່ານ, ຕະຫອດ 24 ຊ່ວໂມງ, 7 ວັນຕ່ອາທິດ. ທ່ານ ສາມາດຮ້ອງຂຮັບບລິການນາຍພາສາ, ໃຫ້ແປເອກະ ສານເປັນພາສາຂອງທ່ານ, ຫ ໃນຮູບແບບອ່ືນ. ພ ງ ແຕ່ໂທຣຫາພວກເຮາທ **1-800-464-4000**, ຕະຫອດ 24 ຊ່ວໂມງ, 7 ວັນຕ່ອາທິດ (ປິດວັນພັກຕ່າງ). ຜ ໃຊ້ສາຍ TTY ໂທຣ **711**.

KAISER PERMANENTE®

Navajo: Saad bee áká'a'ayeed náhóló t'áá jiik'é, naadiin doo bibąą' dįį' ahéé'iikeed tsosts'id yiskąąjį damoo ná'ádleehjį. Atah halne'é áká'adoolwołígíí jóki, t'áadoo le'é t'áá hóhazaadjį hadilyąą'go, éí doodaii' nááná lá ał'ąą ádaat'ehígíí bee hádadilyaa'go. Kojį hodiilnih **1-800-464-4000**, naadiin doo bibąą' dįį' ahéé'iikeed tsosts'id yiskąąjį damoo ná'ádleehjį (Dahodiyin biniiyé e'e'aahgo éí da'deelkaal). TTY chodeeyoolínígíí kojį hodiilnih **711**.

Punjabi: ਬਿਨਾਂਕਿਸੀਲਾਗਤਾਦੇ, ਦਿਨਾਦੇ24 ਘੰਟੇ, ਹਫਤੇਾਦੇ7 ਦਿਨ, ਦੁਭਾਸ਼ੀਆਾਸੇਵਾਵਾਂਤੁਹਾਡੇ ਲਈੀਉਪਲਬਧਾਹੈ।ਾਤੁਸੀਂ ਇੱਕਾਦੁਭਾਸ਼ੀਏਾਦੀੀ ਮਦਦਾਲਈ, ਸਮੱਗਰੀਆਾਨੰਆਾਪਣੀੀਭਾਸ਼ਾ ਵਿੱਚਾਅਨੁਵਾਦਾ ਕਰਵਾਉਣਾ ਲਈ, ਜ਼ਾਂਕਿਸੇਾਵੱਖਾਫਾਰਮੈਟਾਵਿੱਚਾਪ੍ਰਾਪਤਾਕਰਨਾਲਈੀਬੇਨਤੀਾਕਰਾਸਕਦੇਾ ਹੋ।ਾਬਸਾਸਿਰਫ਼ਾਸਾਨੂੰ**1-800-464-4000** ਤੇ, ਦਿਨਾਦੇ24 ਘੰਟੇ, ਹਫ਼ਤੇਾ ਦੇ7 ਦਿਨ (ਛੁੱਟੀਆਾਂ ਵਾਲੇ ਦਿਨਾਬੰਦਾਰਹਿੰਦਾ ਹੈ) ਫ਼ੋਨਾਕਰੋ।ਾTTY ਦਾ ਉਪਯੋਗਾਕਰਨਾਵਾਲੇ **711** 'ਤੇਾਫ਼ੋਨਾਕਰਨ।ਾ

Russian: Мы бесплатно обеспечиваем Вас услугами перевода 24 часа в сутки, 7 дней в неделю. Вы можете воспользоваться помощью устного переводчика, запросить перевод материалов на свой язык или запросить их в одном из альтернативных форматов. Просто позвоните нам по телефону **1-800-464-4000**, который доступен 24 часа в сутки, 7 дней в неделю (кроме праздничных дней). Пользователи линии TTY могут звонить по номеру **711**.

Spanish: Contamos con asistencia de idiomas sin costo alguno para usted 24 horas al día, 7 días a la semana. Puede solicitar los servicios de un intérprete, que los materiales se traduzcan a su idioma o en formatos alternativos. Solo llame al **1-800-788-0616**, 24 horas al día, 7 días a la semana (cerrado los días festivos). Los usuarios de TTY, deben llamar al **711**.

Tagalog: May magagamit na tulong sa wika nang wala kang babayaran, 24 na oras bawat araw, 7 araw bawat linggo. Maaari kang humingi ng mga serbisyo ng tagasalin sa wika, mga babasahin na isinalin sa iyong wika o sa mga alternatibong format. Tawagan lamang kami sa **1-800-464-4000**, 24 na oras bawat araw, 7 araw bawat linggo (sarado sa mga pista opisyal). Ang mga gumagamit ng TTY ay maaaring tumawag sa **711**.

Thai: เรามีบริการล่ามฟรีสาหรับคุณตลอด 24 **ชั่วโมง ทุกวันตลอดชั่วโมงทาการของเราคุณสามารถขอให้ล่าม ช่วยตอบคาถามของคุณที่เกี่ยวกับความคุ้มครองการดูแล สุขภาพของเราและคุณยังสามารถขอให้มีการแปลเอกสา รเป็นภาษาที่คุณใช้ได้โดยไม่มีการคิดค่าบริการเพียงโทร หาเราที่หมายเลข 1-800-464-4000 ตลอด** 24 **ชั่วโมงทุกวัน (ปิดให้บริการในวันหยุดราชการ) ผู้ใช้** TTY **โปรดโทรไปที่ 711**

Vietnamese: Dịch vụ thông dịch được cung cấp miễn phí cho quý vị 24 giờ mỗi ngày, 7 ngày trong tuần. Quý vị có thể yêu cầu dịch vụ thông dịch, tài liệu phiên dịch ra ngôn ngữ của quý vị hoặc tài liệu bằng nhiều hình thức khác. Quý vị chỉ cần gọi cho chúng tôi tại số **1-800-464-4000**, 24 giờ mỗi ngày, 7 ngày trong tuần (trừ các ngày lễ). Người dùng TTY xin gọi **711**.

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