

Georgia Region Group Enrollment/ Change Form for Large Group



TO BE COMPLETED BY EMPLOYER (Please print or type in black ink only.)

COMPANY NAME

GROUP NO.

SUBGROUP NO.

BILLGROUP UN

DATE OF HIRE (MM/DD/YYYY)

EFFECTIVE DATE (MM/DD/YYYY)

NEW ENROLLMENT *Check one:*

- ☐ New group

☐ New hire (*complete sections A, B, E, G*)

☐ Loss of other coverage (*complete sections A, B, E, G*)

☐ Other (*please specify*) _____

☐ Cancel all coverage (employee and family) (*complete section A*)

☐ Open enrollment (*complete sections A, B, E, G*)
☐ COBRA (*complete sections A, B, E, G*)

Date of event

PLAN Check one:

- | | | | |
|--|---|--|---|
| ☐ Signature HMO | ☐ Multi-Choice | ☐ Out-of-Area | ☐ Consumer Choice Option (CCO) |
| ☐ HMO | ☐ HSA-Qualified Deductible HMO (Self Only) | ☐ HSA-Qualified Deductible HMO (Family) | |
| | ☐ Deductible Plan with HRA (Self Only) | ☐ Deductible Plan with HRA (Family) | |

IF MAKING A CHANGE, COMPLETE THE FOLLOWING:

DELETE DEPENDENTS (Complete sections A, B, E, G)

DATE (MM/DD/YYYY)

- ☐ Over age limit

☐ Divorce

☐ Deceased

☐ Other (please specify)

ADD DEPENDENTS (Complete sections A, B, E, G)

DATE (MM/DD/YYYY)

- ☐ Birth

☐ Adoption*

☐ Marriage*

☐ Loss of other coverage

☐ Other (please specify)

OTHER CHANGES (Complete sections A, B, G)

- ☐ Name change _____
 Previous name _____
 Current name _____

☐ Address (complete sections A, G)
☐ Telephone (complete sections A, G)

A. EMPLOYEE INFORMATION—to be completed by the employee.

LAST NAME

FIRST NAME

MI

SUFFIX

SOCIAL SECURITY NUMBER

MEDICAL RECORD NUMBER (IF ANY)

DATE OF BIRTH (MM/DD/YYYY)

MALE FEMALE

*Additional documentation may be required.



EMPLOYEE LAST NAME

SOCIAL SECURITY NUMBER

ADD ☐ DELETE ☐DEPENDENT ☐ CHILD ☐ OTHER ☐ _____

LAST NAME

FIRST NAME

MI

SUFFIX

SOCIAL SECURITY NUMBER

MEDICAL RECORD NUMBER (IF ANY)

DATE OF BIRTH (MM/DD/YYYY)

MALE FEMALE

Primary Care Physician (PCP) Name _____ PCP ID # C. Do any of your dependents above live at another address? YES ☐ NO ☐ If yes, please complete the following:

Name(s) (Last, First, MI)

Address

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D. Are any of your listed dependents over the maximum age? If yes, please complete the following:

Name(s) (Last, First, MI)

Disabled*

Full-time student*

Name of college, university, or trade school

	YES ☐ NO ☐	YES ☐ NO ☐	
	YES ☐ NO ☐	YES ☐ NO ☐	

E. OTHER COVERAGE INFORMATIONIncluding yourself, do any of the persons listed above have other coverage? YES ☐ NO ☐

Name _____ Insurance carrier name _____ Policy number _____ Telephone number _____

Are you or any of your dependants eligible for Medicare? YES ☐ NO ☐**F. Waiver of coverage**

By completing this section, I acknowledge that I was given the opportunity to enroll in this plan of group health benefits offered by my employer. I refuse the following:

- ☐ All coverage ☐ Coverage for my spouse
☐ Coverage for my children

I understand that if I or my dependents later wish to enroll for any of the coverage(s) refused, I/they will be required to submit an *Employee Application and Change Form*, and coverage may be subject to late enrollee provisions, as allowed by law and as directed by my employer.

Reason for refusal: (Please check all appropriate boxes)

- ☐ other group coverage sponsored by my employer*
☐ other group coverage sponsored by my spouse's employer*
☐ other group coverage sponsored by another organization*
☐ other reasons (*please explain*)

*Please provide name of carrier: _____

*Plan number: _____ Telephone number: _____

G. Important: Your application cannot be processed without your signature. Please read the back of this form before signing. I acknowledge by my signature that the information I have supplied on this form is true and correct, and that I have read and agree to the requirements, terms, conditions, limitations, and provisions described on the reverse sides.

Employee/Applicant signature

Date

Employer signature

Date

*Additional documentation may be required.

Mail original to: Kaiser Foundation Health Plan of Georgia, Inc. • P.O. Box 203010 • Denver, CO 80220-9010



Please complete this application and submit it to your company's Benefits Administrator. I understand and agree that if the application is accepted by Kaiser Foundation Health Plan of Georgia, Inc. ("Health Plan") and Kaiser Permanente Insurance Company ("KPIC"), as applicable, the benefits for which I, my spouse, and dependents (if any) will be eligible will be in accordance with the Group Agreement and/or Group Policy, as applicable to the type of plan for which we are enrolled. I further understand and agree that I, my spouse, and dependents (if any) will be bound by the terms and conditions of such agreements. I authorize the deduction from my wages, amounts necessary to pay the employee portion of the premiums for my, my spouse's, and covered dependents' (if any) Health Plan and/or KPIC, as applicable, coverage. I understand that to be eligible for coverage and remain eligible, I must satisfy the eligibility requirements set forth in my employer's agreement with Health Plan, and that the information provided in this application may be relied on and used to determine my, my spouse's, and my dependents' (if any) eligibility for such coverage.

I agree to provide any documentation, including tax returns, payroll records, etc. necessary to establish that I, my spouse, and my dependents (if any) initially met and continue to meet this or any other requirement for coverage.

Dependent Eligibility Guidelines

1. To be a family dependent a person must be:
 - a. The subscriber's spouse (eligibility for a spouse ends at the end of the month in which a divorce is final). If the spouse has a different last name than the subscriber, please attach to this application verification of marriage.
 - b. Any unmarried, dependent child of the subscriber or the subscriber's spouse, or an unmarried, dependent child who is claimed on the subscriber's federal tax return and is under the group's age limit for dependent status.
2. Dependent children meeting the guidelines above may remain under the subscriber's contract until the group's age limit for dependent status. Refer to *Evidence of Coverage*.
3. Dependent children incapable of self-sustaining employment due to mental retardation or physical handicap may remain under the subscriber's contract past the group's age limit for dependent status. Please complete a Coverage Request for Mentally Retarded or Physically Handicapped Children Form and attach it to this application. Dependent children must also meet requirement of 1b above.
4. If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact Customer Service at **(404) 261-2590** before signing this application.

Personal Information

In order to review your application, information may be collected from persons other than you and your covered family members. Information which is collected may be disclosed to others without authorization only as allowed by law. Each covered person has a right to review and correct all personal information which is collected about him. A more complete notice of our information practices is available upon request.

I authorize Kaiser Foundation Health Plan of Georgia, Inc. (Health Plan) and Kaiser Permanente Insurance Company (KPIC) to review existing protected health information (PHI) and history of care provided to me or my minor dependents for a period of 7 years preceding the date of this application for membership in the Health Plan. This authorization applies to information about any and all types of care that is reasonably related to determining my/our eligibility for membership in the Health Plan, including, but not limited to, diagnosis and treatment of mental health, alcohol/chemical dependency, HIV, AIDS, AIDS-related conditions, medication history, pharmacy data, and prescription history.

If accepted as a Health Plan member, I understand that Health Plan and KPIC may, without limitation and including all categories of care stated above, review and use my PHI following my/our actual enrollment and initial usage of services in order to confirm consistency with the information I submitted in this application or for such other purposes as permitted by federal and/or state laws or regulations. I understand that Health Plan and KPIC will not re-disclose any information received except with my written consent, or as permitted by federal and/or state laws or regulations. I understand that PHI disclosed to others may no longer be protected by Kaiser Permanente policy or the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This authorization is effective for a period of 30 months from the date this application is signed. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken based on this authorization. I understand that revocation of an authorization used to secure a policy of insurance, including health coverage from Kaiser Permanente, is not permitted during the period of time the insurer may contest the policy issued or a claim under the policy.

I further understand that to revoke this authorization I must send a written revocation notice to: Kaiser Foundation Health Plan of Georgia, Inc., Nine Piedmont Center; 3495 Piedmont Road NE; Atlanta, Georgia 30305.

NOTICES:

1. I understand and agree that any intentional material misstatement or incomplete statement of fact provided on this application or the failure to notify Kaiser Foundation Health Plan of Georgia, Inc. (Health Plan) and /or Kaiser Permanente Insurance Company (KPIC), as applicable, of any change in health status or impairment or disease that occurs between the date of application and the date coverage is approved will be deemed to be an intentional material misrepresentation and may result in the rescission of my coverage, as well as the coverage of my spouse and covered dependents (if any), without liability to Health Plan and/or KPIC, as applicable, The Southeast Permanente Medical Group, Inc. and their affiliates. (If you are unsure of your medical condition, please ask your physician to clarify your specific medical condition.) If your coverage is rescinded, you may be billed for services received.
2. You must immediately inform us if your health status or current medication(s) change before your membership is approved for coverage by the Health Plan. All updates should be signed, dated in ink, and sent to Kaiser Permanente; Nine Piedmont Center; 3495 Piedmont Road NE; Atlanta, GA 30305.
3. This Plan has a network of participating physicians and other providers. My choice of physician or provider determines the level of benefits I receive. Participating physicians and providers are subject to change. I can view a current list of Kaiser Permanente physicians at kp.org. Physicians and providers are paid in a number of ways, including salary, capitation, case rates, fee for service, and incentive payments. I can get more information about how participating physicians and providers are paid, request a Physician Directory, or obtain a list of current participating physicians and other providers by calling Customer Service at **(404) 261-2590**.
4. HMO plans and the Kaiser Permanente Select Provider benefit level of the Multi-Choice plans are provided by Kaiser Foundation Health Plan of Georgia, Inc. The PPO Provider and Non-participating Provider benefit levels of the Multi-Choice plans and Out-of-Area PPO plans are underwritten by Kaiser Permanente Insurance Company.

IMPORTANT: Please read the conditions above, and sign and date below. All applications **MUST** be signed in ink and dated by Primary Applicant. I have read and understand all of the above conditions and terms. I certify that the answers given are true and complete.

Signature of Employee _____

Date _____ E-mail Address (optional) _____

Kaiser Foundation Health Plan of Georgia, Inc. (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 the number provided below.

Georgia **1-888-865-5813**
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 with the Kaiser Civil Rights Coordinator:

Nine Piedmont Center
3495 Piedmont Road, NE
Atlanta, GA 30305-1736
1-888-865-5813

You can file a grievance by mail or phone. If you need help filing a grievance, the Kaiser 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 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
1-800-868-1019
1-800-537-7697 (TTD)

Complaint forms are available at: **<http://www.hhs.gov/ocr/office/file/index.html>**

English: You have the right to get help in your language at no cost. If you have questions about your application or coverage through Kaiser Permanente, or if this is a notice that requires you to take action by a specific date, call the number provided for your state or region to talk to an interpreter.

বাংলা (Bengali): বিনা খরচে আপনার নিজের ভাষায় সাহায্য পাওয়ার অধিকার আপনার আছে। আপনার যদি আপনার আবেদন বা Kaiser Permanente-এর মাধ্যমে পাওয়া কভারেজ নিয়ে কোনো প্রশ্ন থাকে বা এটি যদি কোনো নোটিস হয় যার ফলে আপনার একটি নির্ধারিত দিনের মধ্যে কোনো পদক্ষেপ গ্রহণ করার প্রয়োজন হয়, তাহলে দোভাষীর সাথে কথা বলতে আপনার রাজ্য বা অঞ্চলের জন্য প্রদত্ত নম্বরটিতে ফোন করুন।

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Cebuano (Bisaya): Anaa moy katungod nga mangayo og tabang sa inyo pinulongan ug kini walay bayad. Kung naa mo pangutana bahin sa inyo aplikasyon o coverage sa Kaiser Permanente, o kung kaning pahibalo nanginahanglan sa inyo paglihok sa dili pa usa ka piho nga petsa, palihug lang pagtawag sa mga numero sa telepono nga gihatag sa imong estado ("state") o rehiyon ("region") para makigstorya sa usa ka interpreter.

中文 (Chinese): 您有權免費以您的語言獲得幫助。如果您對您的Kaiser Permanente申請或承保有任何疑問，或者如果本通知要求您在具體日期之前採取措施，請致電您所在的州或地區的電話，與口譯員進行溝通。

Chuuk (Chukese): Mei wor omw pwuung omw kopwe angei aninis non foosun fonuomw (Chuukese), ese kamo. Ika mei wor omw kapas eis usun omw apilikeison me/ika policy fan nemenien Kaiser Permanente, are ika ei esinesin a erenuk pwe kopwe fori pwan ekoch foror, ka tongeni omw kopwe kori ewe nampa mei kawor faniten omw state ika fonu (asan) iwe eman chon chiakku epwe anisuk non kapasen fonuomw.

Français (French): Une assistance gratuite dans votre langue est à votre disposition. Si vous avez des questions à propos de votre demande d'inscription ou de la couverture par Kaiser Permanente, ou si cet avis vous demande de prendre des mesures à une date précise, appelez le numéro indiqué pour votre Etat ou votre région pour parler à un interprète.

Deutsch (German): Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Falls Sie Fragen bezüglich Ihres Antrags oder Ihres Krankenversicherungsschutzes durch Kaiser Permanente haben oder falls Sie aufgrund dieser Benachrichtigung bis zu bestimmten Stichtagen handeln müssen, rufen Sie die für Ihren Bundesstaat oder Ihre Region aufgeführte Nummer an, um mit einem Dolmetscher zu sprechen.

ગુજરાતી (Gujarati): તમને કોઈ પણ ખર્ચ વગર તમારી ભાષામાં મદદ મેળવવાનો અધિકાર છે. જો તમને Kaiser Permanente મારફતે તમારી અરજી અથવા કવરેજ વિશે પ્રશ્નો હોય, અથવા જો આ નોટિસ હોય જેમાં તમને કોઈ ચોક્કસ તારીખથી પગલાં લેવાની જરૂર હોય, તો દુભાષિયા સાથે વાત કરવા તમારા સ્ટેટ અથવા રીજીયન માટે પૂરા પાડવામાં આવેલ નંબર પર ફોન કરો.

Kreyòl Ayisyen (Haitian Creole): Ou gen dwa pou jwenn èd nan lang ou gratis. Si ou gen nenpòt kesyon sou aplikasyon ou an oswa asirans ou ak Kaiser Permanente, oswa si nan avni sa a gen bagay ou sipoze fè sa a avan yon sèten dat, rele nimewo nou mete pou Eta ouwa rejyon ou a pou w ka pale ak yon entèprèt.

‘ōlelo Hawai‘i (Hawaiian): He pono a ua loa‘a no kekahi kōkua me kāu ‘ōlelo inā makemake a he manuahi no ho‘i. Inā he mau nīnau kāu e pili ana i kāu palapala noi ‘inikua ola kino a i ‘ole i kōkua ma‘ō ka polokalamu kōkua ola kino Kaiser Permanente, a i ‘ole inā ke ha‘i nei paha kēia leka nei iā‘oe e hana koke aku i kēia ma mua o kekahi lā i waiho ‘ia, e kelepona aku i ka helu i loa‘a ma kēia leka nei no kāu moku‘āina a i ‘ole pana‘āina no ka wala‘au ‘ana me kekahi kanaka unuhi ‘ōlelo.

हिन्दी (Hindi): आपको बिना किसी कीमत चुकाए आपकी भाषा में सहायता पाने का अधिकार है। यदि आप आपके आवेदन पत्र के विषय में या Kaiser Permanente के कवरेज के विषय में कुछ पूछना चाहते हैं या यदि यह एक नोटिस है जिसके कारण आपको किसी विशेष तिथि तक कारवाई करनी पड़ेगी तो आपके राज्य या क्षेत्र के लिए दिए गए नंबर पर फोन करके किसी दुभाषिये से बात करें।

Hmoob (Hmong): Koj muaj cai kom tau txais kev pab uas hais koj hom lus yam tsis tau them nqi. Yog koj muaj lus nug txog koj daim ntawv thov los yog cov kev pab them nyiaj tim Kaiser Permanente, los yog tias daim ntawv no yog ib tsab ntawv ceebtoom uas yuav kom koj ua ib yam dabtsi raws li hnuv tau teev tseg, hu rau tus nab npawb xovtooj uas tau muab rau koj lub xeev lossis cheeb tsam kom tau tham nrog tus kws txhais lus.

Igbo (Igbo): ! nwere ikike inweta enyemaka n'asụsụ gi na akwụghị ụgwọ ọ bụla. Ọ bụrụ na i nwere ajụjụ gbasara akwụkwọ anamachọihe gi ma ọ bụ mkpuchi si na Kaiser Permanente, ma ọ bụ ọ bụrụ na nke bụ ọkwa a chọrọ ka i mee ihe tupu otu ụbọchị, kpọọ nomba enyere maka steeti ma ọ bụ mpaghara gi iji kwukọrịta okwu n'etiti onye ọkọwa okwu.

Iloko (Ilocano): Adda ti karbenganyo a dumawat iti tulong iti pagsasaoyo nga awan ti bayadanyo. No addaankayo kadagiti saludsod maipanggep ti aplikasionyo wenno coverage babaen ti Kaiser Permanente, wenno no daytoy ket maysa a pakdaar a kalikagumanna a rumbeng nga aramidenyo ti addang iti espesipiko a petsa, tawagan ti numero nga inpaay para ti estado wenno rehion tapno makipatang ti maysa mangipatarus iti pagsasao.

Italiano (Italian): Hai il diritto di ricevere assistenza nella tua lingua gratuitamente. In caso di domande riguardanti la tua richiesta o la copertura attraverso Kaiser Permanente, o se occorre intervenire entro una data specifica secondo quanto indicato in questa comunicazione, chiama il numero fornito per il tuo stato o la tua regione per parlare con un interprete.

日本語 (Japanese): あなたは、費用負担なしでご使用の言語で支援を受ける権利を保持しています。お申し込みまたはKaiser Permanenteの担保範囲に関してご質問があるか、または本通知により、あなたが特定の日付までに行動を起こすよう依頼されている場合、お住まいの州または地域に対して提供された電話番号に電話して、通訳とお話ください。

ខ្មែរ (Khmer): អ្នកមានសិទ្ធិទទួលបានជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ បើសិនអ្នកមានសំណួរណាមួយអំពីពាក្យស្នើសុំឬការធានារ៉ាប់រងតាមរយៈ Kaiser Permanente ឬប្រសិនបើជាលិខិតជូនដំណឹងដែលតម្រូវឲ្យអ្នកចាត់វិធានការត្រឹមកាលបរិច្ឆេទជាក់លាក់ សូមទូរស័ព្ទទៅលេខដែលបានផ្តល់ជូនសម្រាប់រដ្ឋឬតំបន់របស់អ្នកដើម្បីនិយាយទៅកាន់អ្នកបកប្រែ។

한국어 (Korean): 귀하에게는 한국어 통역서비스를 무료로 받으실 수 있는 권리가 있습니다. Kaiser Permanente를 통한 귀하의 보험 신청서나 보험 보장 범위에 관해 질문이 있을 경우 또는 이 통지서의 요구대로 어느 날짜까지 조치를 취해야만 하는 경우, 귀하의 주 및 지역의 제공된 전화번호로 연락해 통역사와 통화하십시오.

ລາວ (Laotian): ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໂດຍບໍ່ເສັຽຄ່າ. ຖ້າວ່າ ທ່ານມີຄໍາຖາມກ່ຽວກັບການສະໝັກຂອງທ່ານ ຫຼື ການຄຸ້ມຄອງຜ່ານ Kaiser Permanente, ຫຼື ຖ້າອັນນີ້ເປັນແຈ້ງການທີ່ຮຽກຮ້ອງໃຫ້ທ່ານດໍາເນີນການພາຍໃນວັນທີທີ່ເຈາະຈົງໃດໜຶ່ງ, ໃຫ້ໂທຕາມໝາຍເລກທີ່ໃຫ້ໄວ້ສໍາລັບລັດ ຫຼື ເຂດຂອງທ່ານ ເພື່ອຂໍລິມັດຖານພາສາ.

Kajin Majōl (Marshallese): Ewōr jimwe eo aṃ in bōk jipaŋ ilo kajin eo aṃ ejjelōk wōṇāān. Ñe ewōr aṃ kajitōk kōn peba in aplaiki eo aṃ ak insurance eo aṃ jān Kaiser Permanente, ak ñe enaan in kōjelā in ej aikuj bwe kwōn ṃakūtūt ṃokta jān juon raan eo eṃōj an kallikkar, kaḷok nōṃba eo ej lelōk ñan state eo aṃ ak jikūṃ bwe kwōn maroŋ kōnono ippān juon ri-ukōt.

Naabeehó (Navajo): T'áá ni nizaad bee níká i'doolwoł doo bik'é asíníłáágóó éí bee náhaz'á. Kaiser Permanente áká aná'álwo' ná bik'é azláadoo yíníkeedgo naaltsoos hadinílaa, éí bína'idíłkíd doogo, éí doodago díí naaltsoos haa'ída yoolkáalgo hait'áoda í'dííłíł nítłiigo éí nitsaa hahoodzojį éí doodago t'áá aadi nahós'a'di ata' dahalne'ígíí bich'į' hólne'go bee bíł ahíł hódíłníh.

नेपाली (Nepali): तपाईंसँग कुनै शुल्क नदिइ आफ्नो भाषामा सहायता पाउने अधिकार छ । तपाईंसँग आफ्नो आवेदन बारे वा Kaiser Permanente मार्फत कवरज बारेमा कुनै प्रश्नहरू भए, वा यो नोटिस अनुसार तपाईंले कुनै निर्धारित मितिमा कुनै कार्यवाही गर्नु पर्ने आवश्यकता भएमा, दोभाषेसंग कुराकानी गर्न तपाईंको राज्य वा क्षेत्रका लागि दिइएको नम्बरमा कल गर्नुहोस् ।

Afaan Oromoo (Oromo): Baasii malee afaan keetiin gargaarsa argachuudhaaf mirga qabda. Waa'ee iyyata keetii yookaan tajaajila Kaiser Permanente hammatu ilaalchisee gaaffii yoo qabaatte, yookaan yoo kun beeksisa guyyaa murtaa'e irratti tarkaanfii akka ati fudhattu gaafatu ta'e, lakkoofsa bilbilaa naannoo yookaan goodina keetiif kenname bilbiluudhaan turjumaana haasofsiisi.

فارسی (Persian): شما حق دارید که بدون هیچ هزینه ای به زبان خود کمک دریافت کنید. اگر درباره درخواست یا پوشش خود در Kaiser Permanente سوالی داشته یا بر اساس این اعلامیه باید تا تاریخ مشخصی اقدامی بعمل آورید، برای صحبت با یک مترجم شفاهی با شماره تلفن ارائه شده برای ایالت یا منطقه خود تماس بگیرید.

lokaiahn Pohnpei (Pohnpeian): Komw anehki pwung en rapahki sounkawehwe en omw palien lokaia ni sohte isaihs. Ma mie iren owmi kalelapak ohng aplikeisin de iren audepe kan ohng Kaiser Permanente, de ma pakair wet me anahne komwi en mwekid ohng rahn me kileledi, ah komw anahne koahl nempe me sansalehr ohng owmi palien wehi pwe komwi en lokaiaiang owmi tungoal soun kawehwe.

Português (Portuguese): Você tem o direito de obter ajuda em seu idioma sem nenhum custo. Se você tiver dúvidas sobre sua solicitação ou cobertura por meio da Kaiser Permanente, ou se este aviso exigir que você tome alguma medida até uma data específica, ligue para o número fornecido para seu estado ou região para falar com um intérprete.

ਪੰਜਾਬੀ (Punjabi): ਤੁਹਾਨੂੰ ਬਿਨਾਂ ਕਿਸੇ ਸੁਲਕ ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਮਦਦ ਪਾਉਣ ਦਾ ਹੱਕ ਹੈ। ਜੇਕਰ ਤੁਹਾਡੇ ਆਪਣੀ ਅਰਜ਼ੀ ਜਾਂ Kaiser Permanente ਰਾਹੀਂ ਕਵਰੇਜ ਬਾਰੇ ਸਵਾਲ ਹਨ, ਜਾਂ ਇਸ ਨੋਟਿਸ ਵਜੋਂ ਤੁਹਾਨੂੰ ਕਿਸੇ ਨਿਸ਼ਚਿਤ ਮਿਤੀ ਤੱਕ ਕਾਰਵਾਈ ਕਰਨ ਦੀ ਲੋੜ ਪਵੇ, ਤਾਂ ਦੁਬਾਰੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ ਆਪਣੇ ਰਾਜ ਜਾਂ ਇਲਾਕੇ ਲਈ ਮੁਹੱਈਆ ਕਰਵਾਏ ਗਏ ਨੰਬਰ ਤੇ ਫ਼ੋਨ ਕਰੋ।

Română (Romanian): Aveți dreptul de a solicita ajutor care să vă fie oferit în mod gratuit în limba dumneavoastră. Dacă aveți întrebări legate de solicitarea dumneavoastră sau de acoperirea oferită de Kaiser Permanente sau dacă acest aviz vă solicită să luați măsuri până la o anumită dată, sunați la numărul de telefon furnizat pentru statul sau regiunea dumneavoastră pentru a sta de vorbă cu un interpret.

Русский (Russian): У вас есть право получить бесплатную помощь на своем языке. Если у вас имеются вопросы относительно вашего заявления или медицинского страхования в Kaiser Permanente, либо если такое уведомление требует от вас каких-либо действий к определенной дате, позвоните по номеру телефона для своего штата или региона, чтобы поговорить с переводчиком.

Faa-Samoa (Samoan): E iai lou 'aia e maua se fesoasoani i lou gagana e aunoa ma le totogi. Afai e iai ni fesili e uiga i lou tusi apalai po o puipuiga e ala mai Kaiser Permanente, po o lenei tusi e manaomia ona e gaoioi i se taimi atofaina, vili le numera ua fuafuaina mo lou setete po o oganuu e fesoota'i i se faaliliu.

Español (Spanish): Usted tiene derecho a obtener ayuda en su idioma sin costo alguno. Si tiene preguntas acerca de su solicitud o cobertura a través de Kaiser Permanente, o si este es un aviso que requiere que usted tome alguna medida antes de una fecha determinada, llame al número de teléfono que se proporciona para su estado o región para hablar con un intérprete.

Tagalog (Tagalog): Mayroon kang karapatang humingi ng tulong sa iyong wika nang walang bayad. Kung mayroon kang mga katanungan tungkol sa iyong aplikasyon o coverage sa pamamagitan ng Kaiser Permanente, o kung ito ay abisong nangangailangan ng iyong aksyon sa tiyak na petsa, tumawag sa numerong ibinigay para sa iyong estado o rehiyon para makipag-usap sa isang interpreter.

ไทย (Thai): ท่านมีสิทธิที่จะได้รับความช่วยเหลือในภาษาของท่านโดยไม่เสียค่าใช้จ่าย หากท่านมีคำถามเกี่ยวกับการสมัครของท่าน หรือความคุ้มครองผ่าน Kaiser Permanente หรือหากนี่คือหนังสือที่ต้องการให้ท่านดำเนินการภายในวันที่ที่กำหนดไว้ โปรดติดต่อหมายเลขที่ให้ไว้สำหรับรัฐหรือเขตพื้นที่ของท่านเพื่อคุยกับล่าม

Lea Faka-Tonga (Tongan): 'Oku 'ia ho totonu ke ke ma'u ha fakatonulea ta'etotongi. Kapau 'oku 'i ai ha'o fehu'i ki ho tohi kole na'e fakafonu ki he malu'i 'inisiua 'a e Kaiser Permanente, pea kapau ko e tohina 'oku fiema'u keke fai ha me'a ki ai pe ko ha 'aho na'e tuku pau atu ke fai ia, taa ki he fika kuo 'oatu ki ho siteiti pe ko e vahefonua 'oku ke 'i ai ke talanoa mo ha tokotaha tene fakatonu lea atu kiate koe.

Українська (Ukrainian): У Вас є право на отримання допомоги безкоштовно на Вашій рідній мові. Якщо Ви маєте питання стосовно Вашого звернення чи страхового покриття в Kaiser Permanente, чи якщо відповідно до такого повідомлення Вам треба буде здійснити певну дію до конкретної дати, подзвоніть по номеру, що відповідає Вашій країні чи регіону, щоб поговорити з перекладачем.

اردو (Urdu): آپ کو کوئی بھی قیمت ادا کرنے بغیر اپنی زبان میں مدد حاصل کرنے کا حق ہے۔ اگر آپ کے ذہن میں اپنی درخواست یا Kaiser Permanente کے ذریعہ کوریج کے متعلق کوئی بھی سوالات ہیں، یا اگر اس نوٹس کی وجہ سے آپ کو کسی مخصوص تاریخ تک عمل انجام دینے کی ضرورت ہوگی تو، کسی مترجم سے بات چیت کرنے کے لئے آپ کی ریاست یا علاقہ کے لئے فراہم کئے گئے نمبر پر کال کریں۔

Tiếng Việt (Vietnamese): Quý vị có quyền được nhận trợ giúp miễn phí bằng ngôn ngữ của mình. Nếu quý vị có các câu hỏi về mẫu đơn hoặc mức bảo hiểm của mình thông qua Kaiser Permanente, hoặc đây là thông báo yêu cầu quý vị thực hiện vào một ngày cụ thể, hãy gọi đến số điện thoại được cung cấp cho bang hoặc khu vực của quý vị để trò chuyện với phiên dịch viên.

Yorùbá (Yoruba): O ní ètò láti rí ìrànṣẹ́ gba nípa èdè rẹ láìsán owó. Bí ó bá ní ibèèrè nípa iwé tí o kọ tàbí ìṣedéédé nípaṣẹ́ Kaiser Permanente, tàbí ifitonilétí yíì jẹ èyí o nílò láti ìgbésẹ́ kan ní ojò kan patọ́, pé nọmbà tí a pèsè fún ipínlẹ́ tàbí agbègbè rẹ láti bá òhgbifọ́ kan sọrọ́.