Application Instructions for Kaiser Permanente 2017/ Maryland

1. Please print all pages of the application including instructions
2. Complete all questions and sections of the applicaton. Please write legibly.
3. Complete the fax cover letter and application and fax or mail to Virginia Medical Plans for signature. If you do not have access to a fax machine, send the completed application to Virginia Medical Plans along with the required first month's payment.

HELPFUL TIPS:

Here is a checklist of a few things that are commonly overlooked and are mandatory in processing your application.

- Select your preferred billing method.
- Sign and date the application.
- Estimated first month's premium must accompany the application.

IMPORTANT:

If you have requested that your monthly premium be deducted automatically from your checking account, you must attach a voided check to the area provided and also complete, sign, and date the authorization form.
Don't forget to **enclose a check for the required payment made payable to Kaiser Permanente** if you are not paying by credit card for the first month.

Mail completed applications and check to:

Virginia Medical Plans
Attn: New Enrollment
1404 Northpoint Glen Ct.
Herndon, VA 20170

Virginia Medical Plans will review your application for completeness and accuracy before submiting it to Kaiser for processing. This may reduce the approval time because they cannot process unclear or incomplete applications until the missing information has been gathered.

Please contact us if you have any questions regarding the application or the application process. You may reach us at 703-707-8270 or toll free at 888-396-2341 or e-mail us at jkatz@vamedicalplans.com.

Norvax form #IN-1

VIRGINIA MEDICAL PLANS
FAMILY & BUSINESS HEALTH INSURANCE

KAISER PERMANENTE

FAX COVER LETTER

(Please ignore this form if you do not have access to a fax machine.)

**Please FAX this cover letter with the completed application to:
Virginia Medical Plans
FAX# 888-514-4258

Dear Virginia Medical Plans,
Please accept my completed application for submittal and contact me to confirm receipt of this application

Name

E-mail

Date

Time _____

☐ Please contact me at this phone number _____ after you have reviewed my application for completeness and accuracy.

☐ I will contact Virginia Medical Plans at 703-707-8270 or toll free at 888-396-2341 to verify receipt of my application.

I will send the original application as soon as I have been contacted by Virginia Medical Plans with confirmation that my application has been received by fax and reviewed for completeness.

Norvax form #CS-1

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 East Jefferson St., Rockville, MD 20852

Application for health coverage

Kaiser Permanente Individual and Family Plans (KPIF), Maryland

Who can use this application?

You may use this application to apply for individual or family coverage from Kaiser Permanente for Individual and Families (KPIF).

- If you want coverage for your family on the same KPIF plan, please fill out 1 application for the family. If a family member wants a different health plan, he or she must complete a separate application.
- To be eligible for KPIF coverage, you must live in our Maryland service area.
- If you qualify for and want to take advantage of federal financial assistance to help pay for copays, coinsurance, deductibles, or premiums, don't complete this application. You must apply for coverage through Maryland Health Connection at **marylandhealthconnection.gov**.
- If you're already a member, don't use this form. To change your plan, call **1-800-494-5314.**

Things to remember

- You can apply faster online at buykp.org/apply Call our office 888 396 2341
- Please answer all questions, and type or print using ink only. Leave an empty box in between words, and put a hyphen in the box for hyphenated names.
- If we receive your completed application with payment by the 15th of the month and approve it, coverage will be effective on the 1st of the next month. If we receive your completed application with payment after the 15th and approve it, coverage will be effective on the 1st of the month after the next month.
- If you're applying during a special enrollment period, be sure to follow all the instructions in our Enrolling During a Special Enrollment Period Guide and include any required documentation so your application will be complete. If you didn't receive this guide, you can find it at **buykp.org/apply**, or call **1-800-494-5314** to request a copy. Your application submission deadline and effective date may be different than the dates listed above if you apply during a special enrollment period.
- To avoid paying for 2 plans, if you are enrolled in another plan through Maryland Health Connection or through Kaiser Permanente, you should end that plan before the start date of your new plan. To avoid a gap in coverage, be sure that plan ends the day before your new plan starts.
- **If your application is incomplete, not signed, or doesn't include your first month's payment, or doesn't include required special enrollment period documentation, it may be canceled.**
- Send your complete, signed application and first month's premium payment by mail to:

  Employer Services Dept./KPIF 5W
  Kaiser Permanente for Individuals and Families
  2101 East Jefferson St.
  Rockville, MD 20852-9995

  Virginia Medical Plans
  1404 Northpoint Glen Court
  Herndon, VA 20170

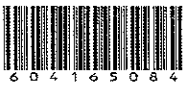
  Or send it by secure fax to: 1-855-414-2796 1-888-514-4258

  Note: Checks must be mailed and can't be faxed.

Need help?

- For help with completing this application, please call 1-800-494-5314. For TTY, call 711. 1-888-396-2341
- **We'll provide language assistance at no cost to you.**
- If you're working with an agent or a broker, please call him or her for assistance.

Primary applicant



STEP 1: Tell us when you're applying

Select 1 option: ☐ Open enrollment 11/01/16–01/31/17 ☐ A special enrollment period

If you are applying during a special enrollment period, please write the date of your triggering event: ☐☐/☐☐/☐☐☐☐

Please complete this section if you are applying during a special enrollment period outside of the open enrollment period of November 1, 2016, through January 31, 2017. For enrollment during a special enrollment period, applicants and their dependents may enroll or change health plans following a triggering event, as defined below.† This form and payment of your first month's premium must be received by Kaiser Permanente within 60 days of the triggering event, unless stated otherwise below.

If you selected "A special enrollment period," choose the triggering event:

☐ Loss of health care coverage*

- Loss of minimum essential coverage – NOTE: This does not apply when termination or loss or coverage is due to (a) failure to pay premiums on a timely basis, including COBRA coverage premiums prior to expiration of COBRA coverage, (b) situations allowing for a rescission as specified by law, which involve an act, practice, or omission that constitutes fraud, or an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage, or (c) voluntary termination of coverage.

Examples of possible valid reasons for loss of minimum essential coverage (this list is not exhaustive):

- Loss of individual coverage
- Loss of Medicare, certain Medicaid and Children's Health Insurance Program coverage
- Loss of coverage due to losing your job or a reduction in hours

The date of the loss of coverage is the last day you and/or your dependent would have coverage under the previous health plan or coverage;

- Loss of pregnancy-related coverage described under section 1902(a)(10)(A)(i)(IV) and(a)(10)(A)(ii)(IX) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(IV), (a)(10)(A)(ii)(IX)). The date of the loss of coverage is the last day you and/or your dependent would have pregnancy-related coverage;
- Loss of medically needy coverage as described under section 1902(a)(10)(C) of the Social Security Act. NOTE: This triggering event allows you and/or your dependent a special enrollment period only once per calendar year. The date of the loss of coverage is the last day that you and/or your dependent would have medically needy coverage; or
- Enrolled in any non-calendar year group health plan or individual health plan coverage and such non-calendar year plan or policy year is ending (even if you and/or your dependent have the option to renew such coverage). The date of the loss of coverage is the date of the expiration of the non-calendar year plan.

☐ Gaining or becoming a dependent through marriage

☐ Gaining or becoming a dependent through the birth of a child, adoption, or placement in adoption or foster care

☐ Losing a dependent through divorce or legal separation

☐ No longer considered a dependent due to divorce or legal separation

☐ Death of the subscriber or a dependent (you qualify for a special enrollment period only if you are enrolled under the same health plan contract or policy as the deceased)

☐ Child support order or other court order to cover a child or dependent

☐ Determination by Maryland Health Connection that your and/or your dependent's enrollment or nonenrollment in a qualified health plan is (a) unintentional, inadvertent, or erroneous; and (b) the result of the error, misrepresentation, misconduct, or inaction of an officer, employee or agent of Maryland Health Connection, HHS, or a non-Maryland Health Connection entity providing enrollment assistance or conducting enrollment activities

☐ Determination by Maryland Health Connection that the qualified health plan (QHP) in which you and/or your dependent are enrolled substantially violated a material provision of contract in relation to you and/or your dependent

☐ Determined newly eligible, or newly ineligible, for advance payments of federal premium tax credits, or other change in eligibility for federal cost-sharing reductions

☐ A permanent move that results in you and/or your dependent gaining access to new qualified health plans*

☐ Determined newly eligible for advance payments of the premium tax credit based in part on a finding that you and/or your dependent are enrolled in an employer-sponsored health benefit plan that is not qualifying coverage (you and/or your dependent must be allowed to terminate existing coverage)*

Please call **1-800-494-5314** to determine the start date of coverage for your enrollment.

*You and your dependent have 60 days before and after the loss of coverage to enroll in or change health plans.

†Adding or removing a domestic partner to coverage as allowed by state law does not constitute a special enrollment period, and no other changes to your current plan or coverage can be made on that basis.

If you will be getting federal financial assistance, don't use this form. We can help you apply through **marylandhealthconnection.gov**.

Primary applicant

STEP 2: Choose your health plan

Choose 1 health plan. If any family members are applying for different health plans, please submit a separate application for each plan.

Bronze	Silver	Gold	Platinum
☐ KP MD Bronze 6500/50 Dental/Ped Dental	☐ KP MD Silver 6000/30/Dental/ Ped Dental	☐ KP MD Gold 1000/20/ Dental/Ped Dental	☐ KP MD Platinum 0/20/ Dental/Ped Dental
☐ KP MD Bronze 6200/20%/HSA / Dental/Ped Dental	☐ KP MD Silver 2800/30/Dental/ Ped Dental	☐ KP MD Gold 0/20/ Dental/Ped Dental	
☐ KP MD Bronze 5000/50/Dental/ Ped Dental	☐ KP MD Silver 2750/20%/HSA/ Dental/Ped Dental		
	☐ KP MD Silver 1800/30/Dental/ Ped Dental		

Catastrophic plan

To purchase a Catastrophic plan, applicants must be younger than 30 on the effective date, or provide a certificate of exemption from Maryland Health Connection that shows hardship or lack of affordable coverage. We won't be able to process your application without the certificate of exemption if you are 30 and older. To see if you qualify, please go to **marketplace.cms.gov/applications-and-forms/hardship-exemption.pdf** and follow the instructions.

☐ KP MD Catastrophic 7150/0/Dental/Ped Dental

For information about health and dental benefits and limitations, cost-sharing amounts, and premiums, please review the details in your enrollment materials. To request a copy of the *Membership Agreement and Evidence of Coverage* for a particular plan, please go to **kp.org/plandocuments**, call **1-800-777-7902** or contact your agent or broker.

STEP 3: Choose your optional adult dental plan

Pediatric dental coverage is included in your health plan for all members 18 and younger. Preventive dental is also included for members 19 and older. We also offer an optional dental plan for adults 19 and older for an additional monthly charge.

☐ Yes. I'd like to enroll in the optional dental plan.

☐ No. I'm not interested in the optional dental coverage.

All plans are offered and underwritten by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

STEP 4: Enter your information

Primary applicant

In an individual plan, the primary applicant is the person who will be covered by the health plan. In a family plan, the primary applicant is the family member on the health plan who is authorized to make changes to the account. If this application is only for a child under 18, the child is the primary applicant.

Check 1 of the following to indicate the level of coverage you'd like: ☐ Adult(s) ☐ Adult(s) and child(ren) ☐ Child(ren)

First name

Social Security number (if you have one)

Last name

Phone

MI | Former medical record number (if any) | Home state (if any) | Gender: ☐ Male ☐ Female | Date of birth (mm/dd/yyyy)

Home address (no P.O. boxes, please)

City | State | ZIP code | County

Mailing address (if different than home address)

City | State | ZIP code

Preferred language spoken (if not English) | Preferred language read (if not English)

Email address (optional) *I understand that Kaiser Permanente may contact me via email.*

Spouse/domestic partner to be covered

A domestic partner is a person legally recognized as your domestic partner by Maryland.

First name | MI

Last name | Social Security number (if you have one)

Former medical record number (if any) | Home state (if any) | Gender: ☐ Male ☐ Female | Date of birth (mm/dd/yyyy)

Parent or legal guardian

(if the primary applicant is a child under 18)

First name | MI

Last name | Social Security number (if you have one)

Preferred language spoken (if not English) | Preferred language read (if not English)

Primary applicant

STEP 4: Enter your information *(continued)*

Dependents to be covered

If you have more than 4 dependents to be covered, attach another application and complete just the information for those applicants.

1 First name

MI

Last name

Social Security number (if you have one)

Former medical record number (if any) Home state (if any) Gender: ☐ Male ☐ Female

Date of birth (mm/dd/yyyy)

Relationship to primary applicant

2 First name

MI

Last name

Social Security number (if you have one)

Former medical record number (if any) Home state (if any) Gender: ☐ Male ☐ Female

Date of birth (mm/dd/yyyy)

Relationship to primary applicant

3 First name

MI

Last name

Social Security number (if you have one)

Former medical record number (if any) Home state (if any) Gender: ☐ Male ☐ Female

Date of birth (mm/dd/yyyy)

Relationship to primary applicant

4 First name

MI

Last name

Social Security number (if you have one)

Former medical record number (if any) Home state (if any) Gender: ☐ Male ☐ Female

Date of birth (mm/dd/yyyy)

Relationship to primary applicant

Primary applicant

STEP 5: Choose an authorized representative (if you have one)

You can give a trusted friend or relative permission to talk about this application with us, see your information, or act for you on matters related to this application. This person is called an authorized representative.

First name

MI

Last name

Phone

By signing, you've appointed this person as your legally authorized representative to get official information about this application, and to act for you on matters related to this application.

X

Primary applicant (parent or legal guardian for children under 18)

Date (mm/dd/yyyy)

STEP 6: Sign the application agreement

Important: All applicants and dependents 18 and older must read, sign, and date below. If the primary applicant is a child under 18, then his or her parent or legal guardian must sign. By signing, the parent or legal guardian agrees to be responsible for paying all premiums, copays, coinsurance, and deductibles for all the applicants listed on this application. A copy of your agreement with your signature is as valid as the original. If signatures are missing, we will cancel the application.

- I understand if I commit fraud or intentional misrepresentation of material fact, then Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Health Plan), may deny or rescind coverage for me and all my dependents back to the date of the fraud or intentional misrepresentation of material fact. I will be given 30 days advance notice by Health Plan before coverage is rescinded. In the event of rescission, I agree to be responsible for all medical costs incurred by Health Plan, and Health Plan may reduce those costs by any premiums paid. If medical costs exceed the amount of premium paid, I agree to be responsible to Health Plan for the difference.
- I know that my information on this form will only be used to determine ongoing eligibility for health coverage and will be kept private as required by law.
- **If you have questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a Member Services representative at 301-468-6000 or 1-800-777-7902 before signing this application.**
- **WARNING: ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.**

X

Primary applicant (parent or legal guardian for children under 18)

Date (mm/dd/yyyy)

X

Spouse/domestic partner

Date (mm/dd/yyyy)

X

Dependent (18 and older)

Date (mm/dd/yyyy)

X

Dependent (18 and older)

Date (mm/dd/yyyy)

X

Dependent (18 and older)

Date (mm/dd/yyyy)

Primary applicant

STEP 7: Enter first month's payment details

Payment information

First name of person responsible for payment

MI

Last name of person responsible for payment

Amount for your first month's premium

$, .

Address

City

State

ZIP code

Payment options

☐ **Credit card** ☐ **Debit card** ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder's first name as it appears on card

MI

Cardholder's last name as it appears on card

Card number

Expiration date (mm/yyyy)

/

X

Cardholder's signature

Date (mm/dd/yyyy)

/ /

☐ **Electronic payment** ☐ Checking account ☐ Savings account

I authorize Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., and the designated financial institution to accept this transfer from my checking or savings account when my application is processed by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

Bank name

Routing number

Account number

Account holder's first name

MI

Account holder's last name

X

Account holder's signature

Date (mm/dd/yyyy)

/ /

☐ **Check** ☐ **Money order**

Write the name of the primary applicant on the check. Mail payment with your application to the address listed on page 1.

Primary applicant

Automatic monthly payments

This **optional** service allows you to automatically pay your monthly premiums electronically. If you'd like to sign up, please fill out your information below. To cancel or update automatic payments, go to **kp.org/payonline** or call the Member Service Contact Center at **301-468-6000 or 1-800-777-7902.**

Billing information

Is this information the same as your first month's payment details? ☐ Yes ☐ No **If no, please fill out this section.**

First name of person responsible for payment

MI

Last name of person responsible for payment

Billing address

City

State

ZIP code

Payment options

Debit cards can't be used for automatic monthly payments.

☐ **Credit card** ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder's first name as it appears on card

MI

Cardholder's last name as it appears on card

Card number

Expiration date (mm/yyyy)

X

Cardholder's signature

Date (mm/dd/yyyy)

☐ **Electronic payment** ☐ Checking account ☐ Savings account

I authorize Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., and the designated financial institution to accept this transfer from my checking or savings account.

Bank name

Routing number

Account number

Account holder's first name

MI

Account holder's last name

X

Account holder's signature

Date (mm/dd/yyyy)

Primary applicant

For applicants using an Agent/Broker/KPIF representative

If you used an agent/broker/KPIF representative, please make sure he or she completes this page. A Kaiser Permanente representative includes any agent/broker/KPIF representative who has helped you decide which plan to enroll in or helped you fill out the application.

Agent/Broker/KPIF representative first name: Jonathan

MI: E

Last name: Katz

The broker of record may receive monetary and/or nonmonetary payments from KPIF in connection with the purchase of this coverage.
Note: Premiums are the same whether or not you use an agent/broker/KPIF representative.

I (the applicant) authorize the insurance agent/broker/KPIF representative listed below to share enrollment and disenrollment information specific to this application with Kaiser Permanente.

X _____ Date (mm/dd/yyyy) __/__/____

Primary applicant (parent or legal guardian for children under 18)

To be completed by your Kaiser Permanente-appointed agent/broker/KPIF representative after completion of this application:

You must answer the following question by selecting Yes or No:

I assisted the applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information, and the applicant understood the explanation.

■ Yes ☐ No

X _____ Date (mm/dd/yyyy) __/__/____

Agent/Broker/KPIF representative

Agent/Broker (first, middle, last) (please print): Jonathan E. Katz

Address: 1404 Northpoint Glen Court

City: Herndon State: VA ZIP code: 20170 National producer number (NPN): 15856166

Phone: 703-707-8270 Fax: 888-514-4258

Broker firm name: Katz Insur General agency name: EBCA

Broker firm federal tax ID number: 47-2708150 General agency's federal tax ID number: 54-2015926

Email address: jkatz@vamedicalplans.com

KPIF representative (first, middle, last) (please print): Jose

KPIF representative's license number: Galliani

Kaiser Foundation Health Plan of the Mid-Atlantic States, 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.

District of Columbia	1-800-777-7902
Maryland	1-800-777-7902
Virginia	1-800-777-7902
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, 2101 East Jefferson Street, Rockville, MD 20852, telephone number: 1-800-777-7902. 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, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Help in your Language

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.

አማርኛ (Amharic): ያለምንም ከፍያ በራስዎ ቋንቋ እገዛ የማግኘት መብት አለዎት። ስለ ማመልከቻዎ ወይም ከኬሰር ፐርማነንቴ Kaiser Permanente ስለሚያገኙት ሽፋን ማንኛውም ጥያቄዎች ካሉዎት፣ ወይም ይህ ማሳወቂያ በግልፅ በተጠቀሰ ቀን ማድረግ ያለብዎ ነገር እንዳለ የሚያስገድድዎ ከሆነ፣ በተጠቀሰው የስልክ ቁጥር ለአስተርጓሚ ጋር ይነጋገሩ።

العربية (Arabic): لك الحق في الحصول على المساعدة بلغتك دون تحمل أي تكاليف. إذا كانت لديك استفسارات بشأن طلبك أو تغطيتك التي تقدمها Kaiser Permanente، أو إذا كان هذا الإشعار الذي يتطلب منك اتخاذ إجراء خلال تاريخ محدد، يُرجى الاتصال بالرقم المخصص لولايتك أو منطقتك للتحدث إلى مترجم فوري.

Հայերեն (Armenian): Դուք ունեք Ձեր լեզվով անվճար օգնություն ստանալու իրավունք: Եթե Դուք հարցեր ունեք Ձեր դիմումի կամ Kaiser Permanente-ի միջոցով Ձեր ծածկույթի վերաբերյալ, կամ եթե սա ծանուցում է, որը պարտադրում է Ձեզ, որպեսզի գործողություններ ձեռնարկեք մինչև որոշակի ամսաթիվ, ապա զանգահարե՛ք Ձեր նահանգի կամ շրջանի համար տրամադրված հեռախոսահամարով՝ թարգմանչի հետ խոսելու համար:

Bàsɔ̀ɔ̀ Wùdù (Bassa): Ɔ mɔ̀ nì kpé ɓɛ́ m̀ ké gbo-kpá-kpá dyé ɖé nì mìɔùn nììn bídí-wùdù mú pídyi. Ɔ jŭ ké m̀ dyi dyi-diè-ɖè ɓě ɓéɖé bá nì céè-ɖè m̀ tò ɓó ɖɛ zɔ̀ jè dyíɛ ní, mɔɔ jŭ bá nì kũùn kpɔ̄ jè dyí dyììn ɖé Kaiser Permanente múɛ ní, mɔɔ ɔ dyi bɔ̃̌ ɖò jŭ ɓé m̀ ké ɖɛ ɖò nyu bó wé jɛ́ɛ́ ɖò kɔ̄ nì, nìí, ɖá nɔ̀bà ɓé wa tòà bó nì bóɖóɔ̀ mɔɔ nì gbɛ̌ɛ̀ɔ̀ bìlɛ, ké nì mu nyɔ-wuɖuún-zà-nyɔ̀ ɖò gbo wùɖùùn.

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।

California	1-800-464-4000
Colorado	1-800-632-9700
District of Columbia	1-800-777-7902
Georgia	1-888-865-5813
Hawaii	1-800-966-5955
Maryland	1-800-777-7902
Oregon	1-800-813-2000
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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 fofor, 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 કોઇ 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 જેમા તમને કોઈચોક્કસ 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 avi sa a gen bagay ou sipoze fè sa a avan yon sèten dat, rele nimewo nou mete pou Eta oswa rejyon ou a pou w ka pale ak yon entèprèt.

ʻōlelo Hawaiʻi (Hawaiian): He pono a ua loaʻa no kekahi kōkua me kāu ʻōlelo inā makemake a he manuahi no hoʻi. Inā he mau nīnau kāu e pili ana i kāu palapala noi ʻinikua ola kino a i ʻole i kōkua maʻō ka polokalamu kōkua ola kino Kaiser Permanente, a i ʻole inā ke haʻi nei paha kēia leka nei iāʻoe e hana koke aku i kēia ma mua o kekahi lā i waiho ʻia, e kelepona aku i ka helu i loaʻa ma kēia leka nei no kāu mokuʻāina a i ʻole panaʻāina no ka walaʻau ʻana me kekahi kanaka unuhi ʻōlelo.

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 hnub 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): Ị nwere ikike ịnweta enyemaka n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ọ bụrụ na ị nwere ajụjụ gbasara akwụkwọ anamachọihe gị ma ọ bụ mkpuchi si na Kaiser Permanente, ma ọ bụ ọ bụrụ na nke bụ ọkwa a chọrọ ka ị mee ihe tupu otu ụbọchị, kpọọ nọmba enyere maka steeti ma ọ bụ mpaghara gị 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 ឬប្រសិនេះគឺជាលិខិតជូនដំណឹងដែលតម្រូវឲ្យអ្នកចាត់វិធានការត្រឹមកាលបរិច្ឆេទជាក់លាក់ 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 조취를 취해야만 하는 경우, 귀하의 주 및 지역의 제공된 전화번호로 연락해 통역사와 통화하십시오.

ລາວ (Laotian): ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໂດຍບໍ່ເສັງຄ່າ. ຖ້າວ່າ ທ່ານມີຄຳຖາມກ່ຽວກັບການສະໝັກຂອງທ່ານ ຫຼື ການຄຸ້ມຄອງຜ່ານ Kaiser Permanente, ຫຼື ຖ້າອັນນີ້ເປັນແຈ້ງການທີ່ຮຽກຮ້ອງໃຫ້ທ່ານດຳເນີນການພາຍໃນວັນທີ່ທີ່ເຈາะจิงใดหนึ่ง, ให้โทรตามหมายเลขที่ให้ไว้สำหลับลัด ຫຼື ເຂດຂອງທ່ານ ເພື່ອຂໍລົມກັບນາຍພາສາ.

Kajin Majōļ (Marshallese): Ewōr jimwe eo aṃ in bōk jipañ ilo kajin eo aṃ ejjeļok wōṇāān. Ñe ewōr aṃ kajjitōk kōn peba in aplaiki eo aṃ ak insurance eo aṃ jān Kaiser Permanente, ak ñe enaan in kōjeļā in ej aikuj bwe kwōn makūtkūt ṃokta jān juon raan eo emōj an kallikkar, kaļok nōṃba eo ej leļok ñan state eo aṃ ak jikūṃ bwe kwōn maroñ 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 yínízeedgo naaltsoos hadinilaa, éí bína'ídíłkid doogo, éí doodago díí naaltsoos haa'ída yoołkáałgo hait'áoda í'díílíił nihníigo éí nitsaa hahoodzojí éí doodago t'áá aadi nahós'a'di ata' dahalne'ígíí bich'į' hólne'go bee bił ahił hodíílnih.

नेपाली (Nepali): तपाईसग कुनै शुल्क नदिइ आफ्नो भाषामा सहायता पाउने अधिकार छ । तपाईसंग आफ्नो आवेदन बारे वा Kaiser Permanente मार्फत कवरेज बारेमा कुनै प्रश्नहरू भए, वा यो नोटिस अनुसार तपाईले कुनै निर्धारित मितिमा कुनै कार्यवाही गर्नु पर्ने आवश्यकता भएमा, दोभाषेसंग कुराकानी गर्न तपाईको 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 سؤالی 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.

Iokaiahn 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 lokaiaieng 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 ਸ਼ੁਲਕ 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 ਦੁਭਾਸ਼ੀਏ 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 pamamagitang 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 tohini '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.

اُردو (Urdu): آپ کوکوئی بھی قیمت ادا کئے 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 ètọ́ láti rí ìrànlọ́wọ́ gbà nípa èdè rẹ láìsan owó. Bí o bá ní ìbéèrè nípa ìwé tí o kọ tàbí ìṣedéédé nípaṣẹ Kaiser Permanente, tàbí ìfitónilétí yìí jẹ́ èyí o nílò láti ìgbésẹ̀ kan ní ọjọ́ kan pató, pé nọ́mbà tí a pèsè fún ìpínlẹ̀ tàbí agbègbè rẹ láti bá òṅgbifọ̀ kan sọ̀rọ̀.