BlueCross BlueShield Nebraska

Individual Enrollment Department
PO Box 3248
Omaha, NE 68180-0001

Medicare Supplement Application

Section I. Subscriber Information

Last Name	First Name	MI	Social Security Number	Date of Birth (MM/DD/YYYY)	☐ M ☐ F

Physical Address (Street, PO Box)	City	State	ZIP

If you wish to receive mailed correspondence at a different address than listed above, please indicate your mailing address below.

Mailing Address (Street, PO Box)	City	State	ZIP

Cell Phone #	Home Phone	Email

Have you used tobacco in any form during the past 12 months? (The use of tobacco products means any use of cigarettes, pipes, cigars, or any other tobacco products regardless of the number of times or frequency of use).

☐ Yes ☐ No

Household Premium Discount

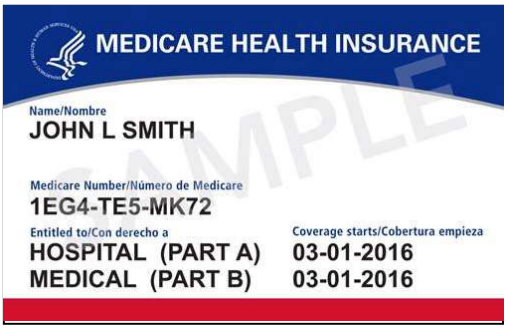
You may be eligible for a lower premium rate based on your answer to the following question:
Do you currently have a person residing in your home, who is:

a) Your legal spouse; or
b) A person 18 years of age or older with whom you have continuously resided for the last 12 months.

☐ Yes ☐ No

Section II. Medicare Information

Please reference your red, white and blue Medicare card to complete this section.



Your Medicare number: _____

Hospital (Part A) Coverage Start Date: _____

Medical (Part B) Coverage Start Date: _____

Section III. Plan Selection

Please select the Blue Cross and Blue Shield of Nebraska (BCBSNE) Medicare Supplement policy you are applying for:

☐ Plan B ☐ Plan G ☐ Plan L ☐ Plan N

☐ Plan A* ☐ Plan C** ☐ Plan F**

*Plan A is available to individuals who are Medicare eligible due to disability and under the age of 65 excluding end stage renal disease

**Plan C and F are only available to individuals who were Medicare eligible prior to Jan. 1, 2020

Section IV. Option Dental Plan Selection

This plan is separate from the Medicare Supplement plan, and is not required for issuance of a Medicare Supplement.
The DentalEssentials plan is an Individual policy offered by BCBSNE. If a dental plan is elected at the same time (initial enrollment) as an approved, issued Medicare Supplement, the six-month waiting period for Coverage B is waived.

The DentalEssentials policy includes the following:
(a) 6-month waiting period before Coverage B benefits are payable
(b) 12-month waiting period before Coverage C benefits are payable

Please select the BCBSNE dental policy you are applying for.

Preventive Plus	Enhanced	Premier
☐ $50 Deductible	☐ $100 Deductible	☐ $100 Deductible
$1,000 Annual Benefit Maximum	$1,500 Annual Benefit Maximum	$2,000 Annual Benefit Maximum

Section V. Medicare Questions

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guarantee issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. **Please include a copy of the notice from your prior insurer with your application. Please answer all questions. Check Yes or No below.**

TO THE BEST OF YOUR KNOWLEDGE:

☐ Yes ☐ No	**1.** (a)	Did you turn age 65 in the last 6 months? Will you turn age 65 in the next 90 days?
☐ Yes ☐ No	(b)	Did you enroll in Medicare Part B in the last 6 months?
	(c)	If yes, what is the effective date? _____ / _____ / _____
☐ Yes ☐ No	**2.** (a)	Are you covered for medical assistance through the state Medicaid program? Note to applicant: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer No to this question.
☐ Yes ☐ No	(b)	If yes, will Medicaid pay your premiums for this Medicare Supplement policy?
☐ Yes ☐ No	(c)	If yes, do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium?
	3. (a)	If you had coverage from any Medicare plan other than Original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO plan), fill in your start and end dates below. If you are still covered under this plan, leave "End" blank. Start _____ / _____ / _____ End _____ / _____ / _____
☐ Yes ☐ No	(b)	If you are still covered under the Medicare plan, do you intend to replace your current coverage with this Medicare Supplement policy?
☐ Yes ☐ No	(c)	Was this your first time in this type of Medicare plan?
☐ Yes ☐ No	(d)	Did you drop a Medicare Supplement policy to enroll in the Medicare plan?
☐ Yes ☐ No	**4.** (a)	Do you have another Medicare Supplement policy in force?
	(b)	If so, with what company, and what plan do you have? _____
	(c)	I understand if approved, my new policy will replace the current policy in effect. If my application is not approved, my existing coverage will remain in effect with no change.
☐ Yes ☐ No	**5.** (a)	Have you had coverage under any other health insurance within the past 63 days? (for example, an employer, union or individual plan)?
	(b)	If so, with what company and what kind of policy? _____
	(c)	What are your dates of coverage under the other policy? If you are still covered under the other policy, leave "End" blank. Start _____ / _____ / _____ End _____ / _____ / _____
☐ Yes ☐ No	(d)	Is this loss of coverage due to retirement (applicant or applicant's spouse) or involuntary loss of coverage?

Section VI. Health Information Questions

If you qualify for this coverage during Open Enrollment or a Guarantee Issue period, you are not required to answer questions in Section 6. If your answer is yes to any of the questions in section 6.1, you are not eligible for coverage.

Height: _____ feet _____ inches Weight: _____ pounds

PLEASE ANSWER ALL OF THE FOLLOWING HEALTH QUESTIONS BELOW:

Section 6.1

☐ Yes	☐ No	**1.** Are you currently confined to a wheelchair or another motorized device?
☐ Yes	☐ No	**2.** Are you currently hospitalized, confined to a bed or in a nursing home?
☐ Yes	☐ No	**3.** Have you ever been diagnosed as having or received treatment by a medical professional for Acquired Immune Deficiency Syndrome (AIDS) and/or positive HIV and/or AIDS Related Complex (ARC)?
☐ Yes	☐ No	**4.** Have you ever had an organ or stem cell transplant or been advised to have an organ or stem cell transplant (excluding cornea implants)?
		5. Within the past two(2) years, have you had, been treated for, taken medication for or been advised by a medical professional that you have any of the following :
☐ Yes	☐ No	(a) Internal cancer, leukemia or melanoma (even if the condition is in remission)
☐ Yes	☐ No	(b) Coronary artery disease, heart attack, cardiac angioplasty, stent placement or bypass surgery
☐ Yes	☐ No	(c) Congestive heart failure, cardiomyopathy (heart muscle disease), cardiomegaly (enlarged heart), atrial fibrillation or other heart rhythm disorder, peripheral vascular disease, carotid artery disease, unoperated valvular heart disease, unoperated aneurysm or implanted pacemaker/ICD (implanted cardiac defibrillator)
☐ Yes	☐ No	(d) Stroke or transient ischemic attack (TIA)
☐ Yes	☐ No	(e) Chronic Kidney Disease (Stages 3, 4, or 5), kidney failure or kidney disease requiring dialysis
☐ Yes	☐ No	(f) Diabetes a. Taking more than 50 units of insulin daily b. Taking three or more medications (oral or injections) to control blood sugar c. With complications including retinopathy, neuropathy, kidney disease, skin ulcers, high blood pressure, poor circulation, peripheral artery disease or peripheral thrombotic disease
☐ Yes	☐ No	(g) Cirrhosis, chronic hepatitis or liver disease
☐ Yes	☐ No	(h) Degenerative disc disease, amputations caused by disease, osteoporosis with related fractures, spinal stenosis, rheumatoid arthritis, psoriatic arthritis, or arthritis that restricts mobility or activities of daily living
☐ Yes	☐ No	(i) Emphysema, Chronic Obstructive Pulmonary Disease (COPD) or any Chronic Pulmonary Disorder or Cardiac Disorder requiring oxygen
☐ Yes	☐ No	(j) Systemic Lupus, Scleroderma, or Myasthenia Gravis
☐ Yes	☐ No	(k) Alcoholism or Drug Abuse
☐ Yes	☐ No	(l) Alzheimer's Disease, Dementia, or other cognitive disorder
☐ Yes	☐ No	(m)Parkinson's disease, Multiple Sclerosis, Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease), Huntington's disease, or Cerebral Palsy
☐ Yes	☐ No	**6.** Have you had a seizure in the last 12 months?
☐ Yes	☐ No	**7.** Have you been hospitalized inpatient three or more times within the past two (2) years?

Section VI. Health Information Questions (continued)

If your answer is yes to any of the questions in Section 6.2, you may not be eligible for coverage and are subject to an underwriting review. If you would like consideration to be given to an application that contains a "yes" answer to any questions in this section, please attach/upload an explanation stating how long the condition has existed, how it is/was being controlled and the recommended treatment.

Section 6.2

☐ Yes	☐ No	**1.** Have you been advised by a medical professional to have surgery, medical tests, treatment, or therapy that has not been performed or do you have any pending test results?
☐ Yes	☐ No	**2.** Have you been hospitalized for complications arising from SARS-CoV-2 (Coronavirus) or the COVID-19 disease? (a) Dates of hospitalization: a. Admission Date ______________________ b. Discharge Date ______________________
☐ Yes	☐ No	(b) Were you placed on a ventilator?

Section VII. Medication Information

Are you currently taking, or have you taken any prescription or over-the-counter medications within the past 12 months?
If yes, please list the medication(s) and condition(s) being treated below. Attach a separate sheet if necessary.

Medication Name (copy from pharmacy label): ______________________

Date originally prescribed: ______________________

Dosage and frequency: ______________________

Diagnosis/condition being treated: ______________________

Medication Name (copy from pharmacy label): ______________________

Date originally prescribed: ______________________

Dosage and frequency: ______________________

Diagnosis/condition being treated: ______________________

Medication Name (copy from pharmacy label): ______________________

Date originally prescribed: ______________________

Dosage and frequency: ______________________

Diagnosis/condition being treated: ______________________

Medication Name (copy from pharmacy label): ______________________

Date originally prescribed: ______________________

Dosage and frequency: ______________________

Diagnosis/condition being treated: ______________________

Medication Name (copy from pharmacy label): ______________________

Date originally prescribed: ______________________

Dosage and frequency: ______________________

Diagnosis/condition being treated: ______________________

Section VIII. Payment Options

☐ Monthly paper bill

☐ Monthly automatic bank withdrawal (Even if you have existing coverage, please complete the section below and **attach a voided check** to avoid processing delays.)

I authorize Blue Cross and Blue Shield of Nebraska to make automatic withdrawals from the account shown below (or on the attached voided check), and the Financial Institution named below to charge the stated account for payment of my premium. The initial authorization will be charged on or after the 20th of each month. Such amount may be changed from time to time by Blue Cross and Blue Shield of Nebraska, giving me written notice before charging the account. This authorization is to remain in effect until Blue Cross and Blue Shield of Nebraska has received written notification from me of a termination date.

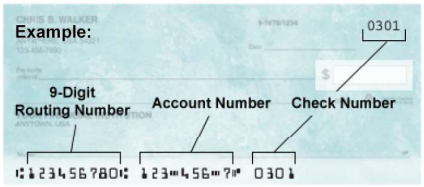
Name of Bank: _____ Town/City: _____

Account Number: _____ Type of Account: ☐ Checking ☐ Savings

Routing/ABA Number: ☐☐☐☐☐☐☐☐☐

Name of Payor as shown on bank account: _____

Please note: Payor must also sign below in the signature section of the application if different from applicant.



For additional payment options, register for an online member account at myNebraskaBlue.com after receiving your member ID card. Registering allows you to set up recurring payments, make one-time payments and see billing statements and history.

BCBSNE prohibits and will not accept premium and cost-sharing payments for BCBSNE members from third party payers with the exception of members' family members, legal personal representatives or conservators, court-appointed representatives or any other parties unless required by law.

Section IX. Applicant Statements

I acknowledge receipt of the following documents at the time I completed this application:

☐ Outline of Coverage ☐ Pamphlet "Guide to Health Insurance for People with Medicare"

By providing your telephone numbers you agree that we, along with our affiliates and/or vendors, may call or text any phone numbers you give us, including a wireless number, using an automatic telephone dialing system and/ or a prerecorded message. Without limit these calls may be about treatment options, other health-related benefits and services, enrollment, payment, or billing.

Coverage will be effective the first of the month following approval. If you wish to request a different effective date, you may do so here: _____.

If an effective date is requested and approved, I understand I cannot request a change of that date, and that premiums are owed from that date forward.

I hereby authorize Blue Cross and Blue Shield of Nebraska to obtain and/or release medical or other information to the extent necessary to process my claims or for underwriting or administrative purposes. I authorize any party, including the Medicare program and its contractors, to release eligibility, claims, payment, or medical information to Blue Cross and Blue Shield of Nebraska for the same purposes. This authorization is ongoing. I understand that any false statements on this application may cause the coverage to be void.

_____ _____

Signature of Applicant Date

_____ _____

Signature of payor as shown on bank account if payor is someone other than applicant Date

AGENT SECTION ONLY

Agent shall list any other health insurance policies they have sold to the applicant:

List policies sold that are still in force. _____

List policies sold in the past five (5) years which are no longer in force. _____

☐ Replacement form (section 9) completed Date: _____ Agent Number: _____

Signature of Agent: _____

Section X. Information to Consider

1. You do not need more than one Medicare Supplement policy.

2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

4. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

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

6. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

7. Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

8. If you are enrolled under a Medicare Advantage plan, you are not eligible for a Medicare Supplement policy in addition to that plan.

9. Blue Cross and Blue Shield of Nebraska reserves the right to accept or decline this application for Medicare Supplement in whole or in part except when application is made during the initial six month open enrollment period beginning with the first month in which you are first enrolled under Medicare Part B and you are 65 years of age or older. No right is created by this application including any advance premium payment and the application shall not be considered accepted unless the contract is actually issued to you. Should you discontinue Medicare Part B Medical Insurance Benefits, it shall be your responsibility to notify Blue Cross and Blue Shield of Nebraska of the change.

Section X. Notice to applicant regarding replacement of Medicare Supplement insurance or Medicare Advantage

Save this Notice! It may be important to you in the future.**

According to your application, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by Blue Cross and Blue Shield of Nebraska. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy. ** This notice will be returned to you after processing your application.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement to Applicant by Issuer, Agent:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) (check one):

☐ Additional benefits.

☐ No change in benefits, but lower premiums.

☐ Fewer benefits and lower premiums.

☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D.

☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

_____

_____

☐ Other. (please specify)

_____

_____

If you still wish to terminate your current policy and replace it with new coverage, be certain to answer all questions truthfully and completely on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your current policy until you have received your new policy and are sure that you want to keep it.

_____ _____

Signature of Agent, Broker or Other Representative Agent Number

_____

Typed Name and Address of Agent, Broker or Other Representative

_____ _____

Applicant's Signature Date

Non-discrimination and Translation Notice

Discrimination is Against the Law

Blue Cross and Blue Shield of Nebraska (BCBSNE) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BCBSNE does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.
BCBSNE:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service at 800-991-5840, TTY 711 between 7:30 a.m. to 6 p.m., Central time, Monday through Friday.

If you believe that Blue Cross and Blue Shield of Nebraska 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:

Manager, Corporate Compliance
Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, NE 68180-001
800-991-5840, TTY: 711
CivilRights@NebraskaBlue.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Manager of Corporate Compliance 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 ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf.
For quick processing, use the OCR online portal to file a complaint.

ATTENTION: This notice may have important information about your application or coverage. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or get help with costs. If you or someone you're helping has questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-991-5840. This notice is translated as federally required.

Arabic

تنبيه: قد يتضمن هذا الإشعار معلومات مهمة عن تطبيقك أو تأمينك. ابحث عن التواريخ الرئيسية في هذا الإشعار. قد يلزمك اتخاذ إجراء قبل المواعيد النهائية المحددة للحفاظ على التأمين الصحي أو للحصول على مساعدة بشأن التكاليف. إذا كنت أنت أو أحد من تساعدهم لديكم أسئلة، فلك الحق في الحصول على مساعدة ومعلومات بلغتك وبدون تكلفة. للتحدث مع أحد المترجمين الفوريين، اتصل برقم 1-800-991-5840

Chinese Traditional

注意：本通知可能含有與您的申請或保險有關的重要資訊。在本通知中尋找重要的日期。您可能需要在某個截止日期前採取行動，以保持您的健康保險或獲得費用方面的幫助。如果您或者您正幫助的人有疑問，您有權利以您的語言免費獲得提供的幫助與資訊。致電口譯員，請撥打1-800-991-5840。

German

Achtung: Diese Mitteilung kann wichtige Informationen über Ihren Antrag oder die Versicherungsdeckung beinhalten. Beachten Sie wichtige Fristen in dieser Mitteilung. Sie müssen unter Umständen Maßnahmen innerhalb bestimmter Fristen ergreifen, um Ihren Krankenversicherungsschutz zu erhalten oder eine Kostenerstattung zu erhalten. Wenn Sie oder jemand, dem Sie helfen, Fragen hat, können Sie kostenlos Hilfe und Informationen in Ihrer Sprache erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte 1-800-991-5840 an.

Spanish (Mexico)
ATENCIÓN: Este aviso puede contener información importante sobre su solicitud o cobertura. Ponga atención a las fechas clave en este aviso. Puede ser que usted necesite realizar algunas acciones para determinadas fechas y así mantener su cobertura de salud o para obtener ayuda con los costos. Si usted o alguien a quien usted ayuda tiene alguna pregunta, tiene el derecho de recibir información y ayuda en su propio idioma sin costo. Para hablar con un intérprete, llame al 1-800-991-5840.

Farsi
توجه این اعلامیه ممکن است اطلاعات مهمی درباره درخواست یا طرح پوشش بیمه‌تان داشته باشد. تاریخ های اصلی را در این اعلامیه جستجو کنید. ممکن است لازم باشد تا موعد مقرری اقدام کنید تا پوشش بیمه درمانیتان حفظ شود یا هزینه های درمانی را دریافت کنید. اگر شما یا فردی دیگر که به او کمک می کنید، سؤالی دارید، از این حق برخوردار هستید تا راهنمایی و اطلاعات را به صورت رایگان به زبان خودتان دریافت کنید. برای صحبت کردن با یک مترجم، با شماره 1-800-991-5840 تماس بگیرید.

French (Europe)
ATTENTION : Cet avis peut contenir des informations importantes concernant votre demande ou votre garantie. Prêtez attention aux dates clés indiquées. Il vous faudra peut-être prendre des mesures avant une certaine date pour pouvoir conserver votre assurance santé ou bénéficier d'aides au paiement. Si vous ou une personne que vous aidez avez des questions, vous pouvez obtenir gratuitement de l'assistance et des informations dans votre langue. Pour parler à un interprète, appelez le 1-800-991-5840.

Japanese
ご注意：本通知書には、患者さんの申請や保険について重大な情報が含まれている可能性があります。本通知書の日付をご覧ください。医療保険を利用したり、費用についてサポートを受けるには、本通知書に従って特定の期限までに手続きしてください。患者さん、または付き添いの方が質問がある場合は、母国語で無料で支援を受けたり、情報を受け取る権利があります。通訳と話したい場合は、1-800-991-5840. まで電話をおかけください。

Karen
ဟ်သူဉ်ဟ်သး–တၢ်ဘိးဘဉ်သ့ဉ်ညါအံၤ ဘဉ်သ့ဉ်သ့ဉ် ကအိဉ်ဒီးတ်ဂ့ၢ်တၢ်ကျိၤလၢ အရူဒိဉ်ဘဉ်ယး နလံာ်ပတံထိဉ်တၢ် မ့တမ့ၢ် တၢ်အ့ဉ်ကီၤသးန့ဉ်လီၤ.
ကွၢ်ယု မ့ၢ်နံၤမ့ၢ်သိအရူဒိဉ်လၢ လံာ်ဘိးဘဉ်သ့ဉ်ညါအံၤအပူၤတက့ၢ်.
ဘဉ်သ့ဉ်သ့ဉ် နကဘဉ် ဟံးဂ့ၢ်ဝိလၢ မ့ၢ်နံၤလၢခံကတၢ်လၢ တၢ်ဟ်ပနီဉ်နှၤ်နၤ လၢနကဟ့ဉ်နတၢ်အိဉ်ဆူဉ်အိဉ်ချ့ တၢ်ဘူးတၢ်လဲတဖဉ် မ့တမ့ၢ် မၤန့ၢ်တၢ်မၤစၢၤလၢ တၢ်ပူၤလိၤလဲတဖဉ်နှဉ်လီၤ.
နၤ မ့တမ့ၢ် ပှၤတဂၤဂၤလၢ နမၤစၢၤမ့ၢ်အိဉ်ဒီးတ်သံကွၢ်အဃိ. နအိဉ်ဒီးတ်ခွဲးတ်ယာ်လၢ ကမၤန့ၢ်တ်မၤစၢၤဒီးတ်ဂ့ၢ်တ်ကျိၤလၢ နကျိာ်လၢ တလၫ်ဘူဉ်လာ်စ့ၤဘဉ်နှဉ်လီၤ.
လၢနကကတိၤတ်ဒိး ပှၤကျိးထံတ်အဂိၢ်. ကိး1-800-991-5840.တက့ၢ်.

Korean
주의: 본고지에는해당신청서또는적용범위에대한중요한정보가있을수있습니다.
본고지의주요날짜를찾으십시오.해당건강보험을유지하거나비용을지원받는특정기한까지조치를취하셔야합니다.본인자신이나본인이돕고있는누군가가질문이있다면무료로모국어로된도움과정보를얻을수있는권리가있습니다.통역사와통화하려면1-800-991-5840. 번으로전화하십시오.

Kurdish
ئاگاداری
ڕەنگە ئەم ئاگادارییە زانیاری گرنگی تێدا بێت دەربارەی داواکاری یان ڕووماڵکردنەکەت.بەدوای بەرواربەرەکییەکانی ناو ئەم ئاگادارییە بگەڕێ.لەوانەیە پێویست بکات لە هەندێک دوا وادە کردارێک بکەیت بۆ ئەوەی ڕووماڵی تەندروستیت بەردەوام بێت یان یارمەتی بۆ تێچووەکانت دەست بخەیت.ئەگەر تۆ یان کەسێک کە تۆ یارمەتی دەدەیت پرسیاری هەیە، تۆ مافی دەسکەوتنی یارمەتی و زانیاریت بە زمانی خۆت بێ بەرامبەر هەیە.بۆ قسەکردن لەگەڵ وەرگێرێک، پەیوەندی بە 18009915840 بکە.

Lao
ສິ່ງທີ່ຄວນເອົາໃຈໃສ່: ແຈ້ງການສະບັບນີ້ ອາດຈະມີຂໍ້ມູນທີ່ສຳຄັນກ່ຽວກັບການສະໝັກ ຫຼື ການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານ.
ຈົ່ງຊອກຫາວັນທີທີ່ສຳຄັນໃນແຈ້ງການສະບັບນີ້. ທ່ານອາດຈະຕ້ອງດຳເນີນການໃນຂອບເຂດເວລາໃດໜຶ່ງ
ເພື່ອຮັກສາການຄຸ້ມຄອງດ້ານສຸຂະພາບຂອງທ່ານ ຫຼື ໄດ້ຮັບການຊ່ວຍເຫຼືອທາງດ້ານການເງິນປະມານ. ຖ້າຫາກທ່ານ ຫຼືບຸກຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອຢູ່ນັ້ນ ມີຄຳຖາມ,ທ່ານມີສິດໄດ້ຮັບການຊ່ວຍເຫຼືອ ແລະ ໄດ້ຮັບຂໍ້ມູນທີ່ເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍ. ຕ້ອງການລົມກັບນາຍແປພາສາ, ຈົ່ງໂທຫາເບີ 1-800-991-5840.

Nepali
ध्यानाकर्षण: यो सूचनामा तपाईको निवेदन वा कभरेजको बारेमा महत्त्वपूर्ण जानकारी हुनसक्छ। यो सूचनामा मुख्य मितिहरू हेर्नुहोस्। तपाईको स्वास्थ्य कभरेज वा लागतमा मद्दत प्राप्त गर्न तपाईले निश्चित समयसीमा भित्र कारबाही लिनुपर्ने हुनसक्छ। तपाईं वा तपाईले सहायता गरेका कसैसँग जिज्ञासाहरू छन् भने तपाईंसँग आफ्नो भाषामा नि:शुल्क सहायता र जानकारी प्राप्त गर्ने अधिकार छ। दोभाषेसँग कुरा गर्न 1-800-991-5840.मा कल गर्नुहोस्।

Oromo
HUBAACHIISA: Beeksisi kun odeeffannoo barbaachisaa waa'ee iyyata keetii yookaan waa'ee tajaajiloota qabaachuu mala. Beeksisa kana irraa guyyoota barbaachisoo ta'an ilaali. Tajaajila fayyaa kee itti fufsiisuuf guyyoota murtaa'an irratti tarkaanfiin ati fudhattu yookaan kaffaltiidhaan gargaarsi ati argattu jiraachu mala. Yoo ati ykn namni ati gargaartu, gaaffii qabaattan, gatii malee gargaarsaa fi oddeeffanno afaan dandeessaaniin argachuun mirga keessaani. Warra afaan hikkaaniif lakkoofsa kanaan bilbilaa 1-800-991-5840.

Russian
ВНИМАНИЕ! В данном уведомлении может содержаться важная информация о вашей заявке или страховке. В нем также указаны ключевые даты. Вам может потребоваться выполнить некоторые действия к определенному сроку для сохранения вашей медицинской страховки или получения помощи в оплате расходов. Если у вас или у человека, которому вы помогаете, возникнут вопросы, вы имеете право получить помощь и информацию на своем языке бесплатно. Чтобы поговорить с переводчиком, позвоните по номеру 1-800-991-5840.

Vietnamese
CHÚ Ý: Thông báo này có thể chứa thông tin quan trọng về đơn đăng ký hoặc bảo hiểm của quý vị. Tìm những ngày chính trong thông báo này. Quý vị có thể cần hành động trước một số thời hạn để duy trì bảo hiểm sức khỏe của mình hoặc được giúp đỡ có tính phí. Nếu quý vị hoặc người quý vị đang giúp đỡ, có thắc mắc, quý vị có quyền lấy thông tin và được trợ giúp bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi số 1-800-991-5840.