Group Employee Application for ACA Small Business Plans (1-50)

A. Employer Information

Employer Name_____ Phone (_____) _____

Group Number_____

Address Line 1 (Street Address or Suite#)_____

Address Line 2 (PO Box, Street Address)_____

City_____ State_____ ZIP_____

B. Member Elections Information *(If you need to list more than four dependents, please write all necessary information on a separate sheet of paper and attach to this application. Your employer determines eligibility for coverage, confirm with your employer that the dependent types listed below are eligible.)*

Member Type	First Name	Last Name	Medical	Blue Dental	Avesis Vision[1]	Waive All Coverage
Employee			☐	☐	☐	☐
Spouse			☐	☐	☐	☐
Dependent 1			☐	☐	☐	☐
Dependent 2			☐	☐	☐	☐
Dependent 3			☐	☐	☐	☐
Dependent 4			☐	☐	☐	☐

NOTE: You may only select Blue Dental or Avesis Vision plans if your employer chooses to offer them. If your employer does not offer Blue Dental or Avesis Vision, you will not be enrolled in those plans. Talk to your employer if you have any questions.

[1]*The vision plan is provided by Avesis Vision, an independent company that does not provide Wellmark Blue Cross and Blue Shield of Iowa products or services. Avesis Vision is underwritten by Fidelity Security Life Insurance Company, Kansas City, Missouri. Vision coverage includes a Hearing Discount Savings Plan provided by Amplifon. Amplifon is an independent company that does not provide Wellmark Blue Cross and Blue Shield of Iowa products or services.*

As a Wellmark contract holder, you will receive a Summary of Benefits and Coverage (SBC) that outlines important information about your coverage. You can also access Wellmark.com/inform to help you make the best decisions for you and your family. This site includes important information on your prescription drug coverage, like the accessibility and availability of prescription drugs, how to request a current drug list and the process for requesting an exception to the drug list. You also can find a list of participating providers and facilities and how to obtain a prior authorization. For more information, or if you have any questions, you can call the Wellmark Customer Service number located on the back of your ID card.

If you are applying for Wellmark Value Health Plan coverage at any time prior to your employer's 2020 renewal date you must designate a personal doctor, including family members who live outside the network area (for example, those who are under age 26 and remain on a parent's plan). See Section H for more information.

Please List Medical Plan Name and Network:_____

Please List Dental Plan Name:_____

If you are waiving coverage for yourself or your dependent(s) (including your spouse or domestic partner), you may be able to enroll yourself or your dependent(s) in this plan if you notify Wellmark within 60 days of a qualifying event.

I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a special enrollment event or at the next open enrollment period.

Signature_____ Date_____/_____/_____

To request special enrollment or obtain more information, contact Customer Service, Wellmark Blue Cross and Blue Shield of Iowa, PO Box 9232, Mail Station 3E499, Des Moines, IA 50306-9232, or call 1-800-524-9242.

C. Enrollment Reason or Event

Enrollment Reason: ☐ Open Enrollment ☐ Newly Eligible ☐ Special Enrollment (If you check this option, complete the following)

Special Enrollment Event Reason:

☐ Birth/adoption or placement for adoption
☐ Marriage
☐ Divorce
☐ Foster child placement
☐ Other_____
☐ Involuntary loss of coverage
☐ Court-ordered coverage
☐ Legal guardianship
☐ Returning from military service

List date of special enrollment event _____/_____/_____ (mm/dd/yyyy)

D. Employee Information

First Name_____ MI_____ Last Name_____ Suffix_____

Date of Birth_____/_____/_____ Gender ☐ Male ☐ Female

Social Security Number[2]

a. ☐ SSN/TIN_____
b. ☐ I do not have a SSN/TIN
c. ☐ I refuse to provide the SSN/TIN

[2]The IRS requires Wellmark to collect SSNs/TINs for federal reporting purposes. Wellmark will follow up with you to collect this information if you do not check/complete a, b, or c. Failure to provide the SSN/TIN information may result in a monetary penalty, per violation, assessed to you by the IRS.

Address Line 1 (Street Address or Apt/Suite#)_____

Address Line 2 (PO Box, Street Address)_____

City_____ State_____ ZIP_____ County_____

Preferred Phone Number (_____)_____ Ext_____ Secondary Phone Number (_____)_____ Ext_____

Email Address_____

Date of Hire_____/_____/_____ Requested Effective Date_____/_____/_____

Employment Status ☐ Active ☐ COBRA ☐ Retired ☐ Seasonal

If applicable, identify your personal/OBGYN doctor:

Doctor

First Name_____ Last Name_____ Clinic Name_____

Address_____

City_____ State_____ ZIP_____

☐ Yes ☐ No Are you an established patient?

OB/GYN Doctor

First Name_____ Last Name_____ Clinic Name_____

Address_____

City_____ State_____ ZIP_____

☐ Yes ☐ No Are you an established patient?

E. Spouse or Domestic Partner Information

First Name_____ MI_____ Last Name_____ Suffix_____

Date of Birth_____/_____/_____ Gender ☐ Male ☐ Female

☐ Yes ☐ No Is this a domestic partnership?[3]

[3]If yes, please attach a completed Certification of Domestic Partnership (M-4328). Wellmark Value Health Plan does not provide coverage for domestic partners. For more information, contact your Wellmark representative.

E. Spouse or Domestic Partner Information, cont'd

Social Security Number[2]

a. ☐ SSN/TIN_____

b. ☐ I do not have a SSN/TIN

c. ☐ I refuse to provide the SSN/TIN

[2]The IRS requires Wellmark to collect SSNs/TINs for federal reporting purposes. Wellmark will follow up with you to collect this information if you do not check/complete a, b, or c. Failure to provide the SSN/TIN information may result in a monetary penalty, per violation, assessed to you by the IRS.

☐ Yes ☐ No **Is your contact information different than the employee? If yes, complete the following:**

Address (Street Address or Apt/Suite#)_____

City_____ State_____ ZIP_____

County_____ Email Address*_____

*Wellmark may use a member's email addresses to contact members with important information about their Wellmark benefits.

If applicable, identify your personal/OBGYN doctor:

Doctor

First Name_____ Last Name_____ Clinic Name_____

Address_____

City_____ State_____ ZIP_____

☐ Yes ☐ No Are you an established patient?

OB/GYN Doctor

First Name_____ Last Name_____ Clinic Name_____

Address_____

City_____ State_____ ZIP_____

☐ Yes ☐ No Are you an established patient?

F1. Dependent 1 Information

First Name_____ MI_____ Last Name_____ Suffix_____

Date of Birth_____/_____/_____ Gender ☐ Male ☐ Female

Social Security Number[2]

a. ☐ SSN/TIN_____

b. ☐ I do not have a SSN/TIN

c. ☐ I refuse to provide the SSN/TIN

[2]The IRS requires Wellmark to collect SSNs/TINs for federal reporting purposes. Wellmark will follow up with you to collect this information if you do not check/complete a, b, or c. Failure to provide the SSN/TIN information may result in a monetary penalty, per violation, assessed to you by the IRS.

☐ Yes ☐ No **Is your contact information different than the employee? If yes, complete the following:**

Address (Street Address or Apt/Suite#)_____

City_____ State_____ ZIP_____

County_____ Email Address_____

If your dependent is over the age of 26, the next three questions are required:

☐ Yes ☐ No Are you married? (If yes, this dependent is not eligible for coverage.)

☐ Yes ☐ No Are you a full time student?
If yes, provide the name of the school_____

☐ Yes ☐ No Are you disabled? (Wellmark Value Health Plan does not provide coverage for disabled dependents age 26 or older. For more information, contact your Wellmark representative.)

F1. Dependent 1 Information, cont'd

If applicable, identify your personal/OBGYN doctor:

Doctor

First Name_____ Last Name_____ Clinic Name_____

Address_____

City_____ State_____ ZIP_____

☐ Yes ☐ No Are you an established patient?

OB/GYN Doctor

First Name_____ Last Name_____ Clinic Name_____

Address_____

City_____ State_____ ZIP_____

☐ Yes ☐ No Are you an established patient?

F2. Dependent 2 Information

First Name_____ MI_____ Last Name_____ Suffix_____

Date of Birth_____/_____/_____ Gender ☐ Male ☐ Female

Social Security Number[2]

a. ☐ SSN/TIN_____

b. ☐ I do not have a SSN/TIN

c. ☐ I refuse to provide the SSN/TIN

[2]The IRS requires Wellmark to collect SSNs/TINs for federal reporting purposes. Wellmark will follow up with you to collect this information if you do not check/complete a, b, or c. Failure to provide the SSN/TIN information may result in a monetary penalty, per violation, assessed to you by the IRS.

☐ Yes ☐ No **Is your contact information different than the employee? If yes, complete the following:**

Address (Street Address or Apt/Suite#)_____

City_____ State_____ ZIP_____

County_____ Email Address_____

If your dependent is over the age of 26, the next three questions are required:

☐ Yes ☐ No Are you married? (If yes, this dependent is not eligible for coverage.)

☐ Yes ☐ No Are you a full time student?
If yes, provide the name of the school_____

☐ Yes ☐ No Are you disabled? (Wellmark Value Health Plan does not provide coverage for disabled dependents age 26 or older. For more information, contact your Wellmark representative.)

If applicable, identify your personal/OBGYN doctor:

Doctor

First Name_____ Last Name_____ Clinic Name_____

Address_____

City_____ State_____ ZIP_____

☐ Yes ☐ No Are you an established patient?

OB/GYN Doctor

First Name_____ Last Name_____ Clinic Name_____

Address_____

City_____ State_____ ZIP_____

☐ Yes ☐ No Are you an established patient?

F3. Dependent 3 Information

First Name_____ MI_____ Last Name_____ Suffix_____

Date of Birth_____/_____/_____ Gender ☐ Male ☐ Female

Social Security Number[2]

a. ☐ SSN/TIN_____
b. ☐ I do not have a SSN/TIN
c. ☐ I refuse to provide the SSN/TIN

[2]The IRS requires Wellmark to collect SSNs/TINs for federal reporting purposes. Wellmark will follow up with you to collect this information if you do not check/complete a, b, or c. Failure to provide the SSN/TIN information may result in a monetary penalty, per violation, assessed to you by the IRS.

☐ Yes ☐ No **Is your contact information different than the employee? If yes, complete the following:**

Address (Street Address or Apt/Suite#)_____

City_____ State_____ ZIP_____

County_____ Email Address_____

If your dependent is over the age of 26, the next three questions are required:

☐ Yes ☐ No Are you married? (If yes, this dependent is not eligible for coverage.)

☐ Yes ☐ No Are you a full time student?
If yes, provide the name of the school_____

☐ Yes ☐ No Are you disabled? (Wellmark Value Health Plan does not provide coverage for disabled dependents age 26 or older. For more information, contact your Wellmark representative.)

If applicable, identify your personal/OBGYN doctor:

Doctor

First Name_____ Last Name_____ Clinic Name_____

Address_____

City_____ State_____ ZIP_____

☐ Yes ☐ No Are you an established patient?

OB/GYN Doctor

First Name_____ Last Name_____ Clinic Name_____

Address_____

City_____ State_____ ZIP_____

☐ Yes ☐ No Are you an established patient?

F4. Dependent 4 Information

First Name_____ MI_____ Last Name_____ Suffix_____

Date of Birth_____/_____/_____ Gender ☐ Male ☐ Female

Social Security Number[2]

a. ☐ SSN/TIN_____
b. ☐ I do not have a SSN/TIN
c. ☐ I refuse to provide the SSN/TIN

[2]The IRS requires Wellmark to collect SSNs/TINs for federal reporting purposes. Wellmark will follow up with you to collect this information if you do not check/complete a, b, or c. Failure to provide the SSN/TIN information may result in a monetary penalty, per violation, assessed to you by the IRS.

☐ Yes ☐ No **Is your contact information different than the employee? If yes, complete the following:**

Address (Street Address or Apt/Suite#)_____

City_____ State_____ ZIP_____

County_____ Email Address_____

F4. Dependent 4 Information, cont'd

If your dependent is over the age of 26, the next three questions are required:

☐ Yes ☐ No Are you married? (If yes, this dependent is not eligible for coverage.)

☐ Yes ☐ No Are you a full time student?
If yes, provide the name of the school_____

☐ Yes ☐ No Are you disabled? (Wellmark Value Health Plan does not provide coverage for disabled dependents age 26 or older. For more information, contact your Wellmark representative.)

If applicable, identify your personal/OBGYN doctor:

Doctor

First Name_____ Last Name_____ Clinic Name_____

Address_____

City_____ State_____ ZIP_____

☐ Yes ☐ No Are you an established patient?

OB/GYN Doctor

First Name_____ Last Name_____ Clinic Name_____

Address_____

City_____ State_____ ZIP_____

☐ Yes ☐ No Are you an established patient?

G. Other Coverages

Medicare Coverage

1. **(Required)** Are you and/or anyone listed in the Dependent Information sections enrolled in Medicare? ☐ Yes ☐ No
2. **(Required)** Are you and/or anyone listed in the Dependent Information sections Social Security disabled? ☐ Yes ☐ No

If yes, provide Medicare information below for all enrollees with Medicare coverage:

Name as it appears on Medicare card_____ Medicare ID_____

Effective Date (Part A)_____/_____/_____ Effective Date (Part B)_____/_____/_____

Name as it appears on Medicare card_____ Medicare ID_____

Effective Date (Part A)_____/_____/_____ Effective Date (Part B)_____/_____/_____

If you need to list more than two dependents, please write all necessary information on a separate sheet of paper and attach to this application.

Other Coverage

☐ Yes ☐ No Will you, your spouse or dependent(s) keep other coverage in addition to Wellmark coverage?

If yes, identify those applicants keeping other coverage:

☐ Employee ☐ Spouse ☐ Dependent 1 ☐ Dependent 2 ☐ Dependent 3 ☐ Dependent 4

Other Insurance Carrier Name_____

Address_____

City_____ State_____ ZIP_____

Other Coverage Effective Date_____/_____/_____ Other Coverage End Date_____/_____/_____

Policyholder Name_____ Policy Number_____

Policyholder Date of Birth_____/_____/_____

List name of person that has primary responsibility for the dependents_____

☐ Yes ☐ No Is there a court-ordered document? (If yes, please attach the court order.)

H. Authorization and Certification

Personal Doctor

A personal doctor is required for applicants applying for Wellmark Value Health Plan coverage at any time prior to the employer's 2020 renewal date. This includes family members who live outside the network area (for example, those who are under age 26 and remain on a parent's plan). The personal designation is not for applicants who permanently live outside of Iowa. You can choose from among five different provider types: General/Family Practice Physicians, Internists, Nurse Practitioners, Physician Assistants, or Pediatricians. The personal doctor you choose must participate in the network associated with your plan. In addition, female members may choose an OB/GYN. You can access the Wellmark provider directory at wellmark.com/HealthAndWellness/FindaDoctor/FindaDoctor.aspx or by calling 1-800-524-9242. You may also see a personal doctor referred to as a Primary Care Provider (PCP) in other Wellmark documentation.

Authorization and Certification

I certify that I am legally authorized to apply for coverage for myself and all other persons named in this application. I understand that I am completing this application for the coverage sponsored by my employer or group sponsor offered by Wellmark, Inc., doing business as Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Health Plan of Iowa, Inc., Wellmark Value Health Plan, Inc. (each referenced herein as "Wellmark") and, when applicable, Avesis Vision & Hearing insurance provided by the vision insurance carrier (collectively the "Insurers"). I authorize my employer, as my agent, to deduct from my pay or collect from me in advance the monthly rates therefore and remit such sums to the Insurers on my behalf. This authorization is to remain in effect until the Insurers are notified by me or my employer to the contrary. I understand that written notice of rate changes will be furnished to my employer as my agent. I further understand that the coverage applied for will not start until after this application and the appropriate coverage rates are received and accepted by each Insurer and an effective date of coverage is established by the Insurers.

I certify that, after this application was completed, I carefully and fully read it, that the statements and answers set forth are full, true, and correct to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that the Insurers will rely on the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentations, or have failed to disclose or concealed any material fact, the Insurers will be entitled to declare the contracts applied for void and to refuse allowance of benefits to any person thereunder.

I acknowledge I have received or have been advised and understand I will receive from my employer the Summary of Benefits and Coverage (SBC).

The coverage effective date will be assigned according to my employer's eligibility rules and Wellmark guidelines. For special enrollment events, Wellmark must be notified within 60 days of event (or 120 days of returning from military service). The coverage effective dates for special enrollment events will be the 1st of the month following the event. Exceptions are birth, adoption, placement for adoption, legal guardianship, court ordered coverage and foster child placement or otherwise required or permitted under federal or state law. For these events, coverage effective date is the date of the event.

My employer is responsible for compliance with all applicable laws related to employee eligibility waiting periods.

Health Savings Account (HSA)

In the event I have selected a High Deductible Health Plan, I understand that enrolling in such coverage does not guarantee that I am or will be eligible to make contributions to an HSA or that contributions can be made to an HSA on my behalf.

Providing Social Security Numbers or Tax Identification Numbers

In order for Wellmark to report my coverage status to the federal government, I must provide to Wellmark my Social Security number or tax identification number and the Social Security numbers or tax identification numbers of all members covered under my coverage. The IRS requires that Wellmark report this information using the Social Security number or tax identification number of the plan member and each dependent. If Wellmark does not have Social Security or tax identification numbers, I understand Wellmark will be unable to report and send the information needed to complete federal tax returns. If I have not previously provided Social Security numbers or tax identification numbers to Wellmark for all members covered under my coverage, I will contact Wellmark by calling the Customer Service number on my ID card. If I do not provide the Social Security numbers or tax identification numbers to Wellmark for this purpose, I may be subject to a monetary penalty per violation imposed by the Internal Revenue Service.

H. Authorization and Certification, cont'd

I have read and understand the Authorization and Certification language on this application and acknowledge receipt of a fully completed copy of this application.

I authorize the Wellmark agent or agency who is identified with this application or my employer's group application to enter my application information through Wellmark's electronic enrollment process. In the event of any discrepancy between this paper application form and the information entered electronically, the information entered electronically may be considered the source of record, and I may contact Wellmark to make any changes to my enrollment information. Wellmark authorized agents are required to retain this original paper application for 11 years.

Print Name: _____

Your Signature X: _____ **Date Signed:** _____/_____/_____

If applicant is a minor, please sign below. (If legal guardian, please provide proof of guardianship)

Power of Attorney or Legal Guardian Printed Name: _____

Power of Attorney or Legal Guardian Signature X: _____ **Date Signed:** _____/_____/_____

Required Federal Accessibility and Nondiscrimination Notice

Discrimination is against the law

Wellmark complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Wellmark does not exclude people or treat them differently because of their race, color, national origin, age, disability or sex.

Wellmark provides:

- Free aids and services to people with disabilities so they may communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- 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, call 800-524-9242.

If you believe that Wellmark 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: Wellmark Civil Rights Coordinator, 1331 Grand Avenue, Station 5W189, Des Moines, IA 50309-2901, 515-376-4500, TTY 888-781-4262, Fax 515-376-9073, Email CRC@Wellmark.com. You can file a grievance in person, by mail, fax or email. If you need help filing a grievance, the Wellmark 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, phone or fax at: U.S. Department of Health and Human Services, 200 Independence Avenue S.W., Room 509F, HHH Building, Washington DC 20201, 800-368-1019, 800-537-7697 (TDD).

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

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意：如果您说普通话，我们可免费为您提供语言协助服务。请拨打 800-524-9242 或（听障专线：888-781-4262）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobe oštećena sluha: 888-781-4262).

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية, فإننا نوفر لك خدمات المساعدة اللغوية، المجانية. اتصل بالرقم 800-524-9242 أو (خدمة الهاتف النصي: 888-781-4262).

ສ່ຽງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາ ໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ຫາ. (TTY: 888-781-4262.)

주의: 한국어 를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

ध्यान रखें : अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, नि:शुल्क उपलब्ध हैं। 800-524-9242 पर संपर्क करें या (TTY: 888-781-4262)।

ATTENTION : si vous parlez français, des services d'assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

Geb Acht: Wann du Deitsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิดค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

တက်ုးသ့ဉ်ညါ–နမ့ါကတိၤကညီကျိာ်,ကျိာ်တါမၤစၢၤတါဖံးတါမၤတဖဉ်,လၢတဘဉ်လာ်ဘူးလဲ,ဆိဉ်လၢနကိၢ်လီၤ.ဆဲးကျိုးဆူ ၈၀၀–၅၂၄–၉၂၄၂မ့တမ့ါ(TTY:၈၈၈–၇၈၁–၄၂၆၂)တက့ာ်.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

सावधान: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंका लागि नि:शुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ। 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस्।

ማሳሰቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ እገዛ አገልግሎቶች፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም (በTTY: 888-781-4262) ይሙሉ ያነጋግሩን።

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maaɗa. Heɓir 800-524-9242 malla (TTY: 888-781-4262).

FUULEFFANNAA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajiloonni gargaarsa afaanii, kaffaltii malee, isiniif ni jiru. 800-524-9242 yookin (TTY: 888-781-4262) quunnamaa.

УВАГА! Якщо ви розмовляєте українською мовою, для вас доступні безкоштовні послуги мовної підтримки. Зателефонуйте за номером 800-524-9242 або (телетайп: 888-781-4262).

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