Employee Enrollment and Waiver Form

PacificSource HEALTH PLANS

Group Policy No. _____
Subgroup No. _____
Class No. or Plan _____
Are you an owner of this company? ☐ Yes ☐ No

Employer/Group Name _____ Effective Date ____/____/____ Date of Full-time Hire ____/____/____

Last Name _____ First Name _____ MI _____ Hours Worked per Week _____

Mailing Address _____ City _____ State _____ ZIP _____

Phone _____ Email _____

Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership

By providing your email address, you are agreeing to receive email communications from PacificSource.

Enrollment due to:

- ☐ New Group
- ☐ Open Enrollment
- ☐ New Hire
- ☐ Adding Dependent(s)
- ☐ Involuntary Loss of Other Coverage

Effective date:^

_____

Eligible for COBRA due to:

- ☐ Employment Termination or Reduced Hours
- ☐ Divorce or Legal Separation
- ☐ Death of Employee
- ☐ Dependent No Longer Meets Eligibility

Effective date:^

_____

^Attach proof of event

Choose the type of coverage each person is enrolling in (including those waiving coverage). To add more family members, please attach additional pages.

Coverage		Name (Last, First, MI)	Sex Assigned at Birth	Gender Identity*	SSN	Birth Date	Race/ Ethnicity**
☐ Medical	☐ Add ☐ Waive	Name:	☐ M ☐ F				
☐ Dental	☐ Add ☐ Waive	Employee					
☐ Medical	☐ Add ☐ Waive	Name:	☐ M ☐ F				
☐ Dental	☐ Add ☐ Waive	Spouse/Domestic Partner					
☐ Medical	☐ Add ☐ Waive	Name:	☐ M ☐ F				
☐ Dental	☐ Add ☐ Waive	Relationship to Employee:					
☐ Medical	☐ Add ☐ Waive	Name:	☐ M ☐ F				
☐ Dental	☐ Add ☐ Waive	Relationship to Employee:					
☐ Medical	☐ Add ☐ Waive	Name:	☐ M ☐ F				
☐ Dental	☐ Add ☐ Waive	Relationship to Employee:					
☐ Medical	☐ Add ☐ Waive	Name:	☐ M ☐ F				
☐ Dental	☐ Add ☐ Waive	Relationship to Employee:					

***Gender identity** (optional): **A**-Agender, **B**-Boy, **GF**-Gender fluid, **GN-**Gender nonconforming, **GQ**-Genderqueer, **G**-Girl, **M**-Man, **NB**-Non-binary, **NL**-Not listed, **P**-Prefer not to answer, **Q**-Questioning or unsure, **TG**-Third gender, **TM**-Trans man, **TW**-Trans woman, **T**-Transgender, **TS**-Two-spirit, **W**-Woman

****Race/Ethnicity** (optional): Choose the code that each family member would most closely identify with: **AI**-American Indian/Alaska Native, **A**-Asian, **B**-Black/African American, **H**-Hispanic/Latino, **N**-Native Hawaiian/Other Pacific Islander, **W**-White/Caucasian.

Do you (or any of the individuals listed above) have a primary care provider? ☐ Yes ☐ No

If yes, please list the name(s) of your primary care provider(s) here: _____

Child Custody: If you, your spouse, or your domestic partner are a Court Ordered Guardian or are required to provide coverage for a child from a previous relationship, then you must complete this section in addition to the previous section, and provide a copy of the legal documentation that shows responsibility for medical expenses. Please use additional paper if needed.

Child's Name _____ Custodial Parent's Name _____

Mailing Address _____ Person Required to Provide Insurance _____

Legal Custody:
☐ Mother ☐ Father
☐ Joint ☐ Other

Health and Dental Coverage Information: Have you or any person listed on this application had health or dental insurance in the last 60 days? ☐ Yes ☐ No
If yes, complete the following and attach proof with dates of coverage.

Name	Insurance Carrier	Coverage Dates	Will Coverage Continue?	Coverage Type(s)
	Carrier Name: Policy No.: Phone:	Begin: End:	☐ Yes ☐ No	☐ Medical ☐ Vision ☐ Dental
	Carrier Name: Policy No.: Phone:	Begin: End:	☐ Yes ☐ No	☐ Medical ☐ Vision ☐ Dental
	Carrier Name: Policy No.: Phone:	Begin: End:	☐ Yes ☐ No	☐ Medical ☐ Vision ☐ Dental
	Carrier Name: Policy No.: Phone:	Begin: End:	☐ Yes ☐ No	☐ Medical ☐ Vision ☐ Dental
	Carrier Name: Policy No.: Phone:	Begin: End:	☐ Yes ☐ No	☐ Medical ☐ Vision ☐ Dental

Medical Waiver—If employee is declining medical coverage

☐ I have qualifying medical coverage through (list carrier name and check coverage type):

Name of Insurance Carrier _____

Through: ☐ My other employer ☐ My spouse's employer ☐ My parent's employer ☐ Medicare ☐ Medicaid ☐ VA/Tricare ☐ Indian Health Service

☐ I have other medical coverage through an Individual Policy. ☐ I do not have other medical coverage.

Dental Waiver—If employee is declining dental coverage

☐ I have qualifying dental coverage through (list carrier name and check coverage type):

Name of Insurance Carrier _____

Through: ☐ My other employer ☐ My spouse's employer ☐ My parent's employer ☐ Medicare ☐ Medicaid ☐ VA/Tricare ☐ Indian Health Service

☐ I have other dental coverage through an Individual Policy. ☐ I do not have other dental coverage.

Notice of enrollment rights: If you are declining enrollment for you or your dependents (including your spouse/domestic partner) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 60 days after your other coverage ends involuntarily, or upon your plan's next open enrollment period, unless otherwise specified in your member handbook.

In addition, if you have a new dependent as a result of a marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 60 days after the marriage, birth, adoption or placement for adoption.

Subscriber acknowledgment: I acknowledge and understand that PacificSource Health Plans may request or disclose health information about me or my dependents (persons listed for benefit coverage on this enrollment form) for the purpose of facilitating healthcare treatment, payment for healthcare services, or for business operations necessary to administer healthcare benefits; or as required by law. A separate authorization will be used for this information. For more information about such uses and disclosures please refer to our Privacy Policy, available at PacificSource.com.

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of insurance benefits.

Employee Signature _____ **Date** _____

You may request a free paper copy of your application and/or enrollment information by contacting us at **866-999-5583** or via email at Membership@PacificSource.com.

Mail: PO Box 7068, Springfield, OR 97475 **Fax:** 541-225-3642

PacificSource HEALTH PLANS

Discrimination Is Against the Law

PacificSource Health Plans ("PacificSource") complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity or sexual identity. PacificSource does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity or sexual identity.

PacificSource:

- 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 (888) 977-9299.

If you believe that PacificSource has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity or sexual identity, you can file a grievance with: Civil Rights Coordinator, PO Box 7068, Springfield, OR 97475-0068, (888) 977-9299, TTY: 711, Fax (541) 684-5264,or email CRC@pacificsource.com. Please indicate your wish to file a civil rights grievance. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Customer Service Department 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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

The Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at https://insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241(TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

Amharic	ይህ ማስታወቂያ አስፈላጊ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም የPacificSource Health Plans ሽፋን አስፈላጊ መረጃ አለው።በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀኖችን ፈልጉ። የጤናን ሽፋንዎን ለመጠበቅና በአከፋፈል እርዳታ ለማግኘት በተውሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ እንዲያገኙ እና ያለምንም ክፍያ በቋንቋዎ እርዳታ እንዲያገኙ መብት አለዎት። (888) 977-9299 ይደውሉ።
Arabic	يحوي هذا الاشعار معلومات هامة. يحوي هذا الاشعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خلال PacificSource Health Plans ابحث عن التواريخ الهامة في هذا الاشعار. قد تحتاج لاتخاذ اجراء في تواريخ معينة للحفاظ على تغطيتك الصحية او للمساعدة في دفع التكاليف. لك الحق في الحصور على المعلومات والمساعدة بلغتك (888) 977-9299 من دون أي تكلفة. اتصل بـ
Bantu-Kirundi	Iyi notice ifise akamaro k'ingenzi. Iyi notice ifise akamaro kingene utegerezwa gusaba canke ivyerekeye PacificSource Health Plans, ucuraba ko ibikenewe kuriyi notice, ushobora gufata umwanzuro ukungene wokurikirana ubuzima bwawe uburihiye. Kandi ukongera kugira uburenganzira bwo kwigenga kuronka amakuru n'ubufasha mu rurimi gwawe atacyo utanze. Hamagara (888) 977-9299.
Cambodian-Mon-Khmer	បសចកតីជូនែំណឹងបនេះ មួនព័ែ៍មួនយា៉ា ងសំខាន់ ។ បសចកតីជូនែំណឹងបនេះ មួនព័ែ៍មួនយា៉ា ងសំខាន់ អ្ំពីេបឆង់ដររេ ឬ ការ៉ា រ់រង រស់អ្នកតាមរយៈ PacificSource Health Plans។ សូមដសែងរកកាលរបិចេេសំខាន់ចាំច់ ជៅកនុងបសចកតីជូនែំណឹងបនេះ ។ អ្នកប្រដែលជាបុ្ែូវការរបចេញសកមមភាព ែ្ល់កំណ្ៅថ្ងៃជាក់ចាស់នានា បែេមបីនឹងរកាេុកការ៉ា រ់រង សុខភាពរស់អ្នក ឬបុាក់ជំនួយបចញថ្ងៃ ។ អ្នកមួនសិេធិេេួលព័ែ៍មួនបនេះ និងជំនួយជៅកនុងភាសារស់អ្នកជោយមិនអ្ស់លុយប េើយ ។ សូមេូរស័ពទ (888) 977-9299[។
Chinese	本通知含有重要的訊息。本通知對於您透過 PacificSource Health Plans 所提出的申請或保險有重要的訊息。請在本通知中查看重要的日期。您可能要在特定的截止日期之前採取行動，以保留您的健康保險或有助於省錢。您有權利免費以您的母語得到幫助和訊息 請致電 (888) 977-9299。
Cushite-Oromo	Beeksisni kun odeeffannoo barbaachisaa qaba. Beeksisti kun sagantaa yookan karaa PacificSource Health Plans tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qaba. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa (888) 977-9299 tii bilbilaa.
French	Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou la couverture par l'intermédiaire de PacificSource Health Plans. Rechercher les dates clés dans le présent avis. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez (888) 977-9299.
German	Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch PacificSource Health Plans. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter (888) 977-9299.
Italian	Questo avviso contiene informazioni importanti sulla tua domanda o copertura attraverso PacificSource Health Plans. Cerca le date chiave in questo avviso. Potrebbe essere necessario un tuo intervento entro una scadenza determinata per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere queste informazioni e assistenza nella tua lingua gratuitamente. Chiama (888) 977-9299.
Japanese	この通知には重要な情報が含まれています。この通知には、PacificSource Health Plans の申請または補償範囲に関する重要な情報が含まれています。この通知に記載されている重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。(888) 977-9299までお電話ください。

Korean	본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 PacificSource Health Plans 을 통한 커버리지 에 관한 정보를 포함하고 있습니다. 본 통지서에서 핵심이 되는 날짜들을 찾으십시오. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 리가 있습니다. (888) 977-9299 로 전화하십시오.
Laotian	ການແຈ້ງການນ ມ ນ ສ ຄ ນ. ການແຈ ງການນ ມ ມ ນ ສ ຄ ນ ກ ຈ ບ ຄ ຂ ສ ກ ຫ ຼ ການ ມ ຄ ຂ ຫ ນ ຜ ນ PacificSource Health Plans. ເ ບ ສ ຄ ບ ກ ນ ດ ນ ສ ຄ ນ ນ ແ ແຈ ງການນ . ຫ ນ ຄ ຈ ປ ນ ຕ ຄ ໃ ເ ລ ດ ນ ການ ດ ຍ ກ ນ ດ ເ ລ ຫ ແ ນ ຈ ຮ ກ ສ ການ ມ ຄ ສ ຂ ພ ບ ຂ ຫ ນ ຫ ຼ ການ ຊ ຍ ຫ ຼ ຢ ຫ ມ ຄ ໃ ຈ ຈ ຍ. ຫ ນ ມ ສ ຫ ຈ ໄ ຮ ບ ຂ ມ ນ ຂ ຈ ສ ນ ການ ຊ ຍ ຫ ຼ ຢ ແ ພ ສ ຂ ຫ ນ ຫ ຼ ຢ ຫ ມ ຄ ໃ ຈ ຈ ຍ. ໂ (888) 977-9299.
Nepali	यो स चनामा ू महत्त्वप र ्ू ू जानकारी छ । यो स चनामा ू तपाईकं ो आवे िन वा PacificSource Health Plans का माध्यमबाटप्राप्त हुने सदु विाबारे महत्त्वपर् ू ्ू जानकारी छ । यो सचू नामा भएका महत्त्वपर् ू ्ू दमदतहरू ख्याल ि नुहु ोस् । तपाईलं े पाइरहके ो स्वास् ्य दबमा पाइरहन वा तपाईकं ो खचुको भक्तानीमा ु सहायता पाउन के ही समयकारवाही ि न -सीमामा काम- ु पनु हनसक्छु । तपाईलं े यो जानकारी र सहायता आफ्नो मातभृ ाषामा दन शल् ु क पाउनु तपाईकं ो अदिकार: हो (888) 977-9299 मा फोन ि नुहु ोस् ।
Norweigen	Denne kunngjøringen har viktig informasjon. Kunngjøringen inneholder viktig informasjon om programmet eller dekning gjennom PacificSource Health Plans. Se etter viktige datoer i denne kunngjøringen. Du må kanskje ta affære ved visse frister for å beholde helse-dekning eller økonomisk bistand. Du har rett til å få denne informasjonen og hjelp i ditt spark uten kostnad. Ring (888) 977-9299.
Pennsylvania Dutch	Die Bekanntmaching gebt wichdichi Auskunft. Die Bekanntmaching gebt wichdichi Auskunft baut dei Application oder Coverage mit PacificSource Health Plans. Geb Acht fer wichdiche Daadem in die Bekanntmachung. Es iss meeglich, ass du ebbes duh muscht, an beschtimmde Deadlines, so ass du dei Health Coverage bhalde kannscht, odder bezaahle helfe kannscht. Du hoscht es Recht fer die Information un Hilf in deinre eegne Schprooch griege, un die Hilf koschtet nix. Kannscht du (888) 977-9299 uffrufe
Persian	این اعلامیه حامی اطلاعات مهم میباشد. این اعلامیه حامی اطلاعات مهم درباره فرم تقاضا و یا پوشش بیمه ای شما مربوط به PacificSource Health Plans به تاریخ های مهم در این اعلامیه توجه نمایید. شما . ممکن است تا به تاریخ های مشخصی برای حفظ پوشش مزایای یا برای کمک به مخارج مزایای ملزوم به انجام کارهایی شما حق این را دارید که این اطلاعات و کمک را به زبان خود به طور رایگان دریافت نمایید 977-9299 (888) باشید
Punjabi	ਇਸ ਨੋ ਜਿਸ ਜਵਚ ਖਾਸ ਜਾਣਕਾਰੀ ਹੈ. ਇਸ ਨੋ ਜਿਸ ਜਵਚ PacificSource Health Plans ਵਲੋਤੁਹਾਡੀ ਕਵਰੇਜ ਅਤੇ ਅਰਜੀ ਿਾਰੇ ਮਹਿੱ ਤਵਪ ਰਨ ਜਾਣਕਾਰੀ ਹੈ . ਇਸ ਨੋ ਜਿਸ ਜਵਚ ਖਾਸ ਤਾਰੀਖਾ ਲਈ ਵੇਖੋ. ਜੇਕਰ ਤੁਸੀ ਜਸਹਤਕਵਰੇਜ ਰਿੱਖਣੀ ਹੋਵੇ ਜਾ ਓਸ ਦੀ ਲਾਗਤ ਜਵਿੱ ਚ ਮਦਦ ਦੇ ਇਛੁਿੱ ਕ ਹੋ ਤਾਂ ਤੁਹਾਨ ੂੰ ਅੰ ਤਮ ਤਾਜਰਖ਼ ਤੋਂ ਪਜਹਲਾਂ ਕੁਿੱ ਝ ਖਾਸ ਕਦਮ ਚੁਿੱ ਕਣ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ. ਤੁਹਾਨ ੂੰ ਮੁਫ਼ਤ ਜਵਚ 'ਤੇ ਆਪਣੀ ਭਾਸਾ ਜਵਿੱ ਚ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਪਰਾਪਤ ਕਰਨ ਦਾ ਅਜਿਕਾਰ ਹੈ. ਕਾਲ (888) 977-9299
Romanian	Prezenta notificare conține informații importante. Această notificare conține informații importante privind cererea sau acoperirea asigurării dumneavoastre de sănătate prin PacificSource Health Plans. Căutați datele cheie din această notificare. Este posibil să fie nevoie să acționați până la anumite termene limită pentru a vă menține acoperirea asigurării de sănătate sau asistența privitoare la costuri. Aveți dreptul de a obține gratuit aceste informații și ajutor în limba dumneavoastră. Sunați la (888) 977-9299.

Russian	Настоящее уведомление содержит важную информацию. Это уведомление содержит важнуюинформацию о вашем заявлении или страховом покрытии через PacificSource Health Plans. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону (888) 977-9299.
Serbo-Croatian	U ovom obavještenju su sadržane važne informacije. U ovom obavještenju su sadržane važne informacije o Vašoj prijavi ili osiguranju preko PacificSource Health Plans. Pogledajte nalaze li se u ovom obavještenju neki ključni datumi. Možda ćete morati poduzeti određenje radnje u datom roku kako biste i dalje zadržali svoje osiguranje ili pomoć pri plaćanju. Imate pravo da ove informacije, kao i pomoć, dobijete besplatno na svom jeziku. Nazovite (888) 977-9299.
Spanish	Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de PacificSource Health Plans. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al (888) 977-9299.
Tagalog	Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng PacificSource Health Plans. Tingnan ang mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa (888) 977-9299.
Thai	ประกาศนี้มีข้อมูลสาคัญประกาศนี้มีข้อมูลที่สาคัญเกี่ยวกับการการสมัครหรือขอบเขตประกันสุขภาพของคุณผ่าน PacificSource Health Plans ดูกาหนดการในประกาศนี้คุณอาจจะต้องดาเนินการภายในกาหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่ายคุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่ายโทร (888) 977-9299.
Ukrainian	Це повідомлення містить важливу інформацію. Це повідомлення містить важливу інформацію про Ваше звернення щодо страхувального покриття через PacificSource Health Plans. Зверніть увагу на ключові дати, вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону (888) 977-9299.
Vietnamese	Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn xin nộp hoặc hợp đồng bảo hiểm qua chương trình PacificSource Health Plans. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình hoàn toàn miễn phí. Xin gọi số (888) 977-9299.