Oregon State University Student Plan

Enrollment Form for Postdoctoral Fellows, Vet Residents, Visiting Scholars

PacificSource HEALTH PLANS

Save time by emailing this completed form to **MembershipStudentReps@PacificSource.com**. Allow 3–5 business days for processing, then call **541-284-7961,** TTY: 711 (we accept all relay calls) to make your payment over the phone. Or you can wait until you receive your first bill, which will include information on how to pay.

Section 1: Student information

Last name _____ First name _____ MI _____

Student ID number _____ Effective date (MM/DD/YY) _____ Date of birth _____

Physical address _____ City _____ State _____ Zip _____

Mailing address (if different) _____ City _____ State _____ Zip _____

Phone _____ Email _____ Sex at birth (M/F) _____ Gender ID* _____ Race/ethnicity** _____

***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.

Section 2: Adding dependents

LIST DEPENDENTS TO BE INSURED BELOW. Dependent enrollment must coincide with the time of student enrollment (with the exception of a newborn, placement of foster child, adopted child or a qualifying event). Dependent coverage is available only if the student is also insured. Dependent coverage must be the exact same coverage period of the Insured; and therefore, will expire concurrently with that of the student. Dependent coverage will end prior to that time if the dependent is no longer eligible under the plan.

Name (Last, first, MI)	**Sex assigned at birth**	**Gender identity***	**Birth date**	**Race/ ethnicity****
Spouse or domestic partner	☐ M ☐ F			
Dependent child	☐ M ☐ F			
Dependent child	☐ M ☐ F			
Dependent child	☐ M ☐ F			

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

Section 3: Other coverage

Health coverage information: Do you, or any people listed on this enrollment form, have other active health or dental insurance coverage, including Medicare, Medicare Advantage, Medicare supplemental, or Pediatric Dental coverage? ☐ Yes ☐ No

Name(s) of individual(s) covered under the policy	Medical insurance carrier	Coverage dates	Will coverage continue?	Coverage type(s)
	Carrier name: Policy no.: Phone: Group name:	Begin: End:	☐ Yes ☐ No	☐ Medical ☐ Vision ☐ Pediatric dental ☐ Adult or family dental

Section 4: Payment information

The billed amount includes non-insured services, and certain federal, healthcare fees/assessments. Below, select your program. Please calculate total initial premium due by multiplying the monthly premium by the amount of members enrolling. Please also select which type of program you are enrolling in. The premium for your enrollment period must be paid in full for coverage to be active. Coverage is effective the 1st of the month after we receive your enrollment application, except for September, which starts on the 11th.

Program: ☐ Postdoctoral fellow ☐ Vet residents ☐ Visiting scholar

$357.00	per month, per member*
X	number of people enrolling
=	total first month payment

*School administration fee of $17.50 per month will be billed directly to your student account by OSU.

Vet Residents, Visiting Scholars, Postdoctoral Fellows: We will mail an invoice to you monthly. The initial invoice from PacificSource will be sent within 10 days once the application is received. You can pay via credit card or e-check, through the PacificSource application InTouch for Members. If you choose to pay by check, money order, or cashier's check, please reference the remittance details provided on your invoice.

If payment is not received with this application, you will have 30 days from the date signed to remit payment in full to PacificSource. Without payment within 30 days, PacificSource will cancel coverage. It is the student's responsibility for timely renewal payment whether or not a renewal notice is received. If you have questions, please call PacificSource Health Plans at **541-284-7961.**

Section 5: Payment

OPTION 1

1. Email this completed form to **MembershipStudentReps@PacificSource.com**.
2. Call **541-284-7961** to make a payment over the phone.
3. Or, wait until you receive information from us on how to pay.

OPTION 2

Mail check, money order, or cashier's check in U.S. dollars payable to PacificSource Health Plans and this enrollment form to:

PacificSource Health Plans
Attn: Membership Student Rep Team
PO Box 7068, Springfield, OR 97475

Section 6: Certify, authorize, and sign

Be sure to sign and date the enrollment form. Your spouse's or domestic partner's signature is also required (if applicable) as is the signature of any child over the age of 18.

NOTICE TO STUDENT: Coverage will be effective on the effective date of the coverage period unless otherwise stated in the Student Guide. By signing below, the student acknowledges the following: 1) Rates are not pro-rated other than as listed on this enrollment form; 2) Student meets the eligibility requirements for this coverage as described in the Student Guide; 3) If it is later determined that the student is not eligible, coverage will be deemed to have not been in force, the premium will be returned and any claims paid will need to be reimbursed; and 4) Other than eligibility or entry into the Armed Forces, the premium is not refundable. It is the student's responsibility to make a timely renewal payment. This plan is underwritten by PacificSource Health Plans.

Certification of completeness and correctness
I affirm that the answers given in this enrollment form are complete and correct. I am providing these answers as part of the enrollment form procedure required by PacificSource to enroll in its insurance coverage. I understand that if this enrollment form contains any intentional misrepresentation of material fact or fraud, PacificSource may modify or cancel the contract, and/or take any other legal action available by law. I will promptly inform PacificSource in writing if anything happens before my coverage takes effect that makes the information I have provided on this enrollment form incomplete or incorrect. I understand and agree that no coverage will be in force until accepted by PacificSource. If accepted, coverage will be in force as of the effective date determined by PacificSource. A representative of PacificSource may contact me to clarify answers on this enrollment form. Representations made by the enrollee are deemed to be representations made on behalf of each person covered under this policy. However, changes to the enrollment form will not be effective until approved in writing by the enrollee. An enrollment form received by PacificSource requiring alterations will be modified by amendment and sent to the enrollee for signature. As the enrollee, I understand I have the right to inspect the information in my file.

I may at any time request a free paper copy of my application and/or enrollment information by contacting the Commercial Enrollment and Billing Department via email at **MembershipStudentReps@PacificSource.com** or by phone at **541-284-7961**. Electronic communications are offered as a convenience only.

Student signature _____ **Date** _____
(or parent signature if student is under age 18)

Spouse/domestic partner signature _____ **Date** _____

Dependent signature _____ **Date** _____
(if age 18+ and enrolling for coverage)

PacificSource HEALTH PLANS

Discrimination is Against the Law

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

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, or sex, 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 you 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

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	បសចកតីជូនំណឹងបនេះ មុនព័ែ៌មុនយា៉ា ងសំខាន់ ។ បសចកតីជូនំណឹងបនេះ មុនព័ែ៌មុនយា៉ា ងសំខាន់ អុំពីេបួង់ដររេ ឬ ការរ៉ា រ់រង ររស់អ្នកតាមរយៈ PacificSource Health Plans។ សូមដសែងរកកាលររិបចេេសំខាន់ចាំច់ បៅកនុងបសចកតីជូនំណឹងបនេះ ។ អ្នកប្រដែលជាបុ័ែូវការរបចេញសកមមភាព ែល់កំណែ់ថ្ងៃជាក់ចាស់នានា បែេើមបីនឹងរកាេុកការរ៉ា រ់រង សុខភាពររស់អ្នក ឬបុ់ាក់ជំនួយបចញថ្ងៃ ។ អ្នកមុនសិេធិេេួលព័ែ៌មុនបនេះ និងជំនួយបៅកនុងភាសាររស់អ្នកបោយមិនអ្ស់លុយបេើយ ។ 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	ການແຈ້ງການນ້ ມໍຂ້ ມູ ນໍສາຄັ ນ. ການແຈ້ງການນ້ ມໍຂ້ ມູ ນ່ທໍສາຄັ ນກ່ ງວກັ ບໍຄາຮ້ ອງສະໝັ ກຫ ຼື ການຄ້ ມ ຄອງຂອງທ່ ານໂດຍຜ່ ານ PacificSource Health Plans. ເບໍ່ງສາລັ ບກໍ ານົ ດວັ ນ່ທ ່ສາຄັ ນໃນແຈ້ ງການນ້ . ທ່ ານອາດໍຈາເປັ ນຕ້ ອງໃຊ້ເວລາ່ດາເນນການໂດຍກໍ ານົ ດເວລາ່ທແນ່ ນອນ ຈະ ຮັ ກສາການຄ້ ມຄອງສຂະພາບຂອງທ່ ານຫ ຼື ການຊ່ ວຍເຫ ຼື ອ່ທມຄ່ າໃຊ້ ຈ່ າຍ. ທ່ ານມີສດ່ທຈະໄດ້ ຮັ ບໍຂ້ ມູ ນ ຂ່ າວສານນ້ ແລະການຊ່ ວຍເຫ ຼື ອໃນພາສາຂອງທ່ ານ່ທໍ່ບມຄ່ າໃຊ້ ຈ່ າຍ. ໂທ (888) 977-9299.
Nepali	यो स चनामा ू महत्त्वप र्ू ु ू जानकारी छ । यो स चनामा ू तपाईकं ो आवे िन वा PacificSource Health Plans का माध्यमबाटप्राप्त हुने सदु विबारे 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 ।
Norwegian	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 (888) 977-9299 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 ਇਛੁ ਿੱ ਕ ਹੋ ਤਾਂ ਤੁਹਾਨ ੂੰ ਅੂੰ ਤਮ ਤਾਜਰਖ਼ ਤੋਂ ਪਜਹਲਾਂ ਕੁ ਿੱ ਝ ਖਾਸ ਕਦਮ ਚੁ ਿੱ ਕਣ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ. ਤੁਹਾਨ ੂੰ ਮੁਫ਼ਤ ਜਵਚ 'ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ 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.