

# Individual and Family Enrollment Form

## Washington



## Thank you for choosing PacificSource!

You may also enroll online at [PacificSource.com](https://PacificSource.com).

### What you'll need to complete this enrollment form:

- A blue or black pen.
- A copy of any documentation you may need to show legal guardianship.
- Your health insurance producer's information, if applicable.
- Your first month's premium payment (required before your policy will take effect).
- Proof of prior coverage if enrolling outside of the open enrollment timeframe. Please provide a certificate of creditable coverage and the prior coverage termination date.

### You are eligible to enroll if:

- You and your dependents (if enrolling) are not receiving benefits under Medicare Part A, Medicare Part B, nor enrolled in a Medicare Choice or Advantage plan.
- You are a resident of the state of Washington residing in Clark, Pierce, Spokane, and Thurston counties. An individual who intends to reside in Washington may submit an application for insurance but would not be eligible to begin coverage prior to the individual physically residing in Washington.
- Your spouse/domestic partner (if applicable) is your legal spouse/domestic partner.
- You or your legal spouse/domestic partner's children (if applicable) are your natural or adopted children, or you are their legal guardian.
- Your employer will not be paying, or reimbursing you, for any part of the premium. You could receive reimbursement if your employer offers an individual coverage Health Reimbursement Arrangement (ICHRA).

**Please note:** If you are eligible for federal financial assistance, you must apply for coverage through Washington Healthplanfinder at [wahealthplanfinder.org](https://wahealthplanfinder.org).

### Need help?

If you have questions about any part of this enrollment form, we'd be happy to help. You can reach us at **855-330-2792**.

### What happens after you submit your application

We'll begin processing your application, and in the coming weeks, you'll receive a few things from us. To get information faster, include your email address in your application.

1. A Summary of Benefits and Coverage
2. New member information
3. Your ID card(s)
4. Your full policy

**Please keep a copy of this application for your records.**

# 1 What type of coverage would you like?

## New Coverage

- For myself only
- For myself + my spouse/domestic partner
- For myself + my family
- For my child(ren) or legal dependent(s) only

Or

## Change to My Current Coverage

- Current PacificSource ID No. \_\_\_\_\_  
(This can be found on your ID card.)
- Add family member(s) (complete section 5)
  - Change my plan as shown below

## Coverage effective dates

**Enrolling due to** Qualifying event (please explain below) The open enrollment period

Qualifying event \_\_\_\_\_ Date of event \_\_\_\_/\_\_\_\_/\_\_\_\_

What date would you like the coverage to begin? \_\_\_\_/\_\_\_\_ Mo./Yr.

Documentation is required if enrolling outside of the open enrollment period, or adding dependents. If you apply from November 1 through December 15, coverage will be effective January 1. If you apply from December 16 through January 15, coverage will be effective February 1.

# 2 Choose a medical plan

For plan benefit information, please visit [PacificSource.com](http://PacificSource.com) or refer to our Washington Individual and Family Plan brochure.

## Navigator

Available in Clark, Pierce, Spokane, and Thurston counties.

- Gold 2000 PD
- Silver 3500 PD
- Silver 5000 PD

- Bronze 7000 PD
- Bronze HSA 7000 PD

# 3 Choose a dental plan (If not enrolling in dental coverage, skip to next section.)

Dental PPO 0-20-50 1000

Dental PPO 0-20-50 1500

These policies include pediatric dental coverage that meets the requirements of the Affordable Care Act.

## Enrolling myself and my family

List all family members you would like insured. Only your legal spouse, domestic partner, and dependent children are eligible. If a child is over the age of 26 and medically certified as disabled and dependent on parents, a copy of a certification is required.

### Individual pediatric dental coverage is required for all dependents under 19 years of age

I will purchase dental coverage from another insurance carrier. This selection requires you to complete the Attestation of Dental Coverage Form on page 9.

I will not enroll any individual under age 19 on this plan.

\***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.

\*\*\*Use of tobacco on average four or more times per week within the past six months. Includes all tobacco products, except for religious or ceremonial use.

\*\*\*\* Not required for plan enrollment. Used for coordinating care with member's dedicated care team.

## 4 | **Myself (required)**

If this is a child/dependent only policy, PacificSource requires the responsible parent or guardian to include their information.

Name (First, MI, Last) \_\_\_\_\_

Sex Assigned at Birth (M/F) \_\_\_\_\_ Gender Identity\* \_\_\_\_\_ Social Security No. \_\_\_\_\_

Race/Ethnicity\*\* \_\_\_\_\_ Date of Birth (MM-DD-YY) \_\_\_\_\_

Marital Status                      Single                      Married                      Domestic Partnership

Physical Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ County \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Primary Care Provider Name\*\*\*\* \_\_\_\_\_

Primary Care Provider Address\*\*\*\* \_\_\_\_\_

Are you a current patient? Yes      No

Do you use tobacco products?\*\*\* Yes      No

Are you enrolled in a tobacco cessation program? Yes      No

Is the tobacco use for Native American or Alaska Native religious or ceremonial purposes? Yes      No

## 5 | **Spouse or Domestic Partner (Skip to section 6 if not enrolling a spouse or domestic partner.)**

Name (First, MI, Last) \_\_\_\_\_

Sex Assigned at Birth (M/F) \_\_\_\_\_ Gender Identity\* \_\_\_\_\_ Social Security No. \_\_\_\_\_

Race/Ethnicity\*\* \_\_\_\_\_ Date of Birth (MM-DD-YY) \_\_\_\_\_

Primary Care Provider Name\*\*\*\* \_\_\_\_\_

Primary Care Provider Address\*\*\*\* \_\_\_\_\_

Are you a current patient? Yes      No

Do you use tobacco products?\*\*\* Yes      No

Are you enrolled in a tobacco cessation program? Yes      No

Is the tobacco use for Native American or Alaska Native religious or ceremonial purposes? Yes      No

**6** | **Dependent Child (Skip to section 7 if not enrolling dependents.)**

Name (First, MI, Last) \_\_\_\_\_

Sex Assigned at Birth (M/F) \_\_\_\_\_ Gender Identity\* \_\_\_\_\_ Social Security No. \_\_\_\_\_

Race/Ethnicity\* \_\_\_\_\_ Date of Birth (MM-DD-YY) \_\_\_\_\_

Primary Care Provider Name\*\*\* \_\_\_\_\_

Primary Care Provider Address\*\*\* \_\_\_\_\_

Are you a current patient? Yes No

Do you use tobacco products?\*\*\* Yes No

Are you enrolled in a tobacco cessation program? Yes No

Is the tobacco use for Native American or Alaska Native religious or ceremonial purposes? Yes No

**Dependent Child**

Name (First, MI, Last) \_\_\_\_\_

Sex Assigned at Birth (M/F) \_\_\_\_\_ Gender Identity\* \_\_\_\_\_ Social Security No. \_\_\_\_\_

Race/Ethnicity\*\* \_\_\_\_\_ Date of Birth (MM-DD-YY) \_\_\_\_\_

Primary Care Provider Name\*\*\*\* \_\_\_\_\_

Primary Care Provider Address\*\*\*\* \_\_\_\_\_

Are you a current patient? Yes No

Do you use tobacco products?\*\*\* Yes No

Are you enrolled in a tobacco cessation program? Yes No

Is the tobacco use for Native American or Alaska Native religious or ceremonial purposes? Yes No

**Dependent Child**

Name (First, MI, Last) \_\_\_\_\_

Sex Assigned at Birth (M/F) \_\_\_\_\_ Gender Identity\* \_\_\_\_\_ Social Security No. \_\_\_\_\_

Race/Ethnicity\*\* \_\_\_\_\_ Date of Birth (MM-DD-YY) \_\_\_\_\_

Primary Care Provider Name\*\*\*\* \_\_\_\_\_

Primary Care Provider Address\*\*\*\* \_\_\_\_\_

Are you a current patient? Yes No

Do you use tobacco products?\*\*\* Yes No

Are you enrolled in a tobacco cessation program? Yes No

Is the tobacco use for Native American or Alaska Native religious or ceremonial purposes? Yes No

Attach additional pages if needed I have attached \_\_\_\_\_ pages

**7** | **My other insurance information**

Please list the most recent health or dental insurance coverage you or any family members listed on this enrollment form have had, including commercial (employer group or individual insurance), Medicaid, Medicare, Medicare Advantage, Medicare supplemental, or Pediatric Dental coverage.

No prior coverage

Name of other insurance company(ies) (include address and phone if available)

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Type of coverage (check all that apply)

Medical      Vision      Pediatric Dental      Adult Dental

Name(s) of individual(s) covered

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Date coverage began \_\_\_\_/\_\_\_\_/\_\_\_\_ Date coverage ended \_\_\_\_/\_\_\_\_/\_\_\_\_

Is coverage active?    Yes    No    Policy No. \_\_\_\_\_

If group insurance, name of group \_\_\_\_\_

## 8 | **Certify, authorize, and sign**

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

### **Certification of Completeness and Correctness**

It is a crime to knowingly provide false, incomplete, or misleading information for the purpose of fraudulently obtaining health coverage. Penalties may include imprisonment, fines, and denial of benefits.

I affirm that the answers given in this enrollment form are complete and correct and, if this form includes 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. 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.

### **Electronic Communications Consent**

By checking the "Yes" box at the top of the next page, you are affirming consent to receive secured electronic communications from PacificSource regarding your application and/or enrollment status, changes in insurance coverage, and termination of coverage.

Your consent continues while the plan you enroll in is effective. You may, at any time, opt out of electronic communications by contacting the Customer Service Department at **888-977-9299**. You may request a free paper copy of your application and/or enrollment information by contacting us via email at [Individual@PacificSource.com](mailto:Individual@PacificSource.com), or by phone at **866-695-8684**. Electronic communications are offered as a convenience only. Your decision to not receive electronic communications will not affect your enrollment. There is no charge associated with switching to paper.

In order to complete the application electronically, you must have a personal computer or other device capable of accessing the internet and the ability to view and revise Portable Document Format (PDF) files. PacificSource may also send PDF documents to you as part of the application process. You can obtain a free copy of software to view PDF files at <http://get.adobe.com/reader/>. PacificSource takes the security of electronic information and communications seriously. If you have any questions about our encryption, technical hardware or software, or our security policies and procedures, please contact us at [Individual@PacificSource.com](mailto:Individual@PacificSource.com).

I agree:      Yes      No      Email address \_\_\_\_\_

**I (We) have reviewed and understand the authorization above.**

Enrollee/Responsible Party/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_ Relationship \_\_\_\_\_

**If enrolling in coverage:**

Spouse/Domestic Partner Signature \_\_\_\_\_ Date \_\_\_\_\_

Child age 18 or older Signature \_\_\_\_\_ Date \_\_\_\_\_

Child age 18 or older Signature \_\_\_\_\_ Date \_\_\_\_\_

**Required if enrollee is a minor:**

Printed name of Parent or Guardian \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**This enrollment form must be signed and dated. All fields must be completed for this authorization to be valid. Once accepted, PacificSource will provide the policyholder with a copy of this completed form with the policy.**

**9 Producer authorization (Skip to section 10 if you are not working with a producer.)**

I, the insurance producer, have not made any representations to the enrollee about any provisions, benefits, conditions, or limitations of the policy, except through written material furnished by PacificSource. The enrollee has been informed that the effective date of coverage is assigned only by PacificSource. I hereby certify that information supplied to me by the enrollee has been truly and accurately recorded hereon.

Enrollee's Name (printed) \_\_\_\_\_

Producer's Name (printed) \_\_\_\_\_

PacificSource Producer Number \_\_\_\_\_

Producer's Signature \_\_\_\_\_ Date \_\_\_\_\_

**10 How do you prefer to pay for future premiums?**

Your first month's premium must be received by check or money order before your policy will take effect. We will not accept third-party payments except as required by federal law.

**Please select your method of payment for future premium payments. Reminder: Your first month's premium can only be paid with a check or money order.**

Send me a paper bill by mail each month.  
*(Skip to section 11.)*

Automatic withdrawal from my bank account,  
Electronic Funds Transfer (EFT). *The first month's  
payment cannot be made by EFT.*

**We authorize and direct PacificSource Health Plans to withdraw funds as follows:**

Amount of monthly withdrawal \$\_\_\_\_\_ Withdrawals will occur on the 5th of each month.

Select one: Begin transfers on next available date Delay transfers until \_\_\_\_\_(Mo.)

## Bank information

Bank Name \_\_\_\_\_

Account No. \_\_\_\_\_ Routing No. \_\_\_\_\_

## Account type

Checking—attach a voided check      Savings—attach a voided savings withdrawal slip

This authorization will remain in effect until termination by either party. If the individual policy premium changes due to a rate increase, alternate plan selection, or age change of the policyholder, this authorization will automatically be amended to authorize withdrawal of an amount equal to the new premium.

Policyholder's Name (printed) \_\_\_\_\_ Date \_\_\_\_\_

Signature of Bank Account Holder \_\_\_\_\_ Date \_\_\_\_\_

## Important details about the automatic withdrawal of your monthly premiums:

- New accounts may take 30 days to set up. If your policy is accepted and coverage starts sooner than your automatic withdrawal is set up, you may need to pay by check until the funds transfer is in place.
- Transfers occur on the 5th of each month. If the 5th falls on a weekend or a holiday, the transfer will occur on the next business day.
- Transfers will be made for the premium balance due.
- If EFT is not set up prior to the bill date of the second month, you may receive a paper bill for the second month.

## 11 | Are you ready to submit your application?

Are all sections filled in completely?

Have you attached requested paperwork (guardianship documentation, etc.)?

Did you select a policy coverage date on page 2?

Have you included a check or money order for your first month's premium payment?

Have you selected an ongoing payment option and attached a voided check if needed?

(See section 10)

Send your signed, completed enrollment form and attachments to us through one of the following:

**Email:** [Individual@PacificSource.com](mailto:Individual@PacificSource.com)

**Fax:** 541-225-3646

**Mail:** PacificSource Health Plans, PO Box 7068, Springfield, OR 97475-0068

Thank you for enrolling!

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Washington law (RCW 48.43.510) requires an offer of certain health plan information before purchase or selection of a health plan. You can review that information at [PacificSource.com](http://PacificSource.com) or request from our Customer Service team at **888-977-9299**. Available information concerns benefits, required preauthorizations, premiums and cost sharing, in-network providers, appeals and grievances, accreditation, and confidentiality. If you wish to purchase coverage through the Health Benefit Exchange, you must apply directly through them.



## Attestation of Dental Coverage Form (your proof)

Complete and sign the form below, and then send a copy to us along with a copy of the proof from your insurance carrier. PacificSource must receive, within 60 days, reasonable assurance that you (the applicant) obtained or will obtain pediatric dental benefits through a stand-alone Qualified Dental Plan (QDP) per WAC 284-43-5760(1)(b).

Member Name (First, MI, Last) \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Member ID Number \_\_\_\_\_

Name of Dental Carrier \_\_\_\_\_

Effective Date of Dental Policy \_\_\_\_\_

Covered Members on the Dental Policy:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**For assistance in a language other than English, please call us at 888-977-9299, 711.**

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

ATENCION: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (888) 977-9299.

注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 (888) 977-9299。



## 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](mailto: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	يحتوي هذا الإشعار معلومات هامة. يحتوي هذا الإشعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خلال PacificSource Health Plans. ابحث عن التواريخ الهامة في هذا الإشعار. قد تحتاج لاتخاذ اجراء في تواريخ معينة للحفاظ على تغطيتك الصحية او للمساعدة في دفع التكاليف. لك الحق في الحصول 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	បសចកតិដ្ឋនៃនីណីឯបនេះ ម្តួនព័រ័ម្មនយ៉ា៉ា ឯសំខាន់ ។ បសចកតិដ្ឋនៃនីណីឯបនេះ ម្តួនព័រ័ម្មនយ៉ា៉ា ឯសំខាន់ អុំពិំប្រដងរវេ ឬ ការវា រវង រវសម្ភកាមរយ: PacificSource Health Plans។ សូមដសែឯរកកាលរិបចេសំខាន់ចាំចំ ចៅកនុឯបសចកតិដ្ឋនៃនីណីឯបនេះ ។ អ្នកប្រដែលជាប្តែរការរបចេញសកមមភាព ែលកំណែថៃជាកតាសនា នា បែរឹមបីនីឯរកកាលរវា រវង សុខភាពរវសម្ភក ឬបុំកជំនួយបចេញថៃ ។ អ្នកម្តួនសិំផិំលព័រ័ម្មនបនេះ នីឯជំនួយចៅកនុឯភាសារវសម្ភកចោយមិនអុំលុយប រឹយ ។ សូមេរ្យស័ព្ទ (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	<p>본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 PacificSource Health Plans 을 통한 커버리지 에 관한 정보를 포함하고 있습니다.</p> <p>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.</p>
Laotian	<p>ການແຈ້ງການນີ້ ມີຂໍ້ ມູ ນໍ້ສາຄໍ ນ. ການແຈ້ງການນີ້ ມີຂໍ້ ມູ ນໍ້ສາຄໍ ນກໍ່ ງອກ ບໍ່ຄາຍ້ ອງສະໜັ ກຫ ັ້ ການຄໍ ມ ອອງຂອງທ່ ານໂດຍຜ່ ານ PacificSource Health Plans. ຕື່ ບໍ່ງໍ້ສາຄໍ ບກໍ່ ານ ດວ້ ນທ ັ້ ສາຄໍ ນໃນແຈ້ ງການນີ້ . ທ່ ານອາດຈາເບ້ ນຕໍ່ ອງໃຊ້ ເວລາອໍ ດາເນນການໂດຍກໍ່ ານ ດເວລາອໍ ດາເນນ ນອນ ຈະ ຮໍ ກສາການຄໍ ມອອງສຂະພາບຂອງທ່ ານຫ ັ້ ການຊໍ ວຍເຫ ັ້ ອໍ ທມຄໍ າໃຊ້ ຈໍ າຍ. ທ່ ານມີສດທຈະໂດ້ ຮໍ ບໍ່ຂໍ້ ມູ ນ ຂໍ າວສານນີ້ ແລະການຊໍ ວຍເຫ ັ້ ອໃນພາສາຂອງທ່ ານທໍ່ ບມຄໍ າໃຊ້ ຈໍ າຍ. ໂທ (888) 977-9299.</p>
Nepali	<p>यो स चनामाा महत्त्वप र्ु जानकारी छ । यो स चनामाा तपाईंको ो आवेिन वा PacificSource Health Plans का माध्यमबाट प्राप्त हुने सद्ु विबारे महत्त्वपर्ु जानकारी छ । यो सचू नामा भएका महत्त्वपर्ु दमदतहरू ख्याल िनुहु ोस् । तपाईंले पाइरहके ो स्वास्थ्य दबमा पाइरहन वा तपाईंको खचुको भक्तानीमाुसहायता पाउन के ही समयकारवाही िन -सीमामा काम-ुपनु हनसक्छु । तपाईंले यो जानकारी र सहायता आफ्नो मातभू ाषामा दन शल्ु क पाउनु तपाईंको अदिकारः हो (888) 977-9299 मा फोन िनुहु ोस् ।</p>
Norweigen	<p>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.</p>
Pennsylvania Dutch	<p>Die Bekanntmachung gebt wichdichi Auskunft. Die Bekanntmachung 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 beschtimnde Deadlines, so ass du dei Health Coverage bhalde kansch, odder bezaahle helfe kansch. Du hoscht es Recht fer die Information un Hilf in deinre eegne Schprooch griege, un die Hilf koschtet nix. Kansch du (888) 977-9299 uffrufe</p>
Persian	<p>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</p>
Punjabi	<p>ਇਸ ਨੇ ਜਿਸ ਜਵਚ ਖਾਸ ਜਾਣਕਾਰੀ ਹੈ. ਇਸ ਨੇ ਜਿਸ ਜਵਚ PacificSource Health Plans ਵਲੋਤੁਹਾਡੀ ਕਵਰੇਜ ਅਤੇ ਅਰਜੀ ਿਾਰੇ ਮਹਿੰ ਤਵਪ ਰਨ ਜਾਣਕਾਰੀ ਹੈ . ਇਸ ਨੇ ਜਿਸ ਜਵਚ ਖਾਸ ਤਾਰੀਖਾ ਲਈ ਵੇਖੋ. ਜੇਕਰ ਤੁਸੀ ਜਸਹਤਕਵਰੇਜ ਰਿੱਖਣੀ ਹੋਵੇ ਜਾ ਓਸ ਦੀ ਲਾਗਤ ਜਵਿੱ ਚ ਮਦਦ ਦੇ ਇਛੁਿੱ ਕ ਹੋ ਤਾਂ ਤੁਹਾਨ ੂੰ ਆ ਤਮ ਤਾਜਰਖ ਤੋ ਪਜਹਲਾਂ ਕੁਿੱ ਝ ਖਾਸ ਕਦਮ ਚੁਿੱ ਕਣ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ. ਤੁਹਾਨ ੂੰ ਮੁਫਤ ਜਵਚ 'ਤੇ ਆਪਣੀ ਭਾਸਾ ਜਵਿੱ ਚ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਪਰਾਪਤ ਕਰਨ ਦਾ ਅਜਿਕਾਰ ਹੈ. ਕਾਲ (888) 977-9299</p>
Romanian	<p>Prezenta notificare conține informații importante. Această notificare conține informații importante privind cererea sau acoperirea asigurării dumneavoastră 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.</p>

Russian	Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию 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 određene 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	ประกาศนี้มีข้อมูลสำคัญประกาศนี้มีข้อมูลที่สำคัญเกี่ยวกับการการสมัครหรือขอเขตประกันสุขภาพของคุณผ่าน PacificSource Health Plans ดูกำหนดการในประกาศนี้คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่ายคุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่ายโทร (888) 977-9299.
Ukrainian	Це повідомлення містить важливу інформацію. Це повідомлення містить важливу інформацію про Ваше звернення щодо страховального 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.