

Hawaii Region Group Enrollment/Change Form

All fields are required unless marked optional. Please see instructions on page 3 on completing this form; print or type in blue or black ink only. Be sure to staple pages 1 and 2 together, also make a copy for yourself and your employer. Use your copy as a temporary ID after the effective date.

TO BE COMPLETED BY EMPLOYER

COMPANY NAME _____

EMPLOYER PHONE _____

 GROUP NO. SUBGROUP NO. BILLGROUP UNIT EFFECTIVE DATE (MM/DD/YYYY)

ENROLLMENT REASON Check one:

 New hire (complete sections A, B, C, D) Open enrollment (complete sections A, B, C, D)

Date of hire (MM/DD/YYYY) ____/____/____

 COBRA (complete sections A, B, D)

 Loss of other coverage (complete sections A, B, C, D)

 Cancel all coverage (empl. and family) (complete section A)

Qualifying event _____

 Other (please specify) _____

 Date of event
PLAN Check one: HMO Added Choice

IF MAKING A CHANGE, EMPLOYEE MUST COMPLETE THE FOLLOWING:
DELETE DEPENDENTS (Complete sections A, B, C, D)

	DATE
<input type="checkbox"/> Over age limit	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Divorce	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Deceased	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Other (please specify)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

ADD DEPENDENTS (Complete sections A, B, C, D)

	DATE
<input type="checkbox"/> Birth	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Adoption*	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Marriage*	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Loss of other coverage	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Other (please specify)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

OTHER CHANGES (Complete sections A, B, D)

 Name change
 Previous name(s) _____
 Current name _____

 Address (complete sections A, D)
 Telephone (complete sections A, D)

A. EMPLOYEE INFORMATION (PLEASE PRINT)

LEGAL LAST NAME _____	LEGAL FIRST NAME _____	MI _____	SUFFIX <input type="text"/> <input type="text"/>
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PREVIOUS NAME(S)/ALIAS (IF ANY) _____

SOCIAL SECURITY NUMBER <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	MEDICAL RECORD NUMBER (IF ANY) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	DATE OF BIRTH (MM/DD/YYYY) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>
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HOME ADDRESS _____	APARTMENT NUMBER <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
CITY _____	STATE <input type="text"/> <input type="text"/>
PRIMARY PHONE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	ZIP CODE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/>

WORK PHONE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	EMAIL ADDRESS _____
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MAILING ADDRESS (if different from home address) _____	APARTMENT NUMBER <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
CITY _____	STATE <input type="text"/> <input type="text"/>
	ZIP CODE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/>



B. FAMILY INFORMATION

EMPLOYEE LAST NAME _____

SOCIAL SECURITY NUMBER

□□□□-□□-□□□□□□

ADD DELETE

SPOUSE DOMESTIC PARTNER

LAST NAME _____

FIRST NAME _____

MI _____ SUFFIX _____

□□

SOCIAL SECURITY NUMBER

MEDICAL RECORD NUMBER (IF ANY)

DATE OF BIRTH (MM/DD/YYYY)

MALE FEMALE

□□□□-□□-□□□□□□

□□□□□□□□□□□□

□□□□□□□□□□□□

ADD DELETE

DEPENDENT CHILD OTHER

LAST NAME _____

FIRST NAME _____

MI _____ SUFFIX _____

□□

SOCIAL SECURITY NUMBER

MEDICAL RECORD NUMBER (IF ANY)

DATE OF BIRTH (MM/DD/YYYY)

MALE FEMALE

□□□□-□□-□□□□□□

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ADD DELETE

DEPENDENT CHILD OTHER

LAST NAME _____

FIRST NAME _____

MI _____ SUFFIX _____

□□

SOCIAL SECURITY NUMBER

MEDICAL RECORD NUMBER (IF ANY)

DATE OF BIRTH (MM/DD/YYYY)

MALE FEMALE

□□□□-□□-□□□□□□

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□□□□□□□□□□□□

Do any of your dependents above live at another address? YES NO If yes, please complete the following:

Name(s) (Last, First, MI) _____

Address _____

Are any of your listed dependents over the maximum age? If yes, please complete the following:

Name(s) (Last, First, MI) _____

Disabled* _____

Full-time student _____

Name of college, university, or trade school _____

YES NO

YES NO

YES NO

YES NO

C. OTHER COVERAGE INFORMATION

Including yourself, do any of the persons listed above have other coverage? YES NO

Name _____ Insurance carrier name _____ Policy number _____ Telephone number _____

D. Important: Your application cannot be processed without your signature. Please read pages 3 through 5 before signing.

I apply for Health Plan membership for the person(s) listed and agree that we shall abide by the *Group Medical and Hospital Service Agreement, Benefit Schedule, Riders, and Group Face Sheet*, including provisions which require that:

1. Except as provided in the arbitration agreement, excerpted from your Service Agreement on pages 4 and 5 of this enrollment form, any and all claims, disputes, or causes of action arising out of or related to the Service Agreement, its performance or alleged breach, or the relationship or conduct of the parties, including but not limited to any and all claims, disputes, or causes of action based on contract, tort, statutory law, or actions in equity, shall be resolved by binding arbitration. I, on behalf of myself and all family members, hereby (i) acknowledge that I have read and understood the provisions of the arbitration agreement on pages 4 and 5 of this enrollment form, (ii) agree to binding arbitration, and (iii) give up the right to a jury trial.
2. Members must reimburse Kaiser Permanente for care provided or paid for by Kaiser Permanente (from the proceeds of any settlement, judgment, or other payment the Member receives) if the care is for harm caused or alleged to be caused by a third party.
3. I had an opportunity to read the privacy information on page 3 of this form.
4. I certify that I am at least 18 years of age and am an authorized agent for all my family members in our agreement to these terms. I also have the legal authority to contract for this medical insurance for each of the person(s) listed on the enrollment form.

Employee/Applicant signature (Required) _____

Date _____

Employer signature _____

Date _____

*Additional documentation may be required.

KAH2465
Pending regulatory approval





Hawaii Region Group Enrollment/Change Form

KAISER PERMANENTE GROUP ENROLLMENT/CHANGE FORM INSTRUCTIONS

USE THIS FORM TO:

1. Enroll employee, spouse, and dependents.
2. Add dependents to the plan.
3. Delete employee and dependents from the plan.
4. Change name for employee and dependents.
5. Change address for employee.

DEFINITIONS OF TERMS:

1. Spouse—Subscriber's legally married spouse. State of Hawaii does not recognize common law marriage.
2. Dependents—Legal dependents and dependent children up to age 26, or as specified by your group's contract.
3. Address—Subscriber may enroll if living or working in the Hawaii service area of Oahu, Maui, Kauai, Lanai, Molokai, and Hawaii at the time of enrollment.

TO COMPLETE FORM:

1. Please print firmly using a black or blue ballpoint pen.
2. When adding or deleting dependents, always include the employee/subscriber's name.
3. If dependent's address is different than employee's, please indicate on section B.
4. If you need to use another enrollment form, remember to include the subscriber's name on all forms.
5. Subscriber signature is required. Enrollment will not be processed without a signature.
6. Please refer to employer for correct group number, subgroup number, and billgroup unit (required).
7. Return entire enrollment form to employer.
8. Employer, give copy to subscriber to use as a temporary ID card after you sign the enrollment form.
9. Employer, return the remaining pages of the enrollment form to address below:

Kaiser Permanente
 Membership Administration
 P.O. Box 203011
 Denver, CO 80220-9011

PRIVACY INFORMATION

Your privacy is important to us. Our physicians and employees are required to keep your protected health information (PHI) confidential whether it is oral, written, or electronically transmitted. We have policies, procedures, and other safeguards in place to help protect your PHI from improper use and disclosure in all settings, as required by state and federal laws.

We will release your PHI when you give us written authorization to do so, when the law requires us to disclose information, or under certain circumstances when the law permits us to use or disclose information without your permission. For example, in the course of providing treatment, our health care professionals may use and disclose your PHI in order to provide and coordinate your care, without obtaining your authorization.

Your PHI may also be used without your authorization to determine who is responsible to pay for medical care and for other health care operations purposes such as quality assessment and improvement, customer service, and compliance programs. If you are enrolled in Kaiser Permanente through your employer or employee organization, we may be allowed under the law to disclose certain PHI to them, such as information regarding health plan eligibility or payment, or regarding a workers' compensation claim. Sometimes, we contract with others (business associates) to perform services for us and in those cases, our business associates must agree to safeguard any PHI they receive.

Our privacy policies and procedures include information on your right to see, correct or update, and receive copies of your PHI. You may also ask us for a list of our disclosures of your PHI that we are required to track under the law.

For a more complete explanation of our privacy policies, please request a copy of our "Notice of Privacy Practices," which is available at kp.org/privacy or by calling Member Services at 1-800-966-5955.

Arbitration Agreement/Procedure

A. BINDING ARBITRATION

Except as provided below, any and all claims, disputes, or causes of action arising out of or related to this Service Agreement, its performance or alleged breach, or the relationship or conduct of the parties, including but not limited to any and all claims, disputes, or causes of action based on contract, tort, statutory law, or actions in equity, shall be resolved by binding arbitration as set forth in this Service Agreement.

1. This includes but is not limited to any claim asserted:

- (a) By or against a Member, a patient, the heirs or the personal representative of the estate of the Member or patient, or any other person entitled to bring an action for damages, arising from or related to harm to the Member or patient as permitted by applicable federal or Hawaii state law existing at the time the claim is filed ("Member Parties"). For purposes of this section, all family members of the Member or patient who have derivative claims arising from such harm, shall also be deemed "Member Parties" and bound to these arbitration terms;
- (b) On account of death, bodily injury, physical ailment, mental disturbance, or economic loss arising out of the rendering or failure to render medical services or the provision or failure to provide benefits under this Service Agreement, premises liability, or arising out of any other claim of any nature, irrespective of the legal theory upon which the claim is asserted; and
- (c) By or against one or more of the following entities or their employees, officers or directors ("Kaiser Permanente Parties"):
 - (i) Kaiser Foundation Health Plan, Inc.,
 - (ii) Kaiser Foundation Hospitals,
 - (iii) Hawaii Permanente Medical Group, Inc.,
 - (iv) The Permanente Federation, LLC,
 - (v) The Permanente Company, LLC,
 - (vi) Any individual or organization that contracts with an organization named in (i), (ii), (iii), (iv) or (v) above to provide medical services to Health Plan Members, when such contract includes a provision requiring arbitration of the claim made.

2. Notwithstanding any provisions to the contrary in this Service Agreement, the following claims shall not be subject to mandatory arbitration:

- (a) claims for monetary damages within the jurisdictional limit of the Small Claims Division of the District Courts of the State of Hawaii;
- (b) actions for appointment of a legal guardian of a person or property subject to probate laws;
- (c) purely injunctive orders reasonably necessary to protect Kaiser Permanente's ability to safely render medical services under this Service Agreement (such as temporary restraining orders, and emergency court orders).

B. INITIATING ARBITRATION

A demand for arbitration shall be initiated by sending a registered or certified letter to each named party against whom the claim is made, with a notice of the existence and nature of the claim, the amount claimed and a demand for arbitration. Any Kaiser Permanente Parties shall be served by registered or certified letter, postage prepaid, addressed to the Kaiser Permanente Parties in care of the Health Plan at the address set forth in section VII-J of this Service Agreement. The arbitrators shall have jurisdiction only over persons and entities actually served.

C. ARBITRATION PROCEEDINGS

1. Within 30 days after the service of the demand for arbitration, the parties shall agree on a panel of arbitrators from which to select arbitrators or shall agree on particular arbitrators who shall serve for the case. If the parties cannot agree on any panel of arbitrators or particular arbitrators within the 30 days, then the panel of arbitrators shall be that of Dispute Prevention and Resolution, Inc. ("DPR"). Unless the parties agree to any other arbitration service and rules, DPR shall administer the arbitration and its arbitration rules shall govern the arbitration (including rules for selection of arbitrators from a panel of arbitrators, if the parties have not already agreed upon particular arbitrators to serve). Kaiser Permanente shall notify DPR (or such other arbitration service as may be chosen by the parties) of the arbitration within 15 days following the expiration of the 30 day period noted above.

(continues on next page)

Arbitration Agreement/Procedure *(continued)*

2. Within 30 calendar days after notice to Dispute Prevention and Resolution, Inc., the parties shall select a panel of three arbitrators from a list submitted to them by the arbitration service. In all claims seeking a total monetary recovery less than \$25,000.00, and in any other case where the parties mutually agree, a panel of one arbitrator selected by both parties from a list submitted to them by the arbitration service will be allowed. The arbitrator(s) will arrange to hold a hearing in Honolulu (or such other location as agreed by the parties) within a reasonable time thereafter.
3. Limited civil discovery shall be permitted only for
 - (a) production of documents that are relevant and material,
 - (b) taking of brief depositions of treating physicians, expert witnesses and parties (a corporate party shall designate the person to be deposed on behalf of the corporation) and a maximum of three other critical witnesses for each side (i.e., respondents or claimants), and
 - (c) independent medical evaluations.

The arbitrator(s) will resolve any discovery disputes submitted by any party, including entry of protective orders or other discovery orders as appropriate to protect the parties' rights under this paragraph.
4. Any payment for the fees and expenses of the arbitration service and the arbitrator(s) shall be borne one-third by the Member Parties and two-thirds by the Kaiser Permanente Parties.
5. Each party shall bear their own attorney's fees, witness fees, and discovery costs.
6. The arbitrator(s) may decide a request for summary disposition of a claim or particular issue, upon request of one party to the proceeding with notice to all other parties and a reasonable opportunity for the other parties to respond. The standards applicable to such request shall be those applicable to analogous motions for summary judgment or dismissal under the Federal Rules of Civil Procedure.
7. In claims involving benefits and coverage due under this Service Agreement or disputes involving operation of the Plan, Health Plan's determinations and interpretations, and its decisions on these matters are subject to de novo review.
8. The arbitration award shall be final and binding. The Member Parties and Kaiser Permanente Parties waive their rights to jury or court trial.
9. With respect to any matter not expressly provided for herein, the arbitration will be governed by the Federal Arbitration Act, 9 U.S.C. Chapter 1.

D. GENERAL PROVISIONS

All claims based upon the same incident, transaction or related circumstances regarding the same Member or same patient shall be arbitrated in one proceeding (for example, all Member Parties asserting claims arising from an injury to the same Health Plan Member, shall be arbitrated in one proceeding).

A claim for arbitration shall be waived and forever barred if on the date notice thereof is received, the claim, if it were then asserted in a civil action, would be barred by the applicable Hawaii statute of limitations. All notices or other papers required to be served or convenient in the conduct of arbitration proceedings following the initial service shall be mailed, postage prepaid, to such address as each party gives for this purpose. If the Federal Arbitration Act or other law applicable to these arbitration terms is deemed to prohibit any term in this Service Agreement in any particular case, then such term(s) shall be severable in that case and the remainder of this Service Agreement shall not be affected thereby. Class actions and consolidation of parties asserting claims regarding multiple Members or patients are prohibited. The arbitration provisions in this Service Agreement shall supercede those in any prior Service Agreement.

Kaiser Foundation Health Plan, Inc. (Kaiser Health Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats, such as large print, audio, and accessible electronic formats
- Provide 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 the number provided below to talk to an interpreter.

Hawaii 1-800-966-5955

TTY 711

If you believe that Kaiser Foundation Health Plan 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 the Kaiser Civil Rights Coordinator, 711 Kapiolani Blvd, Honolulu, HI 96813, telephone number: 1- 800-966-5955. You can file a grievance by mail or phone. If you need help filing a grievance, the Kaiser 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 or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Help in your Language

English: You have the right to get help in your language at no cost. If you have questions about your application or coverage through Kaiser Permanente, or if this is a notice that requires you to take action by a specific date, call the number provided for your state or region to talk to an interpreter.

አማርኛ (Amharic): ያለምንም ክፍያ በራስዎ ቋንቋ እገዛ የማግኘት መብት አለዎት። ስለ ማመልከቻዎ ወይም ከኪሰር ፐርማኒንቴ Kaiser Permanente ስለሚያገኙት ሽፋን ማንኛውም ጥያቄዎች ካሉዎት፣ ወይም ይህ ማሳወቂያ በግልፅ በተጠቀሰ ቀን ማድረግ ያለብዎ ነገር እንዳለ የሚያስገድድዎ ከሆነ፣ በተጠቀሰው የስልክ ቁጥር ለስቴትዎ ወይም ለክልልዎ ደውለው ከአስተርጓሚ ጋር ይነጋገሩ።

العربية (Arabic): لك الحق في الحصول على المساعدة بلغتك دون تحمل أي تكاليف. إذا كانت لديك استفسارات بشأن طلبك أو تغطيتك التي تقدمها Kaiser Permanente، أو إذا كان هذا الإشعار الذي يتطلب منك اتخاذ إجراء خلال تاريخ محدد، يُرجى الاتصال بالرقم المخصص لولايتك أو منطقتك للتحدث إلى مترجم فوري.

Հայերեն (Armenian): Դուք ունեք Ձեր լեզվով անվճար օգնություն ստանալու իրավունք: Եթե Դուք հարցեր ունեք Ձեր դիմումի կամ Kaiser Permanente-ի վիզոցով Ձեր ծածկույթի վերաբերյալ, կամ եթե սա ծանուցում է, որը պարտադրում է Ձեզ, որպեսզի գործուղություններ ձեռնարկեք մինչև որոշակի ամսաթիվ, ապա զանգահարեք Ձեր նահանգի կամ շրջանի համար տրամադրված հեռախոսահամարով՝ թարգմանչի հետ խոսելու համար:

Bàsòò Wùdù (Bassa): Ɔ mò nì kpé bε m̄ ké gbo-kpá-kpá dyé dé nì miòùn niìn bídí-wùdù mú pídyi. Ɔ jũ ké m̄ dyi dyi-diè-dè b̄é bédé bá nì céè-dè m̄ tò bó dε zò jè dyíé ní, m̄w̄ jũ bá nì kũùn kp̄w̄ jè dyi dyiìn dé Kaiser Permanente múé ní, m̄w̄ Ɖ dyi b̄ǒ d̄ò jũ b̄é m̄ ké dε d̄ò nyu bó wé jéé d̄ò k̄o nì, níí, d̄á n̄b̄à bε wa tòà bó nì b̄ód̄ò m̄w̄ nì gb̄èèò b̄iè, ké nì mu nyo-wuquún-zà-nyò d̄ò gbo wùdùùn.

বাংলা (Bengali): বিনা খরচে আপনার নিজের ভাষায় সাহায্য পাওয়ার অধিকার আপনার আছে। আপনার যদি আপনার আবেদন বা Kaiser Permanente-এর মাধ্যমে পাওয়া কভারেজ নিয়ে কোনো প্রশ্ন থাকে বা এটি যদি কোনো নোটিস হয় যার ফলে আপনার একটি নির্ধারিত দিনের মধ্যে কোনো পদক্ষেপ গ্রহণ করার প্রয়োজন হয়, তাহলে দোভাষীর সাথে কথা বলতে আপনার রাজ্য বা অঞ্চলের জন্য প্রদত্ত নম্বরটিতে ফোন করুন।

California	1-800-464-4000
Colorado	1-800-632-9700
District of Columbia	1-800-777-7902
Georgia	1-888-865-5813
Hawaii	1-800-966-5955
Maryland	1-800-777-7902
Oregon	1-800-813-2000
Virginia	1-800-777-7902
Washington	1-800-813-2000
TTY	711

Cebuano (Bisaya): Anaa moy katungod nga mangayo og tabang sa inyo pinulongan ug kini walay bayad. Kung naa mo pangutana bahin sa inyo aplikasyon o coverage sa Kaiser Permanente, o kung kining pahibalo nanginahanglan sa inyo paglihok sa dili pa usa ka pihon nga petsa, palihug lang pagtawag sa mga numero sa telepono nga gihatag sa imong estado ("state") o rehiyon ("region") para makigstorya sa usa ka interpreter.

中文 (Chinese): 您有權免費以您的語言獲得幫助。如果您對您的Kaiser Permanente申請或承保有任何疑問，或者如果本通知要求您在具體日期之前採取措施，請致電您所在的州或地區的電話，與口譯員進行溝通。

Chuuk (Chukese): Mei wor omw pwuung omw kopwe angei aninis non foosun fonuomw (Chuukese), ese kamo. Ika mei wor omw kapas eis usun omw apilikeison me/ika policy fan nemenien Kaiser Permanente, are ika ei esinesin a erenuk pwe kopwe fori pwan ekoch foror, ka tongeni omw kopwe kori ewe nampa mei kawor faniten omw state ika fonu (asan) iwe eman chon chiakku epwe anisuk non kapasen fonuomw.

Français (French): Une assistance gratuite dans votre langue est à votre disposition. Si vous avez des questions à propos de votre demande d'inscription ou de la couverture par Kaiser Permanente, ou si cet avis vous demande de prendre des mesures à une date précise, appelez le numéro indiqué pour votre Etat ou votre région pour parler à un interprète.

Deutsch (German): Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Falls Sie Fragen bezüglich Ihres Antrags oder Ihres Krankenversicherungsschutzes durch Kaiser Permanente haben oder falls Sie aufgrund dieser Benachrichtigung bis zu bestimmten Stichtagen handeln müssen, rufen Sie die für Ihren Bundesstaat oder Ihre Region aufgeführte Nummer an, um mit einem Dolmetscher zu sprechen.

ગુજરાતી (Gujarati): તમને કોઈ પણ ખર્ચ વગર તમારી ભાષામાં મદદ મેળવવાનો અધિકાર છે. જો તમને Kaiser Permanente મારફતે તમારી અરજી અથવા કવરેજ વિશે પ્રશ્નો હોય, અથવા જો આ નોટિસ હોય જેમાં તમને કોઈ ચોક્કસ તારીખથી પગલાં લેવાની જરૂર હોય, તો દુભાષિયા સાથે વાત કરવા તમારા સ્ટેટ અથવા રીજીયન માટે પૂરા પાડવામાં આવેલ નંબર પર ફોન કરો.

Kreyòl Ayisyen (Haitian Creole): Ou gen dwa pou jwenn èd nan lang ou gratis. Si ou gen nenpòt kesyon sou aplikasyon ou an oswa asirans ou ak Kaiser Permanente, oswa si nan avni sa a gen bagay ou sipoze fè sa a avan yon sèten dat, rele nimewo nou mete pou Eta oswa rejyon ou a pou w ka pale ak yon entèprèt.

‘ōlelo Hawai‘i (Hawaiian): He pono a ua loa‘a no kekahi kōkua me kāu ‘ōlelo inā makemake a he manuahi no ho‘i. Inā he mau nīnau kāu e pili ana i kāu palapala noi ‘inikua ola kino a i ‘ole i kōkua ma‘ō ka polokalamu kōkua ola kino Kaiser Permanente, a i ‘ole inā ke ha‘i nei paha kēia leka nei iā‘oe e hana koke aku i kēia ma mua o kekahi lā i waiho ‘ia, e kelepona aku i ka helu i loa‘a ma kēia leka nei no kāu moku‘āina a i ‘ole pana‘āina no ka wala‘au ‘ana me kekahi kanaka unuhi ‘ōlelo.

हिन्दी (Hindi): आपको बिना किसी कीमत चुकाए आपकी भाषा में सहायता पाने का अधिकार है। यदि आप आपके आवेदन पत्र के विषय में या Kaiser Permanente के कवरेज के विषय में कुछ पूछना चाहते हैं या यदि यह एक नोटिस है जिसके कारण आपको किसी विशेष तिथि तक कारवाई करनी पड़ेगी तो आपके राज्य या क्षेत्र के लिए दिए गए नंबर पर फोन करके किसी दुभाषिये से बात करें।

Hmoob (Hmong): Koj muaj cai kom tau txais kev pab uas hais koj hom lus yam tsis tau them nqi. Yog koj muaj lus nug txog koj daim ntawv thov los yog cov kev pab them nyiaj tim Kaiser Permanente, los yog tias daim ntawv no yog ib tsab ntawv ceebtoom uas yuav kom koj ua ib yam dabtsi raws li hnuv tau teev tseg, hu rau tus nab npawb xovtooj uas tau muab rau koj lub xeev lossis cheeb tsam kom tau tham nrog tus kws txhais lus.

Igbo (Igbo): ! nwere ikike inweta enyemaka n'asusụ gi na akwughị ugwo ọ bụla. Ọ bụrụ na ị nwere ajụjụ gbasara akwukwọ anamachoihe gi ma ọ bụ mkpuchi si na Kaiser Permanente, ma ọ bụ ọ bụrụ na nke bụ ọkwa a chọrọ ka ị mee ihe tupu otu ụbọchi, kpọọ nomba enyere maka steeti ma ọ bụ mpaghara gi iji kwukọrịta okwu n'etiti onye ọkwa okwu.

Iloko (Ilocano): Adda ti karbenganyo a dumawat iti tulong iti pagsasaoyo nga awan ti bayadanyo. No addaankayo kadagiti saludsod maipanggep ti aplikasionyo wenno coverage babaen ti Kaiser Permanente, wenno no daytoy ket maysa a pakdaar a kalikagumanna a rumbeng nga aramidenyo ti addang iti espesipiko a petsa, tawagan ti numero nga inpaay para ti estado wenno rehiyon tapno makipatang ti maysa mangipatarus iti pagsasao.

Italiano (Italian): Hai il diritto di ricevere assistenza nella tua lingua gratuitamente. In caso di domande riguardanti la tua richiesta o la copertura attraverso Kaiser Permanente, o se occorre intervenire entro una data specifica secondo quanto indicato in questa comunicazione, chiama il numero fornito per il tuo stato o la tua regione per parlare con un interprete.

日本語 (Japanese): あなたは、費用負担なしでご使用の言語で支援を受ける権利を保持しています。お申し込みまたはKaiser Permanenteの担保範囲に関してご質問があるか、または本通知により、あなたが特定の日付までに行動を起こすよう依頼されている場合、お住まいの州または地域に対して提供された電話番号に電話して、通訳とお話ください。

ខ្មែរ (Khmer): អ្នកមានសិទ្ធិទទួលបានជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ បើសិនអ្នកមានសំណួរណាមួយអំពីពាក្យស្នើសុំប្រការធានារ៉ាប់រងតាមរយៈ Kaiser Permanente ឬប្រសិននេះគឺជាលិខិតជូនដំណឹងដែលតម្រូវឲ្យអ្នកចាត់វិធានការត្រឹមកាលបរិច្ឆេទជាក់លាក់ សូមទូរស័ព្ទទៅលេខដែលបានផ្តល់ជូនសម្រាប់រដ្ឋឬតំបន់របស់អ្នកដើម្បីនិយាយទៅកាន់អ្នកបកប្រែ។

한국어 (Korean): 귀하에게는 한국어 통역서비스를 무료로 받으실 수 있는 권리가 있습니다. Kaiser Permanente를 통한 귀하의 보험 신청서나 보험 보장 범위에 관해 질문이 있을 경우 또는 이 통지서의 요구대로 어느 날짜까지 조치를 취해야만 하는 경우, 귀하의 주 및 지역의 제공된 전화번호로 연락해 통역사와 통화하십시오.

ລາວ (Laotian): ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໂດຍບໍ່ເສັຽຄ່າ. ຖ້າວ່າ ທ່ານມີຄໍາຖາມກ່ຽວກັບການສະໝັກຂອງທ່ານ ຫຼື ການຄຸ້ມຄອງຜ່ານ Kaiser Permanente, ຫຼື ຖ້າອັນນີ້ເປັນແຈ້ງການທີ່ຮຽກຮ້ອງໃຫ້ທ່ານດໍາເນີນການພາຍໃນວັນທີ່ທີ່ເຈາະຈົງໃດໜຶ່ງ, ໃຫ້ໂທຕາມໝາຍເລກທີ່ໃຫ້ໄວ້ສໍາລັບລັດ ຫຼື ເຂດຂອງທ່ານ ເພື່ອຂໍລິມັດຖານພາສາ.

Kajin Majōl (Marshallese): Ewōr jimwe eo aṃ in bōk jipañ ilo kajin eo aṃ ejjelōk wōṇāān. Ñe ewōr aṃ kajitōk kōn peba in aplaiki eo aṃ ak insurance eo aṃ jān Kaiser Permanente, ak ñe enaan in kōjelā in ej aikuj bwe kwōn ṃakūtūt ṃokta jān juon raan eo eṃōj an kallikkar, kaḷok nōṃba eo ej leḷok ñan state eo aṃ ak jikūṃ bwe kwōn maroñ kōnono ippān juon ri-ukōt.

Naabeehó (Navajo): T’áá ni nizaad bee níká i’ doolwoł doo bik’ é asíníłáágóó éí bee náhaz’ á. Kaiser Permanente áká aná’ álwo’ ná bik’ é azláadoo yíníkeedgo naaltsoos hadinílaa, éí bína’ ídíłkíd doogo, éí doodago díí naaltsoos haa’ ída yookááłgo hait’ áoda í’ dííłíł níłniigo éí nitsaa hahoodzojí éí doodago t’ áá aadi nahós’ a’ di ata’ dahalne’ ígíí bich’ í’ hólne’ go bee bíł ahíł hodíílnih.

नेपाली (Nepali): तपाईंसंग कुनै शुल्क नदिइ आफ्नो भाषामा सहायता पाउने अधिकार छ । तपाईंसंग आफ्नो आवेदन बारे वा Kaiser Permanente माफत कवरेज बारेमा कुनै प्रश्नहरू भए, वा यो नोटिस अनुसार तपाईंले कुनै निर्धारित मितिमा कुनै कार्यवाही गर्नु पर्ने आवश्यकता भएमा, दोभाषेसंग कुराकानी गर्न तपाईंको राज्य वा क्षेत्रका लागि दिइएको नम्बरमा कल गर्नुहोस् ।

Afaan Oromoo (Oromo): Baasii malee afaan keetiin gargaarsa argachuudhaaf mirga qabda. Waa’ee iyyata keetii yookaan tajaajila Kaiser Permanente hammatu ilaalchisee gaaffii yoo qabaatte, yookaan yoo kun beeksisa guyyaa murtaa’e irratti tarkaanfii akka ati fudhattu gaafatu ta’e, lakkoofsa bilbilaa naannoo yookaan goodina keetiif kenname bilbiluudhaan turjumaana haasofsiisi.

فارسی (Persian): شما حق دارید که بدون هیچ هزینه ای به زبان خود کمک دریافت کنید. اگر درباره درخواست یا پوشش خود در Kaiser Permanente سوالی داشته یا بر اساس این اعلامیه باید تا تاریخ مشخصی اقدامی بعمل آورید، برای صحبت با یک مترجم شفاهی با شماره تلفن ارائه شده برای ایالت یا منطقه خود تماس بگیرید.

lokaiahn Pohnpei (Pohnpeian): Komw anehki pwung en rapahki sounkawehwe en omw palien lokaia ni sohte isaihs. Ma mie iren owmi kalelapak ohng aplikeisin de iren audepe kan ohng Kaiser Permanente, de ma pakair wet me anahne komwi en mwekid ohng rahn me kileledi, ah komw anahne koahl nempe me sansalehr ohng owmi palien wehi pwe komwi en lokaiaieng owmi tungoal soun kawehwe.

Português (Portuguese): Você tem o direito de obter ajuda em seu idioma sem nenhum custo. Se você tiver dúvidas sobre sua solicitação ou cobertura por meio da Kaiser Permanente, ou se este aviso exigir que você tome alguma medida até uma data específica, ligue para o número fornecido para seu estado ou região para falar com um intérprete.

ਪੰਜਾਬੀ (Punjabi): ਤੁਹਾਨੂੰ ਬਿਨਾਂ ਕਿਸੇ ਸੁਲਕ ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਮਦਦ ਪਾਉਣ ਦਾ ਹੱਕ ਹੈ। ਜੇਕਰ ਤੁਹਾਡੇ ਆਪਣੀ ਅਰਜ਼ੀ ਜਾਂ Kaiser Permanente ਰਾਹੀਂ ਕਵਰੇਜ ਬਾਰੇ ਸਵਾਲ ਹਨ, ਜਾਂ ਇਸ ਨੋਟਿਸ ਵਜੋਂ ਤੁਹਾਨੂੰ ਕਿਸੇ ਨਿਸ਼ਚਿਤ ਮਿਤੀ ਤੱਕ ਕਾਰਵਾਈ ਕਰਨ ਦੀ ਲੋੜ ਪਵੇ, ਤਾਂ ਦੁਬਾਰੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ ਆਪਣੇ ਰਾਜ ਜਾਂ ਇਲਾਕੇ ਲਈ ਮੁਹੱਈਆ ਕਰਵਾਏ ਗਏ ਨੰਬਰ ਤੇ ਫ਼ੋਨ ਕਰੋ।

Română (Romanian): Aveți dreptul de a solicita ajutor care să vă fie oferit în mod gratuit în limba dumneavoastră. Dacă aveți întrebări legate de solicitarea dumneavoastră sau de acoperirea oferită de Kaiser Permanente sau dacă acest aviz vă solicită să luați măsuri până la o anumită dată, sunați la numărul de telefon furnizat pentru statul sau regiunea dumneavoastră pentru a sta de vorbă cu un interpret.

Русский (Russian): У вас есть право получить бесплатную помощь на своем языке. Если у вас имеются вопросы относительно вашего заявления или медицинского страхования в Kaiser Permanente, либо если такое уведомление требует от вас каких-либо действий к определенной дате, позвоните по номеру телефона для своего штата или региона, чтобы поговорить с переводчиком.

Faa-Samoa (Samoan): E iai lou 'aia e maua se fesoasoani i lou gagana e aunoa ma le totogi. Afai e iai ni fesili e uiga i lou tusi apalai po o puipuiga e ala mai Kaiser Permanente, po o lenei tusi e manaomia ona e gaoioi i se taimi atofaina, vili le numera ua fuafuaina mo lou setete po o oganuu e fesoota'i i se faaliliu.

Español (Spanish): Usted tiene derecho a obtener ayuda en su idioma sin costo alguno. Si tiene preguntas acerca de su solicitud o cobertura a través de Kaiser Permanente, o si este es un aviso que requiere que usted tome alguna medida antes de una fecha determinada, llame al número de teléfono que se proporciona para su estado o región para hablar con un intérprete.

Tagalog (Tagalog): Mayroon kang karapatang humingi ng tulong sa iyong wika nang walang bayad. Kung mayroon kang mga katanungan tungkol sa iyong aplikasyon o coverage sa pamamagitan ng Kaiser Permanente, o kung ito ay abisong nangangailangan ng iyong aksyon sa tiyak na petsa, tumawag sa numerong ibinigay para sa iyong estado o rehiyon para makipag-usap sa isang interpreter.

ไทย (Thai): ท่านมีสิทธิที่จะได้รับความช่วยเหลือในภาษาของท่านโดยไม่เสียค่าใช้จ่าย หากท่านมีคำถามเกี่ยวกับการสมัครของท่าน หรือความคุ้มครองผ่าน Kaiser Permanente หรือหากนี่คือหนังสือที่ต้องการให้ท่านดำเนินการภายในวันที่ที่กำหนดไว้ โปรดติดต่อหมายเลขที่ให้ไว้สำหรับรัฐหรือเขตพื้นที่ของท่านเพื่อคุยกับล่าม

Lea Faka-Tonga (Tongan): 'Oku 'ia ho totonu ke ke ma'u ha fakatonulea ta'etotongi. Kapau 'oku 'i ai ha'o fehu'i ki ho tohi kole na'e fakafonu ki he malu'i 'inisiua 'a e Kaiser Permanente, pea kapau ko e tohina 'oku fiema'u keke fai ha me'a ki ai pe ko ha 'aho na'e tuku pau atu ke fai ia, taa ki he fika kuo 'oatu ki ho siteiti pe ko e vahefonua 'oku ke 'i ai ke talanoa mo ha tokotaha tene fakatonu lea atu kiate koe.

Українська (Ukrainian): У Вас є право на отримання допомоги безкоштовно на Вашій рідній мові. Якщо Ви маєте питання стосовно Вашого звернення чи страхового покриття в Kaiser Permanente, чи якщо відповідно до такого повідомлення Вам треба буде здійснити певну дію до конкретної дати, подзвоніть по номеру, що відповідає Вашій країні чи регіону, щоб поговорити з перекладачем.

اردو (Urdu): آپ کو کوئی بھی قیمت ادا کئے بغیر اپنی زبان میں مدد حاصل کرنے کا حق ہے۔ اگر آپ کے ذہن میں اپنی درخواست یا Kaiser Permanente کے ذریعہ کوریج کے متعلق کوئی بھی سوالات ہیں، یا اگر اس نوٹس کی وجہ سے آپ کو کسی مخصوص تاریخ تک عمل انجام دینے کی ضرورت ہوگی تو، کسی مترجم سے بات چیت کرنے کے لئے آپ کی ریاست یا علاقہ کے لئے فراہم کئے گئے نمبر پر کال کریں۔

Tiếng Việt (Vietnamese): Quý vị có quyền được nhận trợ giúp miễn phí bằng ngôn ngữ của mình. Nếu quý vị có các câu hỏi về mẫu đơn hoặc mức bảo hiểm của mình thông qua Kaiser Permanente, hoặc đây là thông báo yêu cầu quý vị thực hiện vào một ngày cụ thể, hãy gọi đến số điện thoại được cung cấp cho bang hoặc khu vực của quý vị để trò chuyện với phiên dịch viên.

Yorùbá (Yoruba): O ní ètò láti rí ìrànṣẹ̀wọ̀ gbà nípa èdè rẹ̀ láìsán owó. Bí o bá ní ìbèèrè nípa iwé tí o kọ tàbí ìṣedéédé nípaṣẹ̀ Kaiser Permanente, tàbí ifitonilétí yíì jẹ̀ èyí o nílò láti ìgbésẹ̀ kan ní ojọ kan patọ̀, pé nọmbà tí a pèsè fún ìpínlẹ̀ tàbí agbègbè rẹ̀ láti bá òhgbifọ̀ kan sọrọ̀.