

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

☐ Over age limit

☐ Divorce

☐ Deceased

☐ Other (please specify)

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

DATE

☐ Birth

☐ Adoption*

☐ Marriage*

☐ Loss of other coverage

☐ Other (please specify)

OTHER CHANGES (Complete sections A, B, D)

☐ Name change

Previous name(s) _____

☐ Address (complete sections A, D)

☐ Telephone (complete sections A, D)

Current name _____

A. EMPLOYEE INFORMATION (PLEASE PRINT)

LEGAL LAST NAME

LEGAL FIRST NAME

MI

SUFFIX

PREVIOUS NAME(S)/ALIAS (IF ANY) _____

SOCIAL SECURITY NUMBER

MEDICAL RECORD NUMBER (IF ANY)

DATE OF BIRTH (MM/DD/YYYY)

MALE FEMALE UNIDENTIFIED

 -

☐ ☐ ☐
☐

HOME ADDRESS

APARTMENT NUMBER

CITY

STATE

ZIP CODE

PRIMARY PHONE

WORK PHONE

EMAIL ADDRESS

MAILING ADDRESS (if different from home address)

APARTMENT NUMBER

CITY

STATE

ZIP CODE



B. FAMILY INFORMATION

EMPLOYEE LAST NAME

SOCIAL SECURITY NUMBER

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ADD ☐ DELETE ☐SPOUSE ☐ DOMESTIC PARTNER ☐

LAST NAME

FIRST NAME

MI

SUFFIX

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SOCIAL SECURITY NUMBER

MEDICAL RECORD NUMBER (IF ANY)

DATE OF BIRTH (MM/DD/YYYY)

MALE FEMALE UNIDENTIFIED

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ADD ☐ DELETE ☐DEPENDENT ☐ CHILD ☐ OTHER ☐

LAST NAME

FIRST NAME

MI

SUFFIX

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SOCIAL SECURITY NUMBER

MEDICAL RECORD NUMBER (IF ANY)

DATE OF BIRTH (MM/DD/YYYY)

MALE FEMALE UNIDENTIFIED

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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 UNIDENTIFIED

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

Name	Insurance carrier name	Policy number	Telephone number
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D. Important: Your application cannot be processed without your signature. Please read pages 4 through 7 before signing.I apply for Health Plan membership for the person(s) listed and agree that we shall abide by *Kaiser Permanente Hawaii's Guide to Your Health Plan (Guide)*, including provisions which require that:

1. Except as provided in the arbitration agreement, excerpted from your Guide on pages 4 through 7 of this enrollment form, any and all claims, disputes, or causes of action arising out of or related to the Guide, 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 through 7 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 the cover sheet 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.

KAH3462

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. Detach and return entire enrollment form (white, yellow, and pink copies) to employer.
8. Employer, give pink 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 23127, San Diego, CA 92193-9921
 Email: 18553555334@fax.kp.org | Fax: 1-855-355-5334

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 Kaiser Permanente Hawaii's Guide to Your Health Plan (Guide), 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 Guide.

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 Guide, 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 Guide, 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 Guide (such as temporary restraining orders, and emergency court orders).
 - (d) for members of Groups, claims for benefits under Section 502(a)(1)(B) of the Employee Retirement Income Security Act (ERISA); and equitable claims for third party liability lien rights under Section 502(a)(3) of ERISA.

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Arbitration Agreement/Procedure *(continued)*

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 as follows: Kaiser Foundation Health Plan, Inc., Member Services, 711 Kapiolani Boulevard, Honolulu, Hawaii 96813. 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.
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 Guide 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.

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Arbitration Agreement/Procedure *(continued)*

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 Guide in any particular case, then such term(s) shall be severable in that case and the remainder of this Guide 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 Guide shall supercede those in any prior Guide.

E. ARBITRATION CONFIDENTIALITY

Neither party nor the arbitrator(s) may disclose the substance of the arbitration proceedings or award, except as required by law or as necessary to file a motion regarding the award pursuant to the Federal Arbitration Act, in any federal or state court of appropriate jurisdiction within Hawaii, and in that event, the parties will take all appropriate action to request that the records of the arbitration be submitted to the court under seal.

F. SPECIAL CLAIMS

1. Medical Malpractice Claims. Prior to initiating any arbitration proceedings alleging medical malpractice, Member Parties shall first submit the claim to a Medical Inquiry and Conciliation Panel pursuant to Chapter 671, Hawaii Revised Statutes (HRS), Sections 11-19. If the claim has not been withdrawn or settled, Member Parties shall serve a demand for arbitration on Kaiser Permanente Parties as specified in the Initiating Arbitration section.
2. ERISA Claims (applies only to private employer Groups). If the Member Party's plan is governed by ERISA (for private employer Groups), and the Member Party has a claim for benefits that is denied or ignored (in whole or in part), the Member Party may file suit in federal court under Section 502(a)(1)(B) of ERISA. The court will decide who should pay court costs and legal fees. If the Member Party is successful, the court may order the person or entity the Member Party has sued to pay these costs and fees. If the Member Party loses, the court may order the Member Party to pay these costs and fees, for example, if it finds the Member Party's claim is frivolous. If the Member Party has any questions about the Member Party's plan, the Member Party should contact the plan administrator, i.e., the Member Party's employer or group sponsor.

Although benefit-related claims subject to ERISA are not required to be resolved by binding arbitration pursuant to this section, Member Parties may still make a voluntary election to use binding arbitration to resolve these claims, instead of court trial, by filing a demand for arbitration upon Kaiser Permanente Parties pursuant to the provisions of the Initiating Arbitration section. If a voluntary election to use binding arbitration is made by a Member Party, the arbitration shall be conducted pursuant to the Binding Arbitration section.

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Arbitration Agreement/Procedure *(continued)*

3. External Appeal of Internal Review Decisions.

If you disagree with Kaiser Permanente's final internal determination, you shall request binding arbitration pursuant to the procedures in this Guide subject to the rights in the ERISA claims section. In addition to the arbitration procedures set forth in this Guide, HRS Chapter 432E also creates certain external review rights for Members of state or county employee Groups, certain employee disability or qualified church plans, and employer Groups subject to ERISA to submit a request for external review to the State Insurance Commissioner within 130 days from the date of Kaiser's final interim determination. These rights are subject to the limitations noted at the end of this Section, and subject to the requirements and limitations in HRS Chapter 432E (including exhausting all of Kaiser Permanente's internal complaint and appeals procedures before requesting external review, except as specified in Chapter 432E for situations when simultaneous external review is permitted to occur or Kaiser Permanente has failed to comply with federal requirements regarding its claims and appeals process). A complete description of Kaiser Permanente's claims and appeals process is described in the Appeals section of the Guide.

Chapter 432E external reviews are limited to situations where (a) the complaint is not for allegations of medical malpractice, professional negligence or other professional fault by health care providers, and (b) the complaint relates to an adverse action as defined in HRS Chapter 432E. An adverse action is a Health Plan determination that a health care service that is a covered benefit has been reviewed and denied, reduced or terminated because it does not meet Health Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness. Health Plan objects to external reviews under Chapter 432E which do not meet these criteria and reserves its full rights and remedies in this regard. The recitation of State law provisions shall not be deemed to constitute any waiver of such objections.

NONDISCRIMINATION NOTICE

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 **1-800-966-5955** (TTY: 711)

If you believe that Kaiser 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 by mail or phone at:

Membership Services

Attn: Kaiser Civil Rights Coordinator

711 Kapiolani Blvd

Honolulu, HI 96813

1-800-966-5955

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

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-966-5955** (TTY: **711**).

Cebuano (Bisaya) ATENSYON: Kung nagsulti ka og Cebuano, aduna kay magamit nga mga serbisyo sa tabang sa lengguwahe, nga walay bayad. Tawag sa **1-800-966-5955** (TTY: **711**).

中文 (Chinese) 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 **1-800-966-5955** (TTY: **711**)。

Chuuk (Chukese) MEI AUCHEA: Ika iei foosun fonuomw: Foosun Chuuk, iwe en mei tongeni omw kopwe angei aninisin chiakku, ese kamo. Kori **1-800-966-5955** (TTY: **711**).

‘Ōlelo Hawai‘i (Hawaiian) E NĀNĀ MAI: Inā ho‘opuka ‘oe i ka ‘ōlelo Hawai‘i, hiki iā ‘oe ke loa‘a i ke kōkua manuahi. E kelepona i ka helu **1-800-966-5955** (TTY: **711**).

Iloko (Ilocano) PAKDAAR: No agsasaoka iti Ilokano, dagiti awan bayadna a serbisio a para iti beddeng ti lengguahe ket sidadaan para kenka. Awagan ti **1-800-966-5955** (TTY: **711**)

日本語 (Japanese) 注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-966-5955** (TTY: **711**) まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-966-5955** (TTY: **711**) 번으로 전화해 주십시오.

ລາວ (Laotian) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການ ບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍ ບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-966-5955 (TTY: **711**).

California	1-800-464-4000
Colorado	1-800-632-9700
District of Columbia	1-800-777-7902
Georgia	1-800-865-5813
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

Kajin Majōl (Marshallese) LALE: Ñe kwōj kōnono Kajin Majōl, kwomaroñ bōk jermal in jipañ ilo kajin ñe am ejjelōk wōñāān. Kaalōk **1-800-966-5955** (TTY: **711**).

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yánílti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, koji' hódíílnih **1-800-966-5955** (TTY: **711**).

Lokaiahn Pohnpei (Pohnpeian) MEHN KAIR: Ma komw kin lokaiahn Pohnpei, wasahn sawas en palien lokaia kak sawas ni sohte isais. Koahl nempe **1-800-966-5955** (TTY: **711**).

Faa-Samoa (Samoan) MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoani, e fai fua e leai se totogi, mo oe, Telefoni mai: **1-800-966-5955** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-966-5955** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-966-5955** (TTY: **711**).

Lea Faka-Tonga (Tongan) FAKATOKANGA'I: Kapau 'oku ke Lea Faka-Tonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea teke lava 'o ma'u ia. Telefoni mai **1-800-966-5955** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-966-5955** (TTY: **711**).