

# Individual Coverage Application

## For Off-Marketplace Plans—For New and Renewing Coverage

*This application must be completed in its entirety or processing time may be delayed. Applicants must reside within the Health First Health Plans service area to be eligible for coverage.*

**Send original completed application to:**

**Health First Health Plans**  
**Attention: Sales**  
 6450 US Highway 1  
 Rockledge, Florida 32955

[myHFHP.org](http://myHFHP.org)

Sales Department: Toll-free **1.877.904.4914**

E-mail: [individualinsurance@hf.org](mailto:individualinsurance@hf.org) ■ TDD/TTY:

1.800.955.8771

November 1–December 15: Call weekdays 8 am to 6 pm

December 16–October 31: Call weekdays 8 am to 5 pm

### Application requirements and instructions

- This Application must be filled out by the Applicant. You (the Applicant) are responsible to guarantee the information provided is accurate, complete, and truthful. Failure to complete any section will result in a delay in processing your application.
- **Do not cancel any health insurance coverage you currently have or decline COBRA benefits until you receive notice of acceptance from Health First Health Plans.** Please retain a copy of this application for your records.
- Any misrepresentation of information on the Application may result in cancellation of coverage.
- Any family member of an Applicant who is age 18 or older must also sign and date the Application.
- All eligible family members must apply on one application.
- A dependent from age 26 to age 30 must meet the eligibility requirements in accordance with Florida law.
- To obtain coverage for a member's newborn or adopted child outside of the annual open enrollment period, a policyholder must complete and submit an Individual Coverage Application or Change Form within sixty (60) days of the child's birth or placement in the home. Send the completed Application, with first month's premium payment, if applicable, to Health First Health Plans at the address above.
- Please be advised that your quoted premium may be adjusted by Health First Health Plans as a result of enrollment fees, billing options, benefit/plan changes, available effective dates, age/birth date, or any other relevant factors.
- Health First Health Plans complies with all federal regulations including guarantee issue provisions as outlined in the Health Insurance Portability and Accountability Act (HIPAA), and in the Affordable Care Act (ACA).
- Please enter your benefit plan selection in Section 3 of the Application.
- All information is confidential.

**Must be completed in blue or black ink.**

### Section 1: PRIMARY APPLICANT INFORMATION

Primary Applicant's Name/Last			First	M.I.	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married			Language		
Home Address (No P.O. Box): Street		Apt.	City	State	Zip
Home phone (    )	Work phone (    )	Cell phone (    )	Other (    )	Best time to call <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Any	
E-mail address _____			By providing my email address, I am authorizing Health First Health Plans to send any and all communications regarding this Application via secure email.		

**Section 2: ADDITIONAL APPLICANT INFORMATION**

	Sex	Name (Last, First, MI)	US citizen?	Social Security Number	Date of Birth (MM/DD/YYYY)	Tobacco use in the past 6 months?
1	M / F	Primary Applicant	Yes / No	____ - ____ - ____	___/___/____	Yes / No
2	M / F	Spouse	Yes / No	____ - ____ - ____	___/___/____	Yes / No
3	M / F	Dependent Child	Yes / No	____ - ____ - ____	___/___/____	Yes / No
4	M / F	Dependent Child	Yes / No	____ - ____ - ____	___/___/____	Yes / No
5	M / F	Dependent Child	Yes / No	____ - ____ - ____	___/___/____	Yes / No
6	M / F	Dependent Child	Yes / No	____ - ____ - ____	___/___/____	Yes / No
7	M / F	Child of Dependent Child	Yes / No	____ - ____ - ____	___/___/____	Yes / No
8	M / F	Child of Dependent Child	Yes / No	____ - ____ - ____	___/___/____	Yes / No

I attest that the children listed on this application are my legal dependents. Initial \_\_\_\_\_

**Section 3: PLAN SELECTION**

**Medical plan**—All medical plans are compliant with the Affordable Care Act and cover all required Essential Health Benefits, including Pediatric Dental and Vision. Please mark your plan choice:

Plan name: \_\_\_\_\_ Plan number (4 digits): \_\_\_\_ \_ \_ \_  
 (For example "Health First HMO 60") (For example "1750")

**Requested effective date**

(Health First will attempt to provide you with the requested effective date however the requested effective date is not guaranteed.)

\_\_Jan. \_\_Feb. \_\_Mar. \_\_April \_\_May \_\_June \_\_July \_\_Aug. \_\_Sept. \_\_Oct. \_\_Nov. \_\_Dec.

**Section 4: PRIOR/OTHER COVERAGE** *Optional for renewing members*

**A.** Have you or any Applicant ever been a member of an individual or group plan with Health First?  Yes  No  
 If yes, please provide the member's name and Policy number:

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

**B.** Do you or any applicant have health insurance coverage which ended within the last 60 days?  Yes  No  
 If yes, please provide Applicant's name, insurance company's information, type of coverage, effective date, and termination date:

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

**C. Do you or any applicant currently have health insurance?**

Complete this section only if you or any of your dependents have other health coverage that will not be cancelled when the coverage under this application becomes effective. List names of each individual covered. If you and/or your dependents will not have other coverage, please initial \_\_\_\_\_.

Group Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No					Name and Address of Other Insurance Carrier					
Effective Date (MM/DD/YYYY)			Type of Policy <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Family							
Name of Policyholder (First, Last)						Birth Date (MM/DD/YYYY)		<input type="checkbox"/> Male <input type="checkbox"/> Female		
Relationship to Applicant <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent			Employer's Name				Coverage Start Date (MM/DD/YYYY)			
Group Number			Policy Number							
Other Group Medical Coverage Information (only list those covered by other plan)			Type (B/S/F)*	Effective Date	End Date	Name & Date of Birth of policyholder for other coverage				
Spouse Name:										
Dependent Name:										
Dependent Name:										
Dependent Name:										
*B. Enter 'B' when this dependent is covered under both you and your spouse's insurance plan (married). S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses. F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.										
I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. Initial _____										

**Section 5: CONDITIONS of ENROLLMENT** Please carefully read the information below.

**GENERAL CONDITIONS:** Coverage will only apply to services provided on or after the effective date of coverage.

**PAYMENT OF PREMIUM:** Please note that this coverage is not to be sold as a commercial group policy. Each Applicant is responsible for the initial premium as well as any future payments. If funds are drawn from a business account, I certify that I am the business owner and the payments are for myself and/or other Applicants as individuals and not as employees. I understand that payments from a business account are not for employees or others outside of my immediate family. Refund of premium is only payable to the primary Applicant. If your policy terminates due to non-payment of premium, Health First Health Plans has the right to apply to any past-due premium amounts owed, the initial premium payment made for new coverage within the 12-month period and past-due balances accumulated within the previous 12-month period prior to the coverage start date may be required before any new coverage commences.

**BINDING AGREEMENT:** The applicable Health First Health Plans Certificate of Coverage and this Application, (collectively the "Contract"), shall constitute the entire agreement between the Applicant(s) and Health First Health Plans. The Applicant(s) hereby agree to be bound by the terms and conditions as set forth in the Contract if accepted for coverage in accordance herewith. **PLEASE RETAIN A COPY OF THIS APPLICATION FOR YOUR RECORDS.**

The Applicant's signature below shall constitute acceptance

of the Contract on behalf of such Applicant and the primary Applicant's signature shall constitute acceptance of the Contract for any Dependent Applicant(s) who are under the age of 18, as listed in Section 2 above.

I hereby agree that the Contract shall automatically renew on January 1 of each year and any benefit changes required to comply with the Affordable Care Act or state statutes will be included as of that effective date subject to any and all amendments to the Contract, including rate or benefit changes, as determined by Health First Health Plans or elected by me on behalf of myself and all Applicants, without my express consent unless I, any Applicant, or Health First Health Plans determines to terminate the Contract in accordance with its terms.

**OMISSION CLAUSE:** I represent that all statements and answers made in this document, by whomsoever written including its reverse side and on any attached papers, are complete, true and correct to the best of my knowledge. I agree that this shall be the basis of my and all Applicants' acceptance of enrollment with Health First. I understand that Health First Health Plans will rescind coverage only due to an act or practice constituting fraud or an intentional misrepresentation of a material fact.

**COUNTERPARTS:** This Application may be executed in multiple counterparts, each of which shall be deemed an original and all of which together shall constitute a single agreement.

## USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

**Please read the following carefully before completing your application. This notice describes how medical information about you may be used and disclosed.**

Health First Health Plans is committed to protecting the privacy of your medical and member information also known as Protected Health Information (PHI). We collect and maintain this information to administer our business, to provide you with products, services, information of importance, and to comply with certain legal requirements. This notice tells you about the ways in which we may use and disclose your information. It also describes your rights and certain obligations we have regarding the use and disclosure of your information.

We are required by law to protect the privacy of your information, notify affected individuals following a compromise of unsecured PHI, provide this notice about our privacy practices, and follow the privacy practices that are described in this notice.

We may use and disclose PHI without your authorization for the following reasons. Not every use or disclosure will be listed below. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

**To provide treatment:** We may disclose your PHI to your health care providers (doctors, dentists, pharmacies, hospitals and other caregivers) who may request it in connection with your treatment. We may also disclose your PHI to health care providers (including their employees and business associates) in connection with preventative health, early detection and disease and case management programs.

**For payment purposes:** We may use or disclose your PHI to administer your health care policy or contract which may involve: determining your eligibility for benefits, paying claims for services you receive, making medical necessity determinations, coordinating your care of other services and coordinating your coverage with other plans.

**For healthcare operations:** We may use and/or disclose your PHI to support daily business activities for healthcare operations, which may include activities like quality management, care management, care coordination, credentialing, medical review, auditing, legal services, business planning and development, public health activities, abuse or neglect, legal proceedings, law enforcement officials, worker's compensation and as required by law.

We may disclose your PHI to a representative acting on your behalf. You must appoint your representative in writing and provide the written appointment to Health First Health Plans at the address included below.

We may disclose your PHI to a friend or family member who is involved in, or helps pay for your care. In addition, we may disclose your PHI to an entity assisting in disaster relief efforts so that your family can be notified about your condition, status and location. You have the right to object to disclosure of your PHI to a friend or family member in this case.

Other than the uses and disclosures described above, we will not disclose your PHI without your written authorization. Health Plan requires your written authorization for most uses and disclosures of psychotherapy notes (psychotherapy notes are notes made by a mental health professional during a private, group or family therapy session and kept separate from the medical record) for marketing (other than a face-to-face communication between you and a Health Plan workforce member or a promotional gift of nominal value) in which financial payment is received or before selling your protected health information resulting in financial or non-financial payment. Additionally, other uses and disclosures of medical information not covered by this notice or by the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

You have rights related to the use and disclosure of your PHI. To exercise these rights, you may contact the locations below:

Health First Health Plans  
6450 US Highway 1  
Rockledge, FL 32955  
PH: 1.855.443.4735

**ACKNOWLEDGEMENT and AGREEMENT:** I understand and agree to abide by all terms, conditions and provisions of the Contract. I have read and understand this Application including the conditions of enrollment. I understand if this Application is accepted it will become part of the Contract. My signature (either signed below or electronically submitted) indicates my acceptance of these terms and that the information entered in this Application is complete, true and correct.

By checking this box and entering my name and date below, I am indicating my intent to electronically sign this Application and warrant that all of the information I have provided is true, complete, and accurate. I acknowledge having been provided the required forms during the application process.

<b>Print Name</b>	_____	<b>Date</b>	_____	<b>X</b>	_____
	Primary Applicant				Signature of Primary Applicant
<b>Print Name</b>	_____	<b>Date</b>	_____	<b>X</b>	_____
	Spouse (if applying for coverage)				Signature of Spouse
<b>Print Name</b>	_____	<b>Date</b>	_____	<b>X</b>	_____
	Dependent (Required if age 18 or older)				Signature of Dependent
<b>Print Name</b>	_____	<b>Date</b>	_____	<b>X</b>	_____
	Dependent (Required if age 18 or older)				Signature of Dependent
<b>Print Name</b>	_____	<b>Date</b>	_____	<b>X</b>	_____
	Dependent (Required if age 18 or older)				Signature of Dependent
<b>Print Name</b>	_____	<b>Date</b>	_____	<b>X</b>	_____
	Dependent (Required if age 18 or older)				Signature of Dependent

**Section 6: ACKNOWLEDGEMENT**

IT IS IMPORTANT YOU REVIEW AND UNDERSTAND THE FOLLOWING BEFORE YOU SIGN. By submitting an application for benefits, I agree with all of the statements listed below:

- I attest the information submitted in this Application is true and accurate to the best of my knowledge. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
- Once benefits are effective, they are contingent on timely and accurate payment of premiums and any other cost sharing as outlined in the policy. If payment is not accurate and paid on time, my coverage will be terminated. If terminated for non-payment, I may no longer be eligible to enroll in Health First Health Plans.

**Authorization for electronic signature**

By checking this box and entering my name below, I am indicating my intent to electronically sign this Application and warrant that all of the information I have provided is true, complete, and accurate. I acknowledge having been provided the required forms during the application process.

Print Name of Primary Applicant \_\_\_\_\_ Signature of Primary Applicant \_\_\_\_\_ Date \_\_\_\_\_





# Health Plans

Underwritten by  Commercial Plans

## Nondiscrimination Notice

Health First 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. Health First Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Health First Health Plans:

- 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, accessible electronic 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, please contact Our Civil Rights Coordinator.

If you believe that Health First Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, 6450 US Highway 1, Rockledge, FL 32955, 321-434-4521, 1-800-955-8771 (TTY), Fax: 321-434-4362, [civilrightscordinator@hf.org](mailto:civilrightscordinator@hf.org). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance our 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, 1-800-868-1019, 800-537-7697 (TDD).

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

Health First Health Plans is underwritten by Health First Commercial Plans, Inc. Health First Commercial Plans does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.



# Health Plans

Underwritten by  Commercial Plans

**English:**

This Notice has Important Information. This notice has important information about your application or coverage through Health First Health Plans. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 855-443-4735.

**Spanish:**

Este Aviso contiene información importante. Este aviso contiene información importante acerca de la solicitud o cobertura que usted tiene con Health First 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 855-443-4735.

**Haitian Creole:**

Avi sila a gen Enfòmasyon Enpòtan ladann. Avi sila a gen enfòmasyon enpòtan konsènan aplikasyon w lan oswa konsènan kouvèti asirans lan atravè Health First Health Plans. Chèche dat ki enpòtan nan avi sila a. Ou ka gen pou pran kèk aksyon avan sèten dat limit pou ka kenbe kouvèti asirans sante w la oswa pou yo ka ede w avèk depans yo. Se dwa w pou resevwa enfòmasyon sa a ak asistans nan lang ou pale a, san ou pa gen pou peye pou sa. Rele nan 855-443-4735.

**Vietnamese:**

Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn đăng ký hoặc hợp đồng bảo hiểm qua chương trình Health First Health Plans của Quý vị. Xin xem các ngày quan trọng trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong 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 miễn phí. Xin gọi số 855-443-4735.

**Portuguese:**

Este aviso contém informações importantes. Este aviso contém informações importantes a respeito da sua solicitação ou cobertura por meio dos Health First Health Plans. Consulte datas importantes neste aviso. Talvez seja necessário que você tome providências dentro de determinados prazos para manter a sua cobertura de plano de saúde ou ajuda com custos. Você tem o direito de obter estas informações e ajuda no seu idioma e sem custos. Ligue para 855-443-4735.

**Chinese:**

本通知包含重要的資訊。本通知包含關於您透過 Health First Health Plans 提交的申請或保險的重要資訊。請留意本通知內的重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或費用補貼。您有權以您的母語免費取得本資訊及幫助。請撥電話 855-443-4735。

**French:**

Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou la couverture par l'intermédiaire Health First 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 855-443-4735.



**Tagalog:**

Ang Paunawa na ito ay naglalaman ng Mahalagang Impormasyon. Ang paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagkakasaklaw sa Health First Health Plans. Tingnan ang mga mahalagang petsa dito sa paunawa. Maaring mangailangan kang magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagkakasaklaw sa kalusugan o makatulong sa mga gastusin. May karapatan kang makuha ang impormasyon at tulong na ito sa iyong wika nang libre. Tumawag sa 855-443-4735.

**Russian:**

Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через Health First 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 855-443-4735.

**Arabic:**

يحتوي هذا الإشعار معلومات هامة. يحوي هذا الإشعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خلال Health First Health Plans. ابحث عن التواريخ الهامة في هذا الإشعار. قد تحتاج لاتخاذ إجراء في تواريخ معينة للحفاظ على تغطيتك الصحية أو للمساعدة في دفع التغطية الصحية أو للمساعدة في دفع التكاليف. لك الحق في الحصول على معلومات والمساعدة بلغتك من دون أي تكلفة. اتصل بالرقم 855-443-4735

**Italian:**

Questo avviso contiene informazioni importanti. Questo avviso contiene informazioni importanti sulla sua domanda o copertura attraverso Health First Health Plans. Cerchi le date chiave in questo avviso. Potrebbe essere necessario un suo intervento entro una scadenza determinata per consentirle di mantenere la sua copertura o sovvenzione. Ha il diritto di ottenere queste informazioni e assistenza nella sua lingua gratuitamente. Chiami il numero 855-443-4735.

**German:**

Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Health First Health Plans. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Anspruch auf Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 855-443-4735.

**Korean:**

본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 Health First Health Plans를 통한 보장에 관한 정보를 포함하고 있습니다. 본 통지서에서 핵심이 되는 날짜들을 확인하십시오. 귀하는 건강 보장을 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 855-443-4735로 전화하십시오.

**Polish:**

Niniejsze ogłoszenie zawiera ważne informacje. Niniejsze ogłoszenie zawiera ważne informacje dotyczące Państwa wniosku lub zakresu świadczeń realizowanych poprzez Health First Health Plans. Może zaistnieć potrzeba podjęcia przez Państwa pewnych działań w określonym terminie w celu zachowania ubezpieczenia zdrowotnego lub otrzymania pomocy związanej z kosztami. Macie Państwo prawo do bezpłatnego uzyskania informacji i pomocy w języku ojczystym. Prosimy zadzwonić pod numer 855-443-4735.

**Gujarati:**

આ સૂચનામાં અગત્યની માહિતી છે. આ સૂચનામાં હેલ્થ ફર્સ્ટ કમર્શિયલ પ્લાન્સ દ્વારા તમારી અરજી અથવા કવરેજ વિશેની અગત્યની માહિતી છે. આ સૂચનામાંની ખાસ તારીખો જુઓ. તમારા આરોગ્ય કવરેજને જાળવી રાખવા અથવા ખર્ચ અંગે મદદ મેળવવા માટે ચોક્કસ સમયમર્યાદા સુધીમાં તમારે કાર્યવાહી કરવાની જરૂર પડી શકે છે. તમને આ માહિતી અને મદદ તમારી ભાષામાં વિના મૂલ્યે મેળવવાનો અધિકાર છે. 855-443-4735 પર કોલ કરો.

**Thai:**

ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้มีข้อมูลที่สำคัญเกี่ยวกับการสมัครหรือขอขบเขตการประกันสุขภาพของคุณผ่าน Health First Health Plans โปรดดูกำหนดการสำคัญในประกาศนี้

คุณอาจจะต้องดำเนินการภายในเวลาที่กำหนดเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร 855-443-4735.