EN HR Use Only

Emp ID _____
Eff Date _____
PS Entry _____
PEBB Entry _____
DV Rec'd _____
Confirm Sent _____

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

2018 Employee Enrollment/Change for Medical Only Groups

- **Type or print clearly in black ink.** Inaccurate, incomplete, or illegible information may delay coverage.
- **List eligible family members you wish to cover or remove from coverage. This form replaces all *Employee Enrollment/ Change* forms previously submitted.**

Subscriber's last name	First name	Middle initial	Social Security number

Are you making changes to an existing account?

☐ **Yes** **If yes, what changes?** *(Check all that apply in the sections below.)*

☐ **No** *(If no, go to Section 1.)*

Changes you can make anytime

☐ Name change ☐ Address change *Give date of event/change* _____

☐ Remove dependent(s) from coverage due to loss of eligibility (divorce, dissolution of state-registered domestic partnership or legal union, death, or other loss of eligibility for PEBB benefits). **Your personnel, payroll, or benefits office must receive this form no later than 60 days after the event.** If applicable, provide former dependent's new address:

_____

Additional changes you can make during the PEBB Program's annual open enrollment (November 1-30)

All changes become effective January 1 of the following year.

Check the box(es) next to the change requested.

☐ Add dependent(s) ☐ Change medical plan ☐ Remove dependent(s) ☐ Enroll after waiving medical coverage

☐ Waive medical due to enrollment in another employer-based group medical, TRICARE, or Medicare.

Additional changes you can make if an event creates a special open enrollment

The PEBB Program only allows changes outside of annual open enrollment when an event creates a special open enrollment. The change must be allowable under the Internal Revenue Code and Treasury regulations and correspond to and be consistent with a special open enrollment event for the employee, employee's dependent, or both. You are required to provide proof of the event. **Your personnel, payroll, or benefits office must receive this form and proof of the event no later than 60 days after the event.** However, if adding a newborn or newly adopted child increases your premium, you must submit this form no later than 12 months after the birth or adoption.

Check the box next to the change you are requesting and the corresponding event on the following page.
In most cases, the enrollment or change will be effective the first day of the month after the event date or the date this form is received, whichever is later.

☐ **Add dependent(s)**

☐ **Enroll after waiving medical coverage**

☐ **Change medical plan**

☐ **Remove dependent(s)**

☐ **Waive medical coverage due to enrollment in other employer-based group medical, TRICARE, or Medicare**

HCA is committed to providing equal access to our services. If you need an accommodation, or require documents in another format or language, please call 1-800-200-1004 (TRS: 711).

Agency name	Agency/subagency	Insurance effective date	Hire date

(continued)

2018 Employee Enrollment/Change for Medical Only Groups

Subscriber's last name	First name	Middle initial	Social Security number

The following events allow an employee to add dependent(s), enroll after waving medical, remove dependent(s), change medical plan, and waive medical coverage due to enrollment in other employer-based group medical, TRICARE, or Medicare.

- ❑ Marriage, registering a domestic partner, as defined by Washington Administrative Code 182-12-260(2), birth, adoption, or assuming a legal obligation for total or partial support in anticipation of adoption. Also complete a *Declaration of Tax Status* form if adding a non-qualified tax dependent.
- ❑ Employee has a change in employment status that affects the employee's eligibility for his or her employer contribution toward his or her employer-based group health plan.
- ❑ Employee's dependent has a change in his or her own employment status that affects his or her eligibility for the employer contribution under his or her employer-based group health plan.
- ❑ Employee or a dependent becomes entitled to or loses eligibility for Medicaid or a state Children's Health Insurance Program (CHIP).

The following events allow an employee to add dependent(s), enroll after waiving medical, and change medical plan.

- ❑ Child becomes eligible as an extended dependent through legal custody or legal guardianship. Also complete an *Extended Dependent Certification* form.
- ❑ Employee or dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act.
- ❑ Employee or dependent becomes eligible for a state premium assistance subsidy for PEBB health coverage from Medicaid or a state CHIP.

The following events allow an employee to add dependent(s), enroll after waving medical, remove dependent(s), and waive medical coverage due to enrollment in other employer-based group medical, TRICARE, or Medicare.

- ❑ Employee or dependent has a change in enrollment under another employer-based group health plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment.
- ❑ Employee's dependent moves from outside the United States to live within the United States or moves from inside the United States to live outside the United States.

The following events allow an employee to add dependent(s), enroll after waiving medical, remove dependent(s) and change medical plan.

- ❑ A court order or National Medical Support Notice requires the employee or any other individual to provide a health plan for an eligible child of the employee.

The following events allow an employee to change medical plan.

- ❑ Employee or dependent has a change in residence that affects health plan availability.
- ❑ Employee or dependent becomes entitled to or loses eligibility for Medicare, or enrolls in or terminates enrollment in a Medicare Part D plan.
- ❑ Employee's or dependent's current health plan becomes unavailable because the employee or dependent is no longer eligible for a health savings account.
- ❑ Employee or dependent experiences a disruption of care that could function as a reduction in benefits for the employee or his or her dependent for a specific condition or ongoing course of treatment (requires approval by the PEBB Program).

The following events allow an employee to enroll after waiving medical, and waive medical coverage due to enrollment in other employer-based group medical, TRICARE, or Medicare.

- ❑ Employee or dependent becomes eligible and enrolls in TRICARE, or loses eligibility for TRICARE.
- ❑ Employee becomes eligible and enrolls in Medicare, or loses eligibility for Medicare.

2018 Employee Enrollment/Change for Medical Only Groups

Section 1: Subscriber Information

Social Security number	Last name	First name	Middle initial	Sex ☐ M ☐ F

Street address	Apt./unit number	City	State	ZIP Code

Mailing address (if different from above)	Apt./unit number	City	State	ZIP Code

County of residence	Date of birth (mm/dd/yyyy)	Work phone number ( )	Home phone number ( )

Are you or any eligible dependents already enrolled in PEBB insurance coverage under another account? ☐ **Yes** ☐ **No**
If yes, please contact your personnel, payroll, or benefits office for assistance.

Medical coverage ☐ Cover ☐ Waive: effective date _____
If waiving, see Section 6. **Note:** If you waive coverage, you must be enrolled in other employer-based group medical, TRICARE, or Medicare. You cannot enroll your eligible dependents in medical.

Tobacco Use Premium Surcharge
The PEBB Program requires a monthly $25-per-account surcharge in addition to your premium if you or a family member (age 13 or older) enrolled on your PEBB medical uses a tobacco product. Tobacco use is defined as any use of tobacco products within the past two months except for religious or ceremonial use. If you check YES or leave the check boxes blank, you will pay the monthly $25 premium surcharge. See the *2018 Premium Surcharge Help Sheet* available at **www.hca.wa.gov/pebb** for instructions on how to respond.

Does the tobacco use premium surcharge apply to you? Check one:

☐ **YES, I am subject to the $25 premium surcharge.** I have used tobacco products in the past two months. If this is a change to a previous attestation, indicate the start date your tobacco use changed _____

☐ **NO, I am not subject to the $25 premium surcharge.** I have not used tobacco products in the past two months, or I have used the tobacco cessation resources noted in the *2018 Premium Surcharge Help Sheet*.

Section 2: Spouse or State-Registered Domestic Partner Information

- Skip this section if you are not enrolling a spouse or state-registered domestic partner.
- List an eligible spouse or state-registered domestic partner, as defined by Washington Administrative Code 182-12-260(2), you wish to cover or remove from coverage.
- Family members cannot be enrolled in two PEBB medical accounts at the same time.
- If adding a spouse or state-registered domestic partner, you must provide proof of eligibility within the PEBB Program's enrollment timelines or the spouse or state-registered domestic partner will not be enrolled.
- Forms and a list of documents we will accept to verify eligibility are available at **www.hca.wa.gov/pebb**.

Relationship to subscriber (If adding a non-qualified tax dependent, please attach a completed *Declaration of Tax Status* form.)

☐ Spouse: date of marriage _____ ☐ State-registered domestic partner: date registered _____

Social Security number	Last name	First name	Middle initial	Sex ☐ M ☐ F

Street address (only if different from subscriber) Apt./unit number	City	State	ZIP Code

Date of birth (mm/dd/yyyy)	

Medical coverage ☐ Cover
☐ Remove from medical Reason _____

Tobacco Use Premium Surcharge

Does the tobacco use premium surcharge apply to your spouse or state-registered domestic partner? Check one:

☐ **YES, I am subject to the $25 premium surcharge.** My spouse or state-registered domestic partner has used tobacco products in the past two months. If this is a change to a previous attestation, indicate the start date their tobacco use changed _____

☐ **NO, I am not subject to the $25 premium surcharge.** My spouse or state-registered domestic partner has not used tobacco products in the past two months, or he or she has used the tobacco cessation resources noted in the *2018 Premium Surcharge Help Sheet*.

(continued)

Subscriber's last name	First name	Middle initial	Social Security number

Section 2: Spouse or State-Registered Domestic Partner Information *(continued from previous page)*

Spouse or State-Registered Domestic Partner Coverage Premium Surcharge

The PEBB Program requires a monthly $50 surcharge in addition to your premium if you are enrolling your spouse or state-registered domestic partner in PEBB medical and your spouse or state-registered domestic partner has elected not to enroll in employer-based group medical that is comparable to Uniform Medical Plan Classic. See the *2018 Premium Surcharge Help Sheet* for instructions on how to respond. If you check YES below or leave this section blank, you will pay the monthly surcharge.

Does the spouse or state-registered domestic partner coverage surcharge apply to you? Check one:

❑ **YES, I am subject to the $50 premium surcharge.** I used the *2018 Premium Surcharge Help Sheet* and completed the *2018 Spousal Plan Calculator* online.

❑ **NO, I am not subject to the $50 premium surcharge.** I used the *2018 Premium Surcharge Help Sheet* and, if needed, completed the *2018 Spousal Plan Calculator* online.

Which questions, if any, on the *2018 Premium Surcharge Help Sheet* did you check NO? Check all that apply.
Question 1 is not applicable. ❑ Question 2 ❑ Question 3 ❑ Question 4 ❑ Question 5 ❑ Question 6

❑ **Employer to determine if premium surcharge applies.** I used the *2018 Premium Surcharge Help Sheet* and am completing and submitting a printed *2018 Spousal Plan Calculator*. My employer will determine whether my spouse's or state-registered domestic partner's employer-based group medical is comparable to UMP Classic.

The *2018 Premium Surcharge Help Sheet* and the *2018 Spousal Calculator* are available at **www.hca.wa.gov/pebb.** To change your attestation, use the *2018 Premium Surcharge Change Form.*

Section 3: Family Member Information (such as a child) *Use additional forms for more members.*

- Skip this section if you are not enrolling additional family members.
- List eligible family members you wish to cover or remove from coverage.
- Family members cannot be enrolled in two PEBB medical accounts at the same time.
- If adding a family member, you must provide proof of eligibility for each family member within PEBB's enrollment timelines or the family member will not be enrolled.
- If adding a non-qualified tax dependent, also attach a *Declaration of Tax Status form.*
- If enrolling an extended dependent attach an *Extended Dependent Certification* form.
- If enrolling a dependent with a disability age 26 or older, submit a completed *Certification of Dependent With a Disability* form and return as instructed on the form. Refer to the *2018 Employee Enrollment Guide* for eligibility information.
- Forms and a list of documents we will accept to verify eligibility are available at **www.hca.wa.gov/pebb.**

A	**Relationship to subscriber**	Disabled? *Check only if age 26 or older* ❑ Yes ❑ No	Extended dependent validated by court order? ❑ Yes ❑ No	Social Security number

Last name	First name	Middle initial	Sex ❑ M ❑ F	Date of birth (mm/dd/yyyy)

Street address (only if different from subscriber) Apt./unit number	City	State	ZIP Code

Medical coverage ❑ Cover ❑ Remove from medical Reason _____

Tobacco Use Premium Surcharge

Does the tobacco use premium surcharge apply to this family member? (Response required for family members ages 13 and older.) Check one:

❑ **YES, I am subject to the $25 premium surcharge.** This family member has used tobacco products in the past two months. If this is a change to a previous attestation, indicate the start date their tobacco use changed _____

❑ **NO, I am not subject to the $25 premium surcharge.** This family member has not used tobacco products in the past two months, or he or she used the tobacco cessation resources noted in the *2018 Premium Surcharge Help Sheet.*

(continued)

2018 Employee Enrollment/Change for Medical Only Groups

Subscriber's last name	First name	Middle initial	Social Security number

B	Relationship to subscriber	Disabled? *Check only if age 26 or older* ❑ Yes ❑ No	Extended dependent validated by court order? ❑ Yes ❑ No	Social Security number
Last name	First name	Middle initial	Sex ❑ M ❑ F	Date of birth (mm/dd/yyyy)
Street address (only if different from subscriber) Apt./unit number		City	State	ZIP Code

Medical coverage ❑ Cover ❑ Remove from medical Reason _____

Tobacco Use Premium Surcharge

Does the tobacco use premium surcharge apply to this family member? (Response required for family members ages 13 and older.) Check one:

❑ **YES, I am subject to the $25 premium surcharge.** This family member has used tobacco products in the past two months. If this is a change to a previous attestation, indicate the start date their tobacco use changed _____

❑ **NO, I am not subject to the $25 premium surcharge.** This family member has not used tobacco products in the past two months, or he or she used the tobacco cessation resources noted in the *2018 Premium Surcharge Help Sheet*.

C	Relationship to subscriber	Disabled? *Check only if age 26 or older* ❑ Yes ❑ No	Extended dependent validated by court order? ❑ Yes ❑ No	Social Security number
Last name	First name	Middle initial	Sex ❑ M ❑ F	Date of birth (mm/dd/yyyy)
Street address (only if different from subscriber) Apt./unit number		City	State	ZIP Code

Medical coverage ❑ Cover ❑ Remove from medical Reason _____

Tobacco Use Premium Surcharge

Does the tobacco use premium surcharge apply to this family member? (Response required for family members ages 13 and older.) Check one:

❑ **YES, I am subject to the $25 premium surcharge.** This family member has used tobacco products in the past two months. If this is a change to a previous attestation, indicate the start date their tobacco use changed _____

❑ **NO, I am not subject to the $25 premium surcharge.** This family member has not used tobacco products in the past two months, or he or she used the tobacco cessation resources noted in the *2018 Premium Surcharge Help Sheet*.

Section 4: Medical Plan Selection *Check only one.*

Contact the plans for benefits information; their contact information is at the end of this form.

Kaiser Foundation Health Plan of Washington
(formerly Group Health Cooperative)[1]

❑ Kaiser Permanente (formerly Group Health) WA Classic

❑ Kaiser Permanente WA (formerly Group Health) Value

Uniform Medical Plan, administered by Regence BlueShield

❑ UMP Classic

❑ UMP Consumer-Directed Health Plan

[1] These plans have a specific service area. If you move out of the service area, you may need to change your plan. You must report your new address to your personnel, payroll, or benefits office **no later than 60 days** after you move. If your chosen plan has a change in contracted service area, you may need to change your plan. You must select a new plan within 60 days of the plan becoming unavailable.

[2] Kaiser Foundation Health Plan of the Northwest, with plans offered in Clark and Cowlitz counties in WA, and the Portland, OR, area.

Please sign and date the next page.

(continued)

2018 Employee Enrollment/Change for Medical Only Groups

Subscriber's last name	First name	Middle initial	Social Security number

Section 6: Signature *Required*

By signing this form, I declare that the information I have provided is true, complete, and correct. If it isn't, or if I do not update this information within the timelines in PEBB Program rules, to the extent permitted by federal and state laws, I must repay any claims paid by my health plan(s) or premiums paid on my behalf. My family members and I may also lose PEBB benefits as of the last day of the month we were eligible. To the extent permitted by law, the PEBB Program or my employer may retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility or do not pay premiums when due. In addition, I understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, denial of PEBB benefits, and loss of my job.

If adding a state-registered domestic partner to my account, I declare that my domestic partner and I have registered through the Washington Secretary of State's Office or another state.

Enrollment is not complete until verification of the family member's eligibility is successful. I understand that if I'm applying to add a dependent to my PEBB insurance, I must provide copies of documents that verify the dependent's eligibility within the PEBB Program's enrollment timelines, or the dependent will not be enrolled.

Employees may waive PEBB medical if they are enrolled in other employer-based group medical, TRICARE, or Medicare. If I waive medical, I understand I can enroll during the annual open enrollment period or **no later than 60 days** after a special open enrollment event as defined in PEBB Program rules. If I waive medical for myself, I cannot enroll my eligible family members in medical.

I allow my employer to deduct money from my earnings to pay for insurance coverage and any applicable premium surcharges.

If I am enrolling in a consumer-directed health plan with a health savings account (HSA), I must meet HSA eligibility conditions. I understand that my employer will contribute to an HSA on my behalf based on the information I have provided, and that there are limits to these contributions and my HSA contributions (if any) under federal tax law.

I understand that my enrollment and my dependents' enrollment are subject to my adherence to all applicable deadlines and PEBB rules and policies. Failure to comply with applicable deadlines and PEBB rules and policies may result in my benefits selection being rejected or defaulted.

This form replaces all *Employee Enrollment/Change* forms previously submitted.

HCA's Privacy Notice: We will keep your information private as allowed by law.
To see our Privacy Notice, go to **www.hca.wa.gov/pebb.**

Subscriber's signature _____ **Date** _____

Please sign and date.
Return completed form and documentation to your personnel, payroll, or benefits office.

2018 PEBB Program Medical Contractors

Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah St., Suite 100, Portland, OR 97232-2099
1-800-813-2000 or TTY: 711

Kaiser Foundation Health Plan of Washington (formerly Group Health Cooperative)
320 Westlake Ave. N, Suite 100, Seattle, WA 98109-5233
1-888-901-4636 or TTY 1-800-833-6388

Kaiser Foundation Health Plan of Washington Options, Inc. (formerly Group Health Options, Inc.)
320 Westlake Ave. N, Suite 100, Seattle, WA 98109-5233
1-888-901-4636 or TTY: 1-800-833-6388

Uniform Medical Plan, administered by Regence BlueShield
1800 Ninth Avenue, Suite 235, Seattle, WA 98101
1-888-849-3681 or TTY: 711

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

PEBB Program Nondiscrimination Notice and Language Access Services

The PEBB Program and its contracted health plans comply with applicable federal civil rights laws and do not discriminate (exclude people or treat them differently) on the basis of race, color, national origin, age, disability, or sex.

The PEBB Program also complies with applicable state civil rights laws and does not discriminate on the basis of creed, gender, gender expression or identity, sexual orientation, marital status, religion, honorably discharged veteran or military status, or the use of a trained dog guide or service animal by a person with a disability.

The PEBB Program 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).
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you believe this organization has failed to provide language access services or discriminated in another way...	You can file a grievance with:
PEBB Program *You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the HCA Compliance Officer is available to help you.*	Health Care Authority Division of Legal Services, Attn: HCA Compliance Officer PO Box 42704 Olympia, WA 98504-2704 1-855-682-0787 (TRS: 711) | Fax 360-586-9551 **compliance@hca.wa.gov**
PEBB MEDICAL PLANS	
Kaiser Foundation Health Plan of the Northwest	Kaiser Foundation Health Plan of the Northwest Attn: Member Relations – Kaiser Civil Rights Coordinator 500 NE Multnomah, Suite 100 Portland, OR 97232 1-800-813-2000 or 503-813-2000 (TTY: 711)
Kaiser Foundation Health Plan of Washington (formerly Group Health Cooperative) **Kaiser Foundation Health Plan of Washington Options, Inc. (formerly Group Health Options, Inc.)**	Kaiser Foundation Health Plan of Washington Civil Rights Coordinator Quality GNE-D1E-07 PO Box 9812 Renton, WA 98057 1-888-901-4636 or 206-630-4636 (TTY: 711) | Fax 206-901-6205 **csforms@ghc.org**
Washington State Rx Services (for discrimination concerns about prescription-drug benefits for Uniform Medical Plan [UMP])	Washington State Rx Services Attn: Appeals Unit PO Box 40168 Portland, OR 97204-0168 1-888-361-1611 (TDD/TTY: 711) | Fax 1-866-923-0412 **compliance@modahealth.com**
Premera Blue Cross (for discrimination concerns about Medicare Supplement Plan F and the Center of Excellence Program for UMP Classic and UMP CDHP members)	Premera Blue Cross Attn: Civil Rights Coordinator - Complaints and Appeals PO Box 91102 Seattle, WA 98111 1-855-332-4535 (TTY: 1-800-842-5357) | Fax 425-918-5592 **AppealsDepartmentInquiries@Premera.com**

(continued)

Washington State Health Care Authority

PUBLIC EMPLOYEES BENEFITS BOARD

[English] Language assistance services, including interpreters and translation of printed materials, are available free of charge. Employees: Contact your employer's personnel, payroll, or benefits office directly. Retirees, COBRA, and Continuation Coverage members only: Contact PEB Division Benefits Services at 1-800-200-1004. (TRS: 711).

[Amharic] የቋንቋ እገዛ አገልግሎት፣ አስተርጓሚ እና የሰነዶችን ትርጉም ጨምሮ በነጻ ይገኛል። ተቀጣሪዎች፡ የቀጣሪዎትን ሰራተኛ፣ የደሞዝ ወይም ጥቅማ-ጥቅም ክፍያ ጽ/ቤትን በቀጥታ ያነጋግሩ። ጡረታ የወጡ፣ COBRA እና ቀጣይነት ያለው ሽፋን አባላት ብቻ፡ የ PEB መምሪያ ጥቅማ-ጥቅም አገልግሎትን በ1-800-200-1004. (TRS: 711) ያነጋግሩ።

[Arabic] خدمات المساعدة في اللغات، بما في ذلك المترجمين الفوريين وترجمة المواد المطبوعة، متوفرة مجاناً. للموظفين: اتصل بمكتب شؤون العاملين بالشركة، أو مكتب المرتبات أو الاستحقاقات مباشرة. للمتقاعدين، وأعضاء COBRA وأعضاء التغطية المستمرة فقط: اتصل بخدمات استحقاقات قسم PEB على الرقم 1-800-200-1004. (TRS: 711).

[Burmese] ဘာသာပြန်ဆိုသူများနှင့် ထုတ်ပြန်ထားသည့် စာရွက်စာတမ်းများဘာသာပြန်ခြင်းအပါအဝင် ဘာသာစကားအထောက်အကူဝန်ဆောင်မှုများကို အခမဲ့ရနိုင်ပါသည်။ အလုပ်သမားများ- သင့်အလုပ်ရှင်၏ကိုယ်ရေးအရာရှိ၊ လစာ သို့မဟုတ် အကျိုးခံစားခွင့်ဆိုင်ရာ ရုံးသို့ တိုက်ရိုက်ဆက်သွယ်ပါ။ ပင်စင်ယူသူများ၊ COBRA နှင့် ဆက်လက်ပြီးအကျုံးဝင်သည့် အဖွဲ့ဝင်များသာလျှင်- PEP ဌာနခွဲ အကျိုးခံစားခွင့်ဝန်ဆောင်မှုများသို့ 1-800-200-1004. (TRS: 711) ကိုဖုန်းခေါ်ဆိုပါ။

[Cambodian] សេវាជំនួយភាសា រួមមានទាំងអ្នកបកប្រែផ្នែកវាចា និង ការបកប្រែឯកសារបោះពុម្ព គឺអាចរកបានដោយឥតគិតថ្លៃ។ ហៅទូរស័ព្ទទៅលេខ 1-800-562-3022 (TRS: 711)។ និយោជិត ៖ សូមទាក់ទងការិយាល័យបុគ្គលិកនិយោជករបស់អ្នក ការិយាល័យបញ្ជីប្រាក់ខែ ការិយាល័យអត្ថប្រយោជន៍ដោយផ្ទាល់។ អ្នកចូលនិវត្តន៍, COBRA, និងសមាជិក Continuation Coverage ប៉ុណ្ណោះ ៖ សូមទាក់ទងសេវាអត្ថប្រយោជន៍ នៃនាយកដ្ឋាន PEB តាមលេខ 1-800-200-1004. (TRS: 711)។

[Chinese] 免费提供语言协助服务，包括口译员和印制资料翻译。雇员：直接联系雇主的私人、工资或福利办公室。仅限退休人员、COBRA 和持续承保成员：联系 PEB 部门福利服务处，电话为 1-800-200-1004 (TRS: 711)。

[Korean] 통역 서비스와 인쇄 자료 번역을 포함한 언어 지원 서비스를 무료로 이용하실 수 있습니다. 직원: 고용주의 인사, 급여 또는 수당을 관리하는 사무소에 직접 문의하십시오. 퇴직자, COBRA 및 Continuation Coverage 회원만 해당: 1-800-200-1004, TRS: 711 로 PEB Division Benefits Services 에 문의하십시오.

[Laotian] ການບໍຣິການດ້ານພາສາ, ລວມທັງນາຍແປພາສາ ແລະ ການ ແປເອກະສານຕີພິມ, ມີໄວ້ໃຫ້ຟຣີໂດຍບໍ່ຄິດຄ່າ. ພະນັກງານ: ຕິດຕໍ່ ຫາຜະແນກທະບຽນພິລະອາຍາຈຳ, ຜະແນກບັນຊີເງິນເດືອນ, ຫລື ຫ້ອງການສະວັດດີການໂດຍກົງໄລຍະໄກ. ຜູ້ອອກບຳນານ, COBRA, ແລະ ການຄຸ້ມກັນທີ່ດຳເນີນຕໍ່ໄປສຳລັບສະມາຊິກເທົ່ານັ້ນ: ຕິດຕໍ່ຫາຜະ ແນກສະວັດດີການ PEB ໄດ້ທີ່ເລກ 1-800-200-1004 (TRS: 711).

[Oromo] Tajajilwwan gargaarsa afaanii, turjumaanaafi i waantota maxxanfaman kan hiikan bilisaan jiru. Hojjetoota: Kallattiidhaan peeroolii personeelii ykn waajira faayidaawwanii hojjechiisaa kee qunnami. COBRA fimiseensota Haguuggii Itti fufinsaa qofa: Tajaajilawwan Faayidaawwan Hirmaannaa PEB 1-800-200-1004. (TRS: 711) irratti qunnamuu dandeessu.

[Persian] خدمات کمک زبانی، از جمله مترجم شفاهی و ترجمه اسناد و مدارک (مطالب) چاپی، بصورت رایگان ارائه خواهد شد. قابل توجه کارگران: با بخش پرسنل کارفرمای خود لیست حقوق، یا اداره‌ی رفاه مستقیماً تماس بگیرید. بازنشستگان، COBRA، و اعضایی که دارای طرح ادامه پوشش بیمه هستند فقط با بخش خدمات و مزایا PEB با شماره 1-800-200-1004 (TRS: 711) تماس بگیرند.

[Punjabi] ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ—ਦੁਭਾਸ਼ੀਏ ਅਤੇ ਪ੍ਰਿੰਟ ਕੀਤੀ ਹੋਈ ਸਮੱਗਰੀ ਦੇ ਅਨੁਵਾਦ ਸਮੇਤ—ਮੁਫ਼ਤ ਉਪਲੱਬਧ ਹਨ। ਮੁਲਾਜ਼ਮ: ਆਪਣੇ ਰੁਜ਼ਗਾਰਦਾਤਾ ਦੇ ਮੁਲਾਜ਼ਮ, ਪੇਅਰੋਲ, ਜਾਂ ਲਾਭਾਂ ਵਾਲੇ ਦਫ਼ਤਰ ਨਾਲ ਸਿੱਧਾ ਸੰਪਰਕ ਕਰਨ। ਸੇਵਾ-ਮੁਕਤ ਮੁਲਾਜ਼ਮ, COBRA (ਕੋਬਰਾ), ਅਤੇ ਸਿਰਫ਼ ਕੰਟੀਨਿਊਏਸ਼ਨ ਕਵਰੇਜ ਮੈਂਬਰ: 1-800-200-1004. (TRS: 711) ਉੱਤੇ PEB (ਪੀਈਬੀ) ਡਿਵੀਜ਼ਨ ਲਾਭ ਸੇਵਾਵਾਂ ਨਾਲ ਸੰਪਰਕ ਕਰਨ।

[Romanian] Serviciile de asistenţă lingvistică, inclusiv cele de interpretariat şi de traducere a materialelor imprimate, sunt disponibile gratuit. Angajaţi: Contactaţi biroul pentru personal, salarii sau beneficii al angajatorului dvs. în mod direct. Numai pentru pensionari, membri COBRA sau Continuation Coverage: Contactaţi Serviciile de beneficii de la Divizia PEB la 1-800-200-1004. (TRS: 711).

[Russian] Языковая поддержка, в том числе услуги переводчиков и перевод печатных материалов, доступна бесплатно. Наемные работники: обратитесь непосредственно в отдел кадров, бухгалтерию или социальный отдел вашего работодателя. Только пенсионеры, пользователи COBRA или программ продленного страхового покрытия: обратитесь в отдел льгот и страхования для государственных служащих (PEB Division Benefits Services) по телефону 1-800-200-1004. (TRS: 711).

[Somali] Adeego caawimaad luuqada ah, ay ku jirto turjubaano afka ah iyo turjumid lagu sameeyo waraaqaha la daabaco, ayaa lagu helayaa lacag la'aan. Shaqaalaha: La xiriir shaqaalaha qofka aad u shaqaysid, liiska mushaarka shaqaalaha, ama si toos ah xafiiska dheefaha. Dadka hawlgabka ah, COBRA, iyo kaliya xubnaha Sii wadista Ceymiska: Kala xiriir Qaybta Adeegaha Dheefaha ee PEB lambarkan 1-800-200-1004. (TRS: 711).

[Spanish] Hay servicios de asistencia con idiomas, incluyendo intérpretes y traducción de materiales impresos, disponibles sin costo. Empleados: Comuníquense directamente con la oficina de personal, nómina o beneficios de su empleador. Sólo para jubilados y miembros de Cobra y cobertura continua: Comuníquese con la División de Servicios y Beneficios de PEB al 1-800-200-1004. (TRS: 711).

[Swahili] Huduma za msaada wa lugha, ikiwa ni pamoja na wakalimani na tafsiri ya nyaraka zilizochapishwa, zinapatikana bure bila ya malipo. Wafanyakazi: wasiliana moja kwa moja na ofisi ya utumishi ya mwajiri wako, ofisi ya malipo, au ya mafao. Wastaafu, wanachama wa COBRA na wenye bima ya kuendelea tu: Wasiliana na Huduma za Mafao za kitengo cha PEB kwa nambari 1-800-200-1004. (TRS: 711).

[Tagalog] Mga serbisyong tulong sa wika, kabilang ang mga tagapagsalin at pagsasalin ng nakalimbag na mga kagamitan, ay magagamit ng walang bayad. Mga empleyado: Makipag-ugnay nang direkta sa mga tauhan, payroll, o tanggapan ng mga benepisyo ng iyong employer. Mga Pensyonado, COBRA, at mga kasapi ng Continuation Coverage lamang: Makipag-ugnay sa mga Serbisyo ng Benepisyo sa Sangay ng PEB sa 1-800-200-1004. (TRS: 711).

[Tigrigna] ተርጎምትን ናይ ዝተፅሓፉ ማተርያላት ትርጉምን ሓዊሱ ናይ ቋንቋ ሓገዝ ግልጋሎት፤ ብዘይ ምንም ክፍሊት ይርከቡ። ሰራሕተኛታት፡ ንናይ መስርሒ ኻ ዉልቃዊ ዝርዝር ደሞዝ ወይ ቤት ጽሕፈት ጥቕምታት ብቕጥታ ርኸቡ። ጡረተኛታት፣ COBRA፣ ኣባላት መቐጸልታ ሽፋን ጥራሕ፡ ንናይ PEB ክፋል ጥቕምታት ግልጋሎት ብ1-800-200-1004 ርኸቡ (TRS: 711) ።

[Ukrainian] Мовна підтримка, у тому числі послуги перекладачів та переклад друкованих матеріалів, доступна безкоштовно. Наймані робітники: зверніться безпосередньо до відділу кадрів, бухгалтерії або соціального відділу вашого роботодавця. Лише пенсіонери, користувачі COBRA або програм продовженого страхового покриття: зверніться до відділу пільг і страхування для державних службовців (PEB Division Benefits Services) за телефоном 1-800-200-1004. (TRS: 711).

[Vietnamese] Các dịch vụ trợ giúp ngôn ngữ, bao gồm thông dịch viên và bản dịch tài liệu in, hiện có miễn phí. Người lao động: Liên hệ trực tiếp với phòng nhân sự, tiền lương, hoặc phúc lợi của sở làm quý vị. Chỉ những người hồi hưu, các thành viên COBRA, và thành viên chương trình Bảo Hiểm Tiếp Tục: Liên hệ với bộ phận Dịch Vụ Phúc Lợi của Phòng PEB theo số 1-800-200-1004. (TRS: 711).