

Application for the Addition of Family Members to an Individual or Group Conversion Plan (Grandfathered)

P.O. Box 91120, MS 295
Seattle, WA 98111-9220
lifewisewa.com



Please read all accompanying material before completing this application. **All questions must have complete and accurate answers.** Omissions or incomplete answers will result in the return of your application and may cause a delay in the effective date of your coverage. Please **PRINT**, sign and date in ink.

To be eligible for coverage, applicants:

- Must be a resident of Washington state. We may require proof of residency.
- Must not be entitled to Medicare (including entitlement due to disability)
- If over 65 years of age and not eligible for Medicare, attach a “not eligible for Medicare document” from the Social Security Administration.

Section 1: Effective date

Application must be received within 60 days of the event (marriage, birth, placement, custody), to be effective on the date of the event.

Approved applications postmarked or received by the last day of the month will be effective on the first day of the following month.

To select a later effective date, please indicate here (no more than 60 days after the signature date): _____ /01/_____

Section 2: Subscriber information

Last name (of current subscriber)	First	Middle Initial	Member Identification number (see your ID card)	
Home address (required): Street, city, state, ZIP (not P.O. Box)			County	Home number ()
Mailing address (if different from home address): Street, city, state, ZIP			County	Work number ()
Billing address (if different from mailing address): Street, city, state, ZIP			County	Cell number ()

Section 3: Dependents to be added

<input type="checkbox"/> Legal Spouse or <input type="checkbox"/> Domestic Partner Name (Last, First, Middle Initial)	Social Security Number (optional)		Gender: <input type="checkbox"/> M <input type="checkbox"/> F
	Date of Birth / /	Date of Marriage* / /	**I used tobacco in the last 6 months: <input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Child Name—under 26 only (Last, First, Middle Initial)	Social Security Number (optional)		Gender: <input type="checkbox"/> M <input type="checkbox"/> F
	Date of Birth / /	*** Date of Placement/Custody / /	**I used tobacco in the last 6 months: <input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Child Name—under 26 only (Last, First, Middle Initial)	Social Security Number (optional)		Gender: <input type="checkbox"/> M <input type="checkbox"/> F
	Date of Birth / /	*** Date of Placement/Custody / /	**I used tobacco in the last 6 months: <input type="checkbox"/> Yes <input type="checkbox"/> No

* If adding a domestic partner, please include a Declaration of Domestic Partnership form, available at lifewisewa.com.

** “Tobacco use” means use of any tobacco product on average four or more times per week within the past 6 months. Tobacco use does not include religious or ceremonial use.

*** For adoption, attach a copy of the placement/adoption agreement. For dependents that court orders for legal wards, guardianship or Medical Child Supprt, attach a copy of the court order.

Section 4: Health Questionnaire

Notice To All Applicants: It is important for you to accurately complete this health questionnaire for all dependents listed. Have you or any family member listed on this application ever experienced symptoms, been advised of, diagnosed with, received treatment or had treatment recommended for any of the following conditions? Provide details on page 3 to any item answered “yes.”

Please check each item either Yes or No	Yes <input type="checkbox"/>	No <input type="radio"/>
1. Alcohol or Drug Abuse / Dependence		
a. Alcohol / Chemical / Drug / DUI	<input type="checkbox"/>	<input type="radio"/>
2. Autoimmune Disorder		
a. Lupus / Scleroderma / Mixed	<input type="checkbox"/>	<input type="radio"/>
3. Bleeding / Blood / Circulatory Disorders		
a. Anemia / Bleeding / Hypercoagulation	<input type="checkbox"/>	<input type="radio"/>
b. Blood Disorder (TCP, etc.) / Leukemia	<input type="checkbox"/>	<input type="radio"/>
c. Aneurysm / Impaired Circulation	<input type="checkbox"/>	<input type="radio"/>
d. High Cholesterol, Triglycerides	<input type="checkbox"/>	<input type="radio"/>
e. Hypertension (Last: ____/____)	<input type="checkbox"/>	<input type="radio"/>
f. Phlebitis / Clots / Raynaud's / PVD	<input type="checkbox"/>	<input type="radio"/>
4. Congenital Conditions		
a. Congenital Disorder / Birth Defects	<input type="checkbox"/>	<input type="radio"/>
5. Ear / Nose / Throat / Eye		
a. Ear Infections (# ____ past yr.) / Tubes	<input type="checkbox"/>	<input type="radio"/>
b. Nasal Malformation / Deviated Septum	<input type="checkbox"/>	<input type="radio"/>
c. Nasal Polyps / Sinusitis / Tonsillitis	<input type="checkbox"/>	<input type="radio"/>
d. Crossed Eyes / Strabismus	<input type="checkbox"/>	<input type="radio"/>
e. Retina / Macular: Detach, Degeneration	<input type="checkbox"/>	<input type="radio"/>
f. Cataract(s) / Lens Implants / Glaucoma	<input type="checkbox"/>	<input type="radio"/>
6. Gastrointestinal Conditions		
a. Swallowing Problems / GERD / Reflux	<input type="checkbox"/>	<input type="radio"/>
b. Ulcers / Chronic Abd. Pain / Gallbladder	<input type="checkbox"/>	<input type="radio"/>
c. Diverticulitis / Hemorrhoids / IBS	<input type="checkbox"/>	<input type="radio"/>
d. Ulcerative Colitis / Crohn's / Colitis	<input type="checkbox"/>	<input type="radio"/>
e. Hernia (Specify type) / Polyps	<input type="checkbox"/>	<input type="radio"/>
f. Weight gain or loss > 10 lbs. within 1 yr.	<input type="checkbox"/>	<input type="radio"/>
7. Glandular or Hormonal Disorders		
a. Diabetes / Elevated Blood Sugar	<input type="checkbox"/>	<input type="radio"/>
b. Goiter / Nodule / Thyroid: Hyper / Hypo	<input type="checkbox"/>	<input type="radio"/>
c. Adrenal / Pituitary Condition	<input type="checkbox"/>	<input type="radio"/>
8. Heart Conditions		
a. Angina / Chest Pain / Heart Attack	<input type="checkbox"/>	<input type="radio"/>
b. Arterio-Atherosclerosis / Coronary Artery Disease / Congestive Failure	<input type="checkbox"/>	<input type="radio"/>
c. Heart Murmur / Arrhythmia / Pacemaker	<input type="checkbox"/>	<input type="radio"/>
d. Valve Disorder (Specify type, cause)	<input type="checkbox"/>	<input type="radio"/>
9. Immune Disorders		
a. AIDS / AIDS Related Complex / HIV	<input type="checkbox"/>	<input type="radio"/>
10. Kidney / Bladder Conditions		
a. Bladder: Infections / Incontinence	<input type="checkbox"/>	<input type="radio"/>
b. Kidney Infections / Kidney Stones	<input type="checkbox"/>	<input type="radio"/>
c. Kidney Failure / Nephritis	<input type="checkbox"/>	<input type="radio"/>
11. Liver Conditions		
a. Hepatitis A / B / C / Other	<input type="checkbox"/>	<input type="radio"/>
b. Cirrhosis / Liver Failure	<input type="checkbox"/>	<input type="radio"/>

Please check each item either Yes or No	Yes <input type="checkbox"/>	No <input type="radio"/>
12. Musculoskeletal Conditions		
a. Chronic Back or Neck Pain / Strain	<input type="checkbox"/>	<input type="radio"/>
b. Disc Problems / Bone spurs	<input type="checkbox"/>	<input type="radio"/>
c. Arthritis / Rheumatoid / Osteoporosis	<input type="checkbox"/>	<input type="radio"/>
d. Fibromyalgia / Chronic Fatigue	<input type="checkbox"/>	<input type="radio"/>
e. Muscular Dystrophy / Polio Residuals	<input type="checkbox"/>	<input type="radio"/>
f. Tendon / Joint: Inflammation / Gout / Carpal Tunnel / Replacement (Specify site)	<input type="checkbox"/>	<input type="radio"/>
g. Foot Disorder / Bunions / Hammertoe	<input type="checkbox"/>	<input type="radio"/>
h. Fractures (Specify site, hardware present)	<input type="checkbox"/>	<input type="radio"/>
i. Gait Abnormality / Loss of Limb(s)	<input type="checkbox"/>	<input type="radio"/>
j. Chronic Pain / Decreased Motion	<input type="checkbox"/>	<input type="radio"/>
13. Mental Health Disorders		
a. Schizophrenia / Bipolar / Psychosis	<input type="checkbox"/>	<input type="radio"/>
b. Depression / Anxiety / Suicide Attempt	<input type="checkbox"/>	<input type="radio"/>
c. Anorexia / Bulimia	<input type="checkbox"/>	<input type="radio"/>
d. Attention Deficit Hyperactivity Disorder	<input type="checkbox"/>	<input type="radio"/>
14. Neurological Conditions		
a. Brain Injury / Seizures / Cerebral Palsy	<input type="checkbox"/>	<input type="radio"/>
b. Stroke / TIA / Paralysis	<input type="checkbox"/>	<input type="radio"/>
c. Headaches (Recurrent or migraine)	<input type="checkbox"/>	<input type="radio"/>
d. MS / Alzheimer's / Huntington's / ALS / Parkinson's	<input type="checkbox"/>	<input type="radio"/>
e. Meningitis / Encephalitis	<input type="checkbox"/>	<input type="radio"/>
f. Developmental delay (Specify type, cause)	<input type="checkbox"/>	<input type="radio"/>
15. Organ		
a. Transplant (Previous or pending)	<input type="checkbox"/>	<input type="radio"/>
b. Critical Organ Cyst / Tumor (i.e., brain)	<input type="checkbox"/>	<input type="radio"/>
c. Cancer (Specify type, location, extent)	<input type="checkbox"/>	<input type="radio"/>
16. Reproductive System Conditions		
a. Menstrual Irregularity / Pregnant	<input type="checkbox"/>	<input type="radio"/>
b. Breast Disorder / Fibrocystic / Implant	<input type="checkbox"/>	<input type="radio"/>
c. Abnormal Pap Smear / Dysplasia	<input type="checkbox"/>	<input type="radio"/>
d. Endometrial / Uterine / Cervix Disorders	<input type="checkbox"/>	<input type="radio"/>
e. Ovarian / Testicular: Cyst / Torsion	<input type="checkbox"/>	<input type="radio"/>
f. Prostate Problems / Sexual Dysfunction	<input type="checkbox"/>	<input type="radio"/>
17. Respiratory Conditions		
a. Allergies / Asthma / Sleep Apnea	<input type="checkbox"/>	<input type="radio"/>
b. Chronic Bronchitis / Pneumonia / TB	<input type="checkbox"/>	<input type="radio"/>
c. Lung Clot / Collapsed Lung	<input type="checkbox"/>	<input type="radio"/>
d. Chronic Obstructive Lung Diseases	<input type="checkbox"/>	<input type="radio"/>
18. Sexually Transmitted Diseases		
a. Genital Herpes / HPV / Other	<input type="checkbox"/>	<input type="radio"/>
19. Skin Conditions		
a. Burns / Scars / Acne / Ulcers (Specify site)	<input type="checkbox"/>	<input type="radio"/>
20. Specify other condition(s) not listed above:		
a.	<input type="checkbox"/>	<input type="radio"/>
b.	<input type="checkbox"/>	<input type="radio"/>

Notice to Applicants For Non-Grandfathered Plans (Individual Plans purchased after March 23, 2010): Applicants under age 19 will not be denied coverage due to a health condition.

21. If you have answered “yes” to ANY of the previous questions or have experienced any other health issues, complete this question. Instructions: Include complete details including site, cause, and extent of condition. Attach additional sheet if needed. You may wish to submit copies of relevant medical records to expedite the process (at your own expense).

#	Name	Dates	Describe Condition	Provider	Current Status	Follow Up
		Start Mo ____ Yr ____	Diagnosis	Practitioner	Condition Present? <input type="checkbox"/> Yes, persists OR <input type="radio"/> No, resolved	Future Care? <input type="checkbox"/> Yes, future surgery or treatment <input type="radio"/> No, resolved
		End Mo ____ Yr ____	Treatment	Hospital	(Describe):	(Describe type, reason):
				_____ Days		
		Start Mo ____ Yr ____	Diagnosis	Practitioner	Condition Present? <input type="checkbox"/> Yes, persists OR <input type="radio"/> No, resolved	Future Care? <input type="checkbox"/> Yes, future surgery or treatment <input type="radio"/> No, resolved
		End Mo ____ Yr ____	Treatment	Hospital	(Describe):	(Describe type, reason):
				_____ Days		
		Start Mo ____ Yr ____	Diagnosis	Practitioner	Condition Present? <input type="checkbox"/> Yes, persists OR <input type="radio"/> No, resolved	Future Care? <input type="checkbox"/> Yes, future surgery or treatment <input type="radio"/> No, resolved
		End Mo ____ Yr ____	Treatment	Hospital	(Describe):	(Describe type, reason):
				_____ Days		
		Start Mo ____ Yr ____	Diagnosis	Practitioner	Condition Present? <input type="checkbox"/> Yes, persists OR <input type="radio"/> No, resolved	Future Care? <input type="checkbox"/> Yes, future surgery or treatment <input type="radio"/> No, resolved
		End Mo ____ Yr ____	Treatment	Hospital	(Describe):	(Describe type, reason):
				_____ Days		

22. Yes No **Has anyone listed on this application taken medications within the past year? If yes:**

Name	Medication (name, dose, duration)	Prescriber	Diagnosis

23. Yes No **Has any insurance company refused or restricted any insurance coverage for you or any person listed on this application? If yes, explain:**

24. Yes No **Has any other future surgery, diagnostic testing or medical treatment been recommended or discussed for any person listed on this application?** If yes, explain:

25. Yes No **Is any family member applying for coverage currently pregnant?** If yes, explain:

26. Yes No **Is any person on this application, including male applicants and dependent males or females, responsible for a current pregnancy?** If yes, explain:

27. **Please list the date of last menstrual cycle for every female applicant age 13 and over:**

Section 5: Health information

To identify applicants who may benefit from our health management programs, please complete the following questions.

Note: Do not list individuals who will not be enrolled for coverage.

A. **Yes** **No** Do you or any dependents have a disability, chronic health condition (i.e. diabetes, heart condition, etc.), or been advised in the last 12 months that hospitalization, surgery or treatment is needed or pending?

NAME	REASON

Section 6: Prior or current coverage (use for adding dependents only)

If you have prior creditable coverage:

Yes **No**: Do you intend to continue this other coverage if you are accepted by LifeWise?
(If no, remember to contact your insurance company to cancel, including our corporate affiliates.)

Section 7: Notice of information use and disclosure

Type Of Information To Be Disclosed: I (We) authorize: any physician, health care provider, hospital, insurance or reinsurance company, pharmacy benefits manager or third party benefits administrator to disclose a copy of my (our) personal health information, including any and all diagnostic, procedural, treatment, claim, prescription or other health related information including records concerning alcohol and/or chemical dependency, reproductive health (including abortion), sexually transmitted diseases, HIV, AIDS, psychiatric disorders and mental illness to LifeWise or its representatives as allowed by law.

Purpose Of Disclosure: I (We) understand that personal information will be used for underwriting, evaluating enrollment in the health plan, determining eligibility for benefits and paying claims. This information will not be used to make a decision on your eligibility for coverage.

Timeframe Of Release: Unless I revoke it, this release will remain valid for twenty-four (24) months from the date of my signature below.

Revocation Of Release: I understand that I may change my mind and revoke this release at any time. I will do this by letting LifeWise know of my decision. Any change will be effective five (5) business days after LifeWise receives my written notice at the address listed on this form. I understand that some or all of this information may already have been used by LifeWise to make decisions, which will not be affected by its revocation.

Redisclosure: LifeWise Health Plan of Washington may be required to redisclose this information to another party that is not subject to state and federal privacy rules.

Effect of Not Authorizing: This authorization is a condition of your enrollment in our health plan or your eligibility for benefits. If you decide not to sign this authorization, we may decline to enroll you in our health plan or to give you benefits.

Please Note: You or your authorized representative will receive a copy of this authorization.

Section 8: Signatures

I hereby apply for enrollment with LifeWise for the family members listed on this application for coverage under my Individual or Group Conversion Contract. I certify that:

- I have read this form, and I have supplied all of the required information on this form.
- The persons listed qualify for dependent enrollment as stated in my subscriber contract.
- Benefits may be subject to pre-existing condition or benefit-specific waiting periods as stated in my subscriber contract.
- In applying for enrollment as indicated on this application, I declare that to the best of my knowledge, all of the information on all forms necessary for enrollment is true and complete, and that all of the persons for whom I am requesting enrollment are eligible for coverage. I understand that if I have made intentionally false or misleading statements or answers on behalf of myself or any family members, that all entitlements to benefits are void and this Contract may be cancelled or modified retroactively to its effective date. I further understand that it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
- I affirm the subscription charge payments are not paid or sponsored by third-party payers including employers, business accounts, providers, not-for-profit agencies, government agencies, or any other third-party payer, either directly or indirectly, except as required by law.
- I understand and agree that this coverage is issued as individual health coverage, is not sold or issued for use as a government or third-party sponsored health plan, and is not partially or fully paid for by third-party payers including employers, business accounts, providers, not-for-profit agencies, government agencies, or any other third-party payer, either directly or indirectly, except as required by law.

Yes No: If one or more family members is not accepted for coverage, I authorize LifeWise to enroll those who are eligible in the plan I have selected.

X	/ /	X	/ /
Signature of Primary Applicant (parent/legal guardian)	Date of signature	Signature of Spouse or Domestic Partner	Date of signature
X	/ /	X	/ /
Signature of Dependent Child over age 18	Date of signature	Signature of Dependent Child over age 18	Date of signature
X	/ /	X	/ /
Signature of Dependent Child over age 18	Date of signature	Signature of Dependent Child over age 18	Date of signature
X	/ /	X	/ /
Signature of Dependent Child over age 18	Date of signature	Signature of Dependent Child over age 18	Date of signature

If not the primary applicant, I am the: Parent Holder of Power of Attorney Legal Guardian
(If you are the legal guardian or holder of a power of attorney for the applicant, attach legal documentation.)



Discrimination is Against the Law

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

LifeWise:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that LifeWise 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 - Complaints and Appeals
PO Box 91102, Seattle, WA 98111
Toll free 855-332-6396, Fax 425-918-5592, TTY 800-842-5357
Email AppealsDepartmentInquiries@LifeWiseHealth.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the 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, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Getting Help in Other Languages

This Notice has Important Information. This notice may have important information about your application or coverage through LifeWise Health Plan of Washington. There may be 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 800-592-6804 (TTY: 800-842-5357).

አማርኛ (Amharic):

ይህ ማስታወቂያ አስፈላጊ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም የ LifeWise Health Plan of Washington ሽፋን አስፈላጊ መረጃ ሊኖረው ይችላል። በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀናት ሊኖሩ ይችላሉ። የጤናን ሽፋን ለመጠበቅና በአስፈላጊ አርዳታ ለማግኘት በተውሰኑ የጊዜ ገደቦች አርምቫ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ እንዲያገኙ እና ያለምንም ክፍያ በቋንቋዎ አርዳታ እንዲያገኙ መብት አለዎት። በስልክ ቁጥር 800-592-6804 (TTY: 800-842-5357) ይደውሉ።

العربية (Arabic):

يحتوي هذا الإشعار معلومات هامة. قد يحتوي هذا الإشعار معلومات مهمة بخصوص طلبك أو التغطية التي تريد الحصول عليها من خلال LifeWise Health Plan of Washington. قد تكون هناك تواريخ مهمة في هذا الإشعار. وقد تحتاج لاتخاذ إجراء في تواريخ معينة للحفاظ على تغطيتك الصحية أو للمساعدة في دفع التكاليف. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك دون تكبد أية تكلفة. اتصل بـ 800-592-6804 (TTY: 800-842-5357).

中文 (Chinese):

本通知有重要的訊息。本通知可能有關於您透過 LifeWise Health Plan of Washington 提交的申請或保險的重要訊息。本通知內可能有重要日期。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者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 800-592-6804 (TTY: 800-842-5357)。

Omoo (Cushite):

Beeksisni kun odeeffannoo barbaachisaa qaba. Beeksisti kun sagantaa yookan karaa LifeWise Health Plan of Washington tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qabaachuu danda'a. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhuma irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa 800-592-6804 (TTY: 800-842-5357) tii bilbilaa.

Français (French):

Cet avis a d'importantes informations. Cet avis peut avoir d'importantes informations sur votre demande ou la couverture par l'intermédiaire de LifeWise Health Plan of Washington. Le présent avis peut contenir des dates clés. 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 le 800-592-6804 (TTY: 800-842-5357).

Kreyòl ayisyen (Creole):

Avi sila a kapab genyen enfòmasyon enpòtan Enpòtan ladann. Avi sila a kapab genyen enfòmasyon enpòtan konsènan aplikasyon w lan oswa konsènan kouvèti asirans lan atravè LifeWise Health Plan of Washington. Kapab genyen 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 800-592-6804 (TTY: 800-842-5357).

Deutsche (German):

Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält unter Umständen wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch LifeWise Health Plan of Washington. Suchen Sie nach eventuellen wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 800-592-6804 (TTY: 800-842-5357).

Hmoob (Hmong):

Tsaw ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb. Tej zaum tsaw ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog koj qhov kev pab cuam los ntawm LifeWise Health Plan of Washington. Tej zaum muaj cov hnuab tseem ceeb uas sau rau hauv daim ntawv no. Tej zaum koj kuj yuav tau ua qee yam uas peb kom koj ua tsis pub dhau cov caij nyoog uas teev tseg rau hauv daim ntawv no mas koj thiaj yuav tau txais kev pab cuam kho mob los yog kev pab them tej nqi kho mob ntawd. Koj muaj cai kom lawv muab cov ntshiab lus no uas tau muab sau ua koj hom lus pub dawb rau koj. Hu rau 800-592-6804 (TTY: 800-842-5357).

Iloko (Ilocano):

Daytoy a Pakdaar ket naglaon iti Napateg nga Impormasion. Daytoy a pakdaar mabalin nga adda ket naglaon iti napateg nga impormasion maipanggep iti aplikasyonyo wenno coverage babaen iti LifeWise Health Plan of Washington. Daytoy ket mabalin dagiti importante a petsa iti daytoy a pakdaar. Mabalin nga adda rumbeng nga aramidenyo nga addang sakbay dagiti partikular a naituding nga aldaw tapno mapagtalinaedyo ti coverage ti salun-atyo wenno tulong kadagiti gastos. Adda karbenganyo a mangala iti daytoy nga impormasion ken tulong iti bukodda a pagsasao nga awan ti bayadanyo. Tumawag iti numero nga 800-592-6804 (TTY: 800-842-5357).

Italiano (Italian):

Questo avviso contiene informazioni importanti. Questo avviso può contenere informazioni importanti sulla tua domanda o copertura attraverso LifeWise Health Plan of Washington. Potrebbero esserci date chiave in questo avviso. Potrebbe essere necessario un tuo intervento entro una scadenza determinata per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere queste informazioni e assistenza nella tua lingua gratuitamente. Chiama 800-592-6804 (TTY: 800-842-5357).

日本語 (Japanese):

この通知には重要な情報が含まれています。この通知には、LifeWise Health Plan of Washington の申請または補償範囲に関する重要な情報が含まれている場合があります。この通知に記載されている可能性がある重要な重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。800-592-6804 (TTY: 800-842-5357)までお電話ください。

한국어 (Korean):

본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 LifeWise Health Plan of Washington 를 통한 커버리지에 관한 정보를 포함하고 있을 수 있습니다. 본 통지서에는 핵심이 되는 날짜들이 있을 수 있습니다. 귀하의 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하의 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 800-592-6804 (TTY: 800-842-5357) 로 전화하십시오.

ລາວ (Lao):

ແຈ້ງການນີ້ມີຂໍ້ມູນສໍາຄັນ. ແຈ້ງການນີ້ອາດຈະມີຂໍ້ມູນສໍາຄັນກ່ຽວກັບຄ່າຄ່ອງສະໜັກ ຫຼື ຄວາມຄົມຄອງປະກັນໄພຂອງທ່ານຜ່ານ LifeWise Health Plan of Washington. ອາດຈະມີວັນທີ່ສໍາຄັນໃນແຈ້ງການນີ້. ທ່ານອາດຈະຈຳເປັນຕ້ອງດໍາເນີນການຕາມກຳນົດດວງສະເພາະເພື່ອຮັກສາຄວາມຄົມຄອງປະກັນສະພາບ ຫຼື ຄວາມຊ່ວຍເຫຼືອເວັ້ນຄ່າໃຊ້ຈ່າຍຂອງທ່ານໄວ້. ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໃຫ້ໃບທາ 800-592-6804 (TTY: 800-842-5357).

ភាសាខ្មែរ (Khmer):

សេចក្តីជូនដំណឹងនេះមានព័ត៌មានយ៉ាងសំខាន់។ សេចក្តីជូនដំណឹងនេះប្រហែលជាមានព័ត៌មានយ៉ាងសំខាន់អំពីទម្រង់បែបបទ ឬការរ៉ាប់រងរបស់អ្នកកម្មវិធី LifeWise Health Plan of Washington ។ ប្រហែលជាមាន កាលបរិច្ឆេទសំខាន់នៅក្នុងសេចក្តីជូនដំណឹងនេះ។ អ្នកប្រហែលជាត្រូវការបញ្ជាក់សមត្ថភាព ដល់កំណត់ថ្លៃជាក់លាក់នានា ដើម្បីនឹងរក្សាទុកការធានារ៉ាប់រងសុខភាពរបស់អ្នក ឬប្រាក់ជំនួយចេញថ្លៃ។ អ្នកមានសិទ្ធិទទួលព័ត៌មាននេះ នឹងជំនួយនៅក្នុងការសរសេរអ្នកដោយមិនអស់លុយឡើយ។ សូមទូរស័ព្ទ 800-592-6804 (TTY: 800-842-5357)។

ਪੰਜਾਬੀ (Punjabi):

ਇਸ ਨੋਟਿਸ ਵਿੱਚ ਖਾਸ ਜਾਣਕਾਰੀ ਹੈ. ਇਸ ਨੋਟਿਸ ਵਿੱਚ LifeWise Health Plan of Washington ਵਲੋਂ ਤੁਹਾਡੀ ਕਵਰੇਜ ਅਤੇ ਅਰਜੀ ਬਾਰੇ ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ ਹੋ ਸਕਦੀ ਹੈ . ਇਸ ਨੋਟਿਸ ਜਵਾਬ ਖਾਸ ਤਾਰੀਖਾਂ ਹੋ ਸਕਦੀਆਂ ਹਨ. ਜੇਕਰ ਤੁਸੀਂ ਜਸਹਤ ਕਵਰੇਜ ਚਿੱਖਣੀ ਹੋਵੇ ਜਾਂ ਓਸ ਦੀ ਲਾਗਤ ਜਵਿੱਚ ਮਦਦ ਦੇ ਇਛੁੱਕ ਹੋ ਤਾਂ ਤੁਹਾਨੂੰ ਅੰਤਮ ਤਾਰੀਖ ਤੋਂ ਪਹਿਲਾਂ ਕੁੱਝ ਖਾਸ ਕਦਮ ਚੁੱਕਣ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ ,ਤੁਹਾਨੂੰ ਮੁਫਤ ਵਿੱਚ ਤੇ ਅਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ ,ਕਾਲ 800-592-6804 (TTY: 800-842-5357).

فارسی (Farsi):

این اعلامیه حاوی اطلاعات مهم میباشد. این اعلامیه ممکن است حاوی اطلاعات مهم درباره فرم تقاضا و یا پوشش بیمه ای شما از طریق LifeWise Health Plan of Washington باشد. به تاریخ های مهم در این اعلامیه توجه نمایید. شما ممکن است برای حفظ پوشش بیمه تان یا کمک در پرداخت هزینه های درمانی تان، به تاریخ های مشخصی برای انجام کارهای خاصی احتیاج داشته باشید. شما حق این را دارید که این اطلاعات و کمک را به زبان خود به طور رایگان دریافت نمایید. برای کسب اطلاعات با شماره 800-592-6804 (TTY: 800-842-5357) تماس بگیرید.

Polskie (Polish):

To ogłoszenie może zawierać ważne informacje. To ogłoszenie może zawierać ważne informacje odnośnie Państwa wniosku lub zakresu świadczeń poprzez LifeWise Health Plan of Washington. Prosimy zwrócić uwagę na kluczowe daty, które mogą być zawarte w tym ogłoszeniu aby nie przekroczyć terminów w przypadku utrzymania polisy ubezpieczeniowej lub pomocy związanej z kosztami. Macie Państwo prawo do bezpłatnej informacji we własnym języku. Zadzwońcie pod 800-592-6804 (TTY: 800-842-5357).

Português (Portuguese):

Este aviso contém informações importantes. Este aviso poderá conter informações importantes a respeito de sua aplicação ou cobertura por meio do LifeWise Health Plan of Washington. Poderão existir datas importantes neste aviso. Talvez seja necessário que você tome providências dentro de determinados prazos para manter sua cobertura de saúde ou ajuda de custos. Você tem o direito de obter esta informação e ajuda em seu idioma e sem custos. Ligue para 800-592-6804 (TTY: 800-842-5357).

Română (Romanian):

Prezenta notificare conține informații importante. Această notificare poate conține informații importante privind cererea sau acoperirea asigurării dumneavoastră de sănătate prin LifeWise Health Plan of Washington. Pot exista date cheie în această notificare. Este posibil să fie nevoie să acționați până la anumite termene limită pentru a vă menține acoperirea asigurării de sănătate sau asistența privitoare la costuri. Aveți dreptul de a obține gratuit aceste informații și ajutor în limba dumneavoastră. Sunați la 800-592-6804 (TTY: 800-842-5357).

Русский (Russian):

Настоящее уведомление содержит важную информацию. Это уведомление может содержать важную информацию о вашем заявлении или страховом покрытии через LifeWise Health Plan of Washington. В настоящем уведомлении могут быть указаны ключевые даты. Вам, возможно, потребуется принять меры к определенным предельным сроком для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 800-592-6804 (TTY: 800-842-5357).

Fa'asamoa (Samoan):

Atonu ua iai i lenei fa'asilasilaga ni fa'amatalaga e sili ona taua e tatau ona e malamalama i ai. O lenei fa'asilasilaga o se fesoasoani e fa'amatala atili i ai i le tulaga o le polokalame, LifeWise Health Plan of Washington, ua e tau fia maua atu i ai. Fa'amolemole, ia e iloilu fa'alelei i aso fa'apitoa olo'o iai i lenei fa'asilasilaga taua. Masalo o le'a iai ni feau e tatau ona e faia ao le'i aulia le aso ua ta'ua i lenei fa'asilasilaga ina ia e iai pea ma lenei fesoasoani mai ai i le polokalame a le Malo olo'o e iai i ai. Olo'o iai iate oe le aia tatau e maua atu i lenei fa'asilasilaga ma lenei fa'matalaga i legagana e te malamalama i ai aunoa ma se togiga tupe. Vili atu i le telefoni 800-592-6804 (TTY: 800-842-5357).

Español (Spanish):

Este Aviso contiene información importante. Es posible que este aviso contenga información importante acerca de su solicitud o cobertura a través de LifeWise Health Plan of Washington. Es posible que haya fechas clave en 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 800-592-6804 (TTY: 800-842-5357).

Tagalog (Tagalog):

Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay maaaring naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng LifeWise Health Plan of Washington. Maaaring may mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng habbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 800-592-6804 (TTY: 800-842-5357).

ไทย (Thai):

ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้อาจมีข้อมูลที่สำคัญเกี่ยวกับการสมัครหรือขอบเขตประกันสุขภาพของคุณผ่าน LifeWise Health Plan of Washington และอาจมีกำหนดการในประกาศนี้ คุณอาจจะต้องดำเนินการบางอย่างในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลืออื่นในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร 800-592-6804 (TTY: 800-842-5357)

Український (Ukrainian):

Це повідомлення містить важливу інформацію. Це повідомлення може містити важливу інформацію про Ваше звернення щодо страховального покриття через LifeWise Health Plan of Washington. Зверніть увагу на ключові дати, які можуть бути вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону 800-592-6804 (TTY: 800-842-5357).

Tiếng Việt (Vietnamese):

Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn xin tham gia hoặc hợp đồng bảo hiểm của quý vị qua chương trình LifeWise Health Plan of Washington. Xin xem 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 800-592-6804 (TTY: 800-842-5357).