

Notice of Privacy Practices

for your **personal** health and financial information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The privacy of your personal and health information is important. You don't need to do anything unless you have a request or complaint.

Relationships are built on trust. One of the most important elements of trust is respect for an individual's privacy. We at Humana value our relationship with you, and we take your personal privacy seriously.

This notice explains Humana's privacy practices, our legal responsibilities, and your rights concerning your personal and health information. We follow the privacy practices described in this notice and will notify you of any changes.

We reserve the right to change our privacy practices and the terms of this notice at any time, as allowed by law. This includes the right to make changes in our privacy practices and the revised terms of our notice effective for all personal and health information we maintain. This includes information we created or received before we made the changes. When we make a significant change in our privacy practices, we will change this notice and send the notice to our health plan subscribers.

What is personal and health information?

Personal and health information - from now on referred to as "information" - includes both medical information and individually identifiable information, like your name, address, telephone number, or Social Security number. The term "information" in this notice includes any personal and health information created or received by a healthcare provider or health plan that relates to your physical or mental health or condition, providing healthcare to you, or the payment for such healthcare.

How does Humana protect my information?

In keeping with federal and state laws and our own policy, Humana has a responsibility to protect the privacy of your information. We have safeguards in place to protect your information in various ways including:

- Limiting who may see your information
- Limiting how we use or disclose your information
- Informing you of our legal duties about your information
- Training our associates about company privacy policies and procedures

How does Humana use and disclose my information?

We must use and disclose your information:

- To you or someone who has the legal right to act on your behalf
- To the Secretary of the Department of Health and Human Services
- Where required by law.

We have the right to use and disclose your information:

- To a doctor, a hospital, or other healthcare provider so you can receive medical care
- For payment activities, including claims payment for covered services provided to you by healthcare providers and for health plan premium payments
- For healthcare operation activities including processing your enrollment, responding to your inquiries and requests for services, coordinating your care, resolving disputes, conducting medical management, improving quality, reviewing the competence of healthcare professionals, and determining premiums
- For performing underwriting activities
- To your plan sponsor to permit them to perform plan administration functions
- To contact you with information about health-related benefits and services, appointment reminders, or about treatment alternatives that may be of interest to you
- To your family and friends if you are unavailable to communicate, such as in an emergency



Notice of Privacy Practices *(continued)*

- To provide payment information to the subscriber for Internal Revenue Service substantiation
- To public health agencies if we believe there is a serious health or safety threat
- To appropriate authorities when there are issues about abuse, neglect, or domestic violence
- In response to a court or administrative order, subpoena, discovery request, or other lawful process
- For law enforcement purposes, to military authorities and as otherwise required by law
- To assist in disaster relief efforts
- For compliance programs and health oversight activities
- To fulfill Humana's obligations under any workers' compensation law or contract
- To avert a serious and imminent threat to your health or safety or the health or safety of others
- For research purposes in limited circumstances
- For procurement, banking, or transplantation of organs, eyes, or tissue
- To a coroner, medical examiner, or funeral director.

Will Humana use my information for purposes not described in this notice?

In all situations other than described in this notice, Humana will request your written permission before using or disclosing your information. You may revoke your permission at any time by notifying us in writing. We will not use or disclose your information for any reason not described in this notice without your permission.

What does Humana do with my information when I am no longer a Humana member or I do not obtain coverage through Humana?

Your information may continue to be used for purposes described in this notice when your membership is terminated or you do not obtain coverage through Humana. After the required legal retention period, we destroy the information following strict procedures to maintain the confidentiality.

What are my rights concerning my information?

The following are your rights with respect to your information:

- **Access** – You have the right to review and obtain a copy of your information that may be used to make decisions about you, such as claims and case or medical management records. You also may receive a summary of this health information. If you request copies, we may charge you a fee for each page, a per hour charge for staff time to locate and copy your information, and postage.
- **Alternate Communications** – You have the right to receive confidential communications of information in a different manner or at a different place to avoid a life-threatening situation. We will accommodate your request if it is reasonable.
- **Amendment** – You have the right to request an amendment of information we maintain about you if you believe the information is wrong or incomplete. We may deny your request if we did not create the information, we do not maintain the information, or the information is correct and complete. If we deny your request, we will give you a written explanation of the denial.
- **Disclosure** – You have the right to receive a listing of instances in which we or our business associates have disclosed your information for purposes other than treatment, payment, health plan operations, and certain other activities. Effective April 1, 2003 or whenever you became a Humana member, Humana began maintaining these types of disclosures and will maintain this information for a period of six years. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
- **Notice** – You have the right to receive a written copy of this notice any time you request.
- **Restriction** – You have the right to ask to restrict uses or disclosures of your information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement. You also have the right to agree to or terminate a previously submitted restriction.

Notice of Privacy Practices *(continued)*

How do I exercise my rights or obtain a copy of this notice?

All of your privacy rights can be exercised by obtaining the applicable privacy rights request forms. You may obtain any of the forms by:

- Contacting us at 1-866-861-2762 at any time
- Accessing our Website at **Humana.com** and going to the Privacy Practices link
- E-mailing us at privacy.office@humana.com

Send completed request form to:
Humana Privacy Office
P.O. Box 1438
Louisville, KY 40202

What should I do if I believe my privacy has been violated?

If you believe your privacy has been violated in any way, you may file a complaint with Human by calling us at: 1-866-861-2762 any time.

You may also submit a written complaint to the U.S. Department of Health and Human Services, Office of Civil Rights (OCR). We will give you the appropriate OCR regional address on request. You also have the option to e-mail your complaint to OCRComplaint@hhs.gov. We support your right to protect the privacy of your personal and health information. We will not retaliate in any way if you elect to file a complaint with us or with the U.S. Department of Health and Human Services.

PRIVACY NOTICE CONCERNING FINANCIAL INFORMATION

Humana and our affiliates understand that the privacy of your personal information is important to you. We take your privacy seriously and your trust in our ability to protect your private information is very important to us. This notice describes our policy regarding the confidentiality and disclosure of personal financial information.

How does Humana collect information about me?

We collect information about you and your family when you complete applications and forms. We also collect information from your dealings with us, our affiliates, or others. For example, we may receive

information about you from participants in the healthcare system, such as your doctor or hospital, as well as from employers or plan administrators, credit bureaus, and the Medical Information Bureau.

What information does Humana receive about me?

The information we receive may include such items as your name, address, telephone number, date of birth, Social Security number, premium payment history, and your activity on our Website. This also includes information regarding your medical benefit plan, your health benefits, and health risk assessments.

Where will Humana disclose my information?

We may share your information with affiliated companies and non-affiliated third parties, as permitted by law. We may also provide your information to other financial institutions with which we have joint marketing agreements in order to provide you with offers for products and services you may find of value or which are health-related.

What can I prevent with an opt-out disclosure?

You can prevent the disclosures to non-affiliated third parties that provide products and services not offered by Humana or where the non-affiliated company provides services related to your plan by requesting to opt-out of such disclosures. Your opt-out request will apply to all members or individuals covered under your Humana identification number or member account.

Your opt-out request will continue to apply until you revoke your request or terminate your membership.

How do I request an opt-out?

At any time you can tell Humana not to share any of your personal information with affiliated companies that provide offers of non-Humana products or services. If you wish to exercise your opt-out option, or to revoke a previous opt out request, you need to provide the following information to process your request: your name, date of birth, and your Humana member identification number. You can use any of the methods below to request or revoke your opt-out:

- Call us at 1-866-861-2762
- E-mail us at privacyoffice@humana.com.

Notice of Privacy Practices *(continued)*

- Send your opt-out request to us in writing:
Humana Privacy Office
P. O. Box 1438
Louisville, KY 40202

Humana follows all federal and state laws, rules, and regulations addressing the protection of personal and health information. In situations when federal and state laws, rules, and regulations conflict, Humana follows the law, rule, or regulation which provides greater protection.

The following affiliates and subsidiaries also adhere to Humana's privacy policies and procedures:

American Dental Providers of Arkansas, Inc.
American Dental Plan of North Carolina, Inc.
Cariten Insurance Company
Cariten Health Plan
CarePlus Health Plans, Inc.
CompBenefits Company
CompBenefits Dental, Inc.
CompBenefits Insurance Company
CompBenefits of Alabama, Inc.
CompBenefits of Georgia, Inc.
CorpHealth, Inc.
CorpHealth Provider Link, Inc.
DentiCare, Inc.
EmpheSys, Inc.
EmpheSys Insurance Company
HumanaDental Insurance Company

Humana AdvantageCare Plan, Inc. fna Metcare Health Plans, Inc.
Humana Benefit Plan of Illinois, Inc. fna OSF Health Plans, Inc.
Humana Health Benefit Plan of Louisiana, Inc.
Humana Employers Health Plan of Georgia, Inc.
Humana Health Insurance Company of Florida, Inc.
Humana Health Plan of Ohio, Inc.
Humana Health Plan of Texas, Inc.
Humana Health Plan, Inc.
Humana Health Plans of Puerto Rico, Inc.
Humana Insurance Company
Humana Insurance Company of Kentucky
Humana Insurance Company of New York
Humana Insurance of Puerto Rico, Inc.
Humana Medical Plan, Inc.
Humana MarketPOINT, Inc.*
Humana MarketPOINT of Puerto Rico, Inc.*
Humana Medical Plan of Utah, Inc.
Humana Wisconsin Health Organization Insurance Corporation
Kanawha Insurance Company*
Managed Care Indemnity, Inc.
Preferred Health Partnership, Inc.*
Preferred Health Partnership of Tennessee, Inc.
The Dental Concern, Inc.
The Dental Concern, Ltd.

* These affiliates and subsidiaries are only covered by the Privacy Notice Concerning Financial Information section.

HUMANA[®]
Guidance when you need it most

Humana Employee Enrollment Application

CALIFORNIA

Dental, Life & Vision

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in this application as "Humana."

Life & Vision plans insured or administered by Humana Insurance Company. Dental HMO plans underwritten by Golden West Dental and Vision. All other Dental plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company.

Please print clearly and fill in each applicable circle.

Dental Group number	Benefit number	Division
Company name	Proposed Effective Date __/__/____	
Company city	State	

Employee Information

CA-80124-GN 7/2007

Last name	First name	MI	Date of birth __/__/____
Social Security number	Phone number		
Gender: <input type="radio"/> Female <input type="radio"/> Male	Email address		
Street address	Apt / Suite / PO Box number		
City	State	Zip code	County
Language of choice: <input type="radio"/> English <input type="radio"/> Spanish			
Employment status: Number of hours worked per week	Date of full-time hire __/__/____	<input type="radio"/> Full-time employee	<input type="radio"/> Retiree
Are you disabled or unable to perform normal activities? <input type="radio"/> No <input type="radio"/> Yes If yes, indicate reason:			

Dependent Information

CA-80124-DP 7/2007

Please enter information for each dependent, including spouse, applying for coverage. For additional dependents, copy and attach an additional Dependent Information form.

1. Last name	First name	MI	Date of birth __/__/____
Social Security number	Gender: <input type="radio"/> Female <input type="radio"/> Male	Relationship: <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other:	
Dependent status (if applicable): <input type="radio"/> Full-time student <input type="radio"/> Disabled	If disabled, indicate reason:		
DHMO: Primary dentist	Facility number	Current Patient: <input type="radio"/> No <input type="radio"/> Yes	
2. Last name	First name	MI	Date of birth __/__/____
Social Security number	Gender: <input type="radio"/> Female <input type="radio"/> Male	Relationship: <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other:	
Dependent status (if applicable): <input type="radio"/> Full-time student <input type="radio"/> Disabled	If disabled, indicate reason:		
DHMO: Primary dentist	Facility number	Current Patient: <input type="radio"/> No <input type="radio"/> Yes	
3. Last name	First name	MI	Date of birth __/__/____
Social Security number	Gender: <input type="radio"/> Female <input type="radio"/> Male	Relationship: <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other:	
Dependent status (if applicable): <input type="radio"/> Full-time student <input type="radio"/> Disabled	If disabled, indicate reason:		
DHMO: Primary dentist	Facility number	Current Patient: <input type="radio"/> No <input type="radio"/> Yes	
4. Last name	First name	MI	Date of birth __/__/____
Social Security number	Gender: <input type="radio"/> Female <input type="radio"/> Male	Relationship: <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other:	
Dependent status (if applicable): <input type="radio"/> Full-time student <input type="radio"/> Disabled	If disabled, indicate reason:		
DHMO: Primary dentist	Facility number	Current Patient: <input type="radio"/> No <input type="radio"/> Yes	

Group Number

Social Security Number

Dental CA-80124-HD 7/2007

Group number Benefit number Class/Division

Coverage type: Employee only Employee and spouse Employee and child(ren) Family Other

Plan name

DHMO: Primary dentist Facility number Current Patient: No Yes

Within the past 12 months, have you had any individual or other group dental coverage? No Yes Orthodontia coverage? No Yes

Effective date __/__/____ Term date __/__/____

Prior coverage type: Employee only Employee and spouse Employee and child(ren) Family

Basic Life CA-80124-HL 7/2007

Group number Benefit number Class/Division

Primary beneficiary name Secondary beneficiary name

Class (employer will provide you with this information if needed) Annual salary (if applicable) \$

Basic dependent life: No Yes If no, complete waiver section.

Voluntary Life

Group number Benefit number Class/Division

Do you elect voluntary employee life coverage? No Yes Amount (minimum of \$15,000) \$ Annual salary \$

Primary beneficiary name Secondary beneficiary name

Voluntary dependent life: (available only if employee elects voluntary life coverage) Do you elect voluntary child(ren) life coverage? No Yes

Do you elect voluntary spouse life coverage? No Yes Amount (minimum of \$5,000) \$

Vision CA-80124-VS 7/2007

Group number Benefit number Class/Division

Coverage type: Employee only Employee and spouse Employee and child(ren) Family Other

Plan name

Waiver (Refusal of coverage) CA-80124-WV 7/2007

I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer. I proclaim that I was not pressured or forced by my employer, the writing agent, or Humana into waiving (declining) coverage. If I have waived any coverage offered to me or my dependents, my signature below is evidence of this action. I hereby waive coverage for (check all that apply):

Dental for: Myself My spouse My dependent child(ren) Vision for: Myself My spouse My dependent child(ren)

Basic life for: Myself My spouse My dependent child(ren)

I decline to apply for group coverage because of (check all that apply): Spousal coverage Medicare supplement Individual coverage Coverage under another carrier's plan provided by my employer Other:

- I understand and agree:
- In the event that I should decide to apply for such coverage hereafter, that such subsequent application shall be subject to the applicable terms and conditions of the master group contract(s) or plan provisions as described in the Summary Plan Description which may require additional limitations and waiting periods.
 - I may be required to furnish, at my own expense, evidence of health status satisfactory to Humana.
 - If I am declining coverage for myself or my dependents (including my spouse) because of other coverage, I may in the future be able to enroll myself or my dependents provided that I request enrollment within 31 days after my other coverage ends.
 - If I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
 - Humana reserves the right to delay medical coverage and/or deny life or dental coverage with any future application for coverage.

Agreement CA-80124-AA 7/2007

True and complete acknowledgement

I understand, agree and represent:

- I have read this document or it has been read to me.
- The answers provided within this entire application for coverage are to the best of my knowledge and belief, true and complete.
- Neither my employer nor the agent has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, or waive any of Humana’s other rights and requirements.
- If this application for coverage is accepted, coverage will be effective on the date specified by Humana on the certificate of coverage/certificate of insurance.
- Any misrepresentation contained herein relied on by Humana may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affected the acceptance of the risk.
- Medical and life domestic partner coverage eligibility is subject to my domestic partner and I being of the same sex or the opposite sex if either of us are over age 62.

I hereby enroll for benefits for which I am presently eligible or for which I may become eligible under my employer’s group contract(s). If any deductions are required for this coverage, I authorize such deductions from my earnings. I reserve the right to revoke this deduction authorization at any time upon written notice unless I have chosen to use pretax deductions.

This document, together with any supplements, will form part of any contract and be the basis for any certificate of coverage/certificate of insurance issued.

Authorization

My dependents and I authorize any physician, medical or health care practitioner, hospital, clinic, veterans administration facility, other medical or medically-related facility, third party administrator, Pharmacy Benefit Manager, insurance, HMO or reinsuring company, the Medical Information Bureau, Inc., employer, the Consumer Reporting Agency or banking and financial institutions having information regarding myself and my dependents, including information concerning, advice, diagnosis, treatment and care of the physical, psychiatric, mental or emotional conditions, drug, substance or alcohol abuse, illness, and copies of all hospital or medical records, non-public personal health information, and any other non-medical information to share any and all such information with Humana, its reinsurer or its legal representatives, and its affiliates.

My dependents and I understand and agree:

- The information obtained by use of this authorization may be used by Humana to determine eligibility for coverage, eligibility for benefits under an existing policy, plan administration, and make claim determinations.
- If you decide not to sign this authorization, Humana can not complete your plan enrollment or determine your premium rate due to the inability to obtain the necessary information.
- Any information obtained will not be released by Humana to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc. or insurance support organizations performing health care operations or business or legal services in connection with an application, claim or as may be otherwise lawfully required, or as I (we) may further authorize.
- Once personal and health (including medical, dental and pharmacy) information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal and state privacy requirements.
- A copy of this authorization is available to me or my legal representative upon written request.
- A photographic copy of this authorization shall be as valid as the original.
- This authorization shall be valid for two years from the date shown below.
- I have the right to revoke this authorization at any time:
 - To revoke this authorization, I must do so in writing and send my written revocation to Humana’s Privacy Office.
 - The revocation will not apply to information that has already been released in response to this authorization.
 - The revocation will become effective after it is received by Humana’s Privacy Office.

CALIFORNIA PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.

Signature - please sign below if enrolling or waiving group coverage

Employee or legal representative signature: _____ Date: _____

Name and relationship of legal representative: _____

Spouse signature: _____ Date: _____

(Only if selecting Life coverage over the guarantee issue amount.)

No Cost Language Services



No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card. For more help call the CA Dept. of Insurance at 1-800-927-4357. (English)

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. (Spanish)

خدمات ترجمه بدون هزینه. می‌توانید خدمات ترجمه را به زبان خود دریافت کنید و برخی اسناد را به زبان خود بخوانید. برای کمک، با ما از طریق شماره تلفنی که روی کارت شناسایی شما قید شده است تماس بگیرید. به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تلفن کنید. (Arabic)

Անվճար լեզվական ծառայություններ: Դուք կարող եք թարգմանիչ ձեռք բերել: Դուք կարող եք փաստաթղթերն ընթերցել տալ ձեզ համար եւ դրանց որոշ մասը կարող է ձեզ ուղարկվել ձեր լեզվով: Օգնության համար զանգահարեք մեզ ձեր ինքնության (ID) քարտի վրա նշված համարով: Լրացուցիչ օգնության համար զանգահարեք Կալիֆոռնիայի Ապահովագրության Բաժանմունք 1-800-927-4357 համարով: (Անգլերեն) (Armenian)

免費語言服務。您可獲得口譯員服務，用漢語把文件唸給您聽，並且把部分漢語文件發送給您。欲取得協助，請撥打您的ID卡上所列示的電話號碼與我們聯絡。欲取得其他協助，請致電 1-800-927-4357 (英語) 與加州保險部聯絡。(Chinese)

Kev Pab Txhais Lus Tsis Yuav Nqi. Koj muaj peev xwm thov tau neeg txhais lus rau koj. Koj muaj peev xwm thov kom neeg nyeem ntawv rau koj thiab xav ntawv rau koj ua koj cov lus. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuav nrog cev (ID card). Yog xav tau kev pab ntxiv hu rau CA lub Rooj Tsav Xwm Saib Xyuas Kev Faj Seeb ntawm 1-800-927-4357 (Hmong)

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号までご連絡ください。詳細については、カリフォルニア州保険庁 1-800-927-4357 (英語) まで電話でお問い合わせください。(Japanese)

សេវាកម្មឥតគិតថ្លៃ ។ អ្នក អាចទទួលបានអ្នកបកប្រែភាសា និង អាសន្នការជូនអ្នក ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅលេខក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 (Khmer)

무료 언어지원 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있습니다. 한국어로 문서를 낭독해주는 서비스를 받으시거나 한국어로 된 문서를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID카드에 나와있는 안내 전화로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357 번으로 연락해 주십시오. (Korean)

خدمات مجاني مربوط به زبان. میتوانید خدمات یک مترجم شفاهی استفاده کنید و بگویند مدارک به زبان فارسی برایتان خوانده و یا فرستاده شوند برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسایی شما قید شده است تماس بگیرید. برای دریافت کمک بیشتر، به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تلفن کنید. (Persian)

ਮੁਫਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਹਾਨੂੰ ਕਈ ਦੁਭਾਸ਼ੀਆਂ ਮਿਲ ਸਕਦਾ ਹੈ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ ਅਤੇ ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਤੁਹਾਨੂੰ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਸਾਨੂੰ ਫ਼ੌਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ ਇਨਸੂਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੌਨ ਕਰੋ। (ਅੰਗ੍ਰੇਜ਼ੀ) (Punjabi)

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика. Для вас могут прочесть документы или выслать вам некоторые из них на вашем языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной (ID) карте. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния по телефону 1-800-927-4357. (Английский) (Russian)

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 (Taglog)

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch. Được người khác đọc giúp các tài liệu và một vài tài liệu sẽ được gửi cho quý vị bằng ngôn ngữ của quý vị. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị. Để được trợ giúp thêm, xin gọi Phòng bảo hiểm California tại số 1-800-927-4357 (Vietnamese)