KAISER PERMANENTE®

Application for health coverage

Individual and Family Plans

Who can use this application?

You may use this application to apply for a Kaiser Permanente for Individuals and Families (KPIF) plan.

- If you want coverage for your family on the same KPIF plan, please fill out one application for the family. If someone in your family wants a different health plan, they must complete a separate application.
- To be eligible for KPIF coverage, you must live in our Hawaii service area.

Who should not use this application?

- If you or any dependent you're applying for are entitled to Medicare Part A or are enrolled in Medicare Part B, that applicant is not eligible to apply for new KPIF coverage. Please visit **kp.org/medicare** to learn more about your Medicare plan options or to apply for Medicare coverage.
- If you qualify for and want federal financial assistance to help pay for copays, coinsurance, deductibles, or premiums, don't complete this application. You must apply for coverage through health benefit exchange at **HealthCare.gov**.
- If you're already a KPIF member, don't use this form. To make changes to your account, call **1-800-966-5955.**

Things to remember

- If you're applying during open enrollment, the date we receive your application may change your effective date – it will usually be January 1 if you apply by December 15.
- If you're applying during a special enrollment period, go to **kp.org/specialenrollment** or call **1-800-494-5314** for instructions.
- Please send this application back as quickly as you can – or you can apply faster online at **buykp.org/apply**.
- Please answer all questions, and type or print using ink only. Leave an empty box in between words, and put a hyphen in the box for hyphenated names.
- Remember, if you're enrolling in a new plan, that won't automatically cancel any other coverage you have. To avoid paying for 2 plans or having a gap in coverage, make sure to cancel any other coverage as of the day before your new coverage starts.
- **To make sure your application is processed in time and isn't canceled,** please return every page of the application, completed, with all the required signatures, first month's payment, and proof of your qualifying life event (if required). Send these materials by mail to:

  Kaiser Permanente for Individuals and Families
  P.O. Box 23219
  San Diego, CA 92193-9921

  Or send it by secure fax to: **1-866-920-6470**

  Note: Checks must be mailed and can't be faxed.

Need help?

- For help with completing this application, please call **1-800-670-5420** (TTY **711**).
- **We'll provide language assistance at no cost to you.**
- If you're working with a broker, please call them for assistance.

All plans are offered and underwritten by Kaiser Foundation Health Plan, Inc., 711 Kapiolani Blvd., Honolulu, HI 96813.
This document is still pending regulatory approval and may be subject to change.

Primary applicant

5 0 0 5 0 4 7 6 3 3

STEP 1: Choose your enrollment period

Select one option: ☐ Open enrollment **(skip to Step 2)** ☐ A special enrollment period (continue below)

Choose your qualifying life event. If you had more than one, review your options because effective dates vary by event. **Proof of eligibility is also required.** Visit **kp.org/specialenrollment** or call **1-800-494-5314** for more about qualifying life events.

- ☐ Loss of minimum essential health coverage (write the last full day you had coverage)*
- ☐ Gaining or becoming a dependent through marriage or domestic partnership
- ☐ Gaining or becoming a dependent through the birth of a child, adoption, or placement for adoption or foster care
  Note: In this case, you also need to choose between 2 effective date options:
  - ☐ The date of birth, adoption, or placement for adoption or foster care
  - ☐ The first day of the month after gaining the dependent
- ☐ Child support order or other court order to cover a dependent
  Note: In this case, you also need to choose between 2 effective date options:
  - ☐ The date of the child support order or other court order to cover a dependent
  - ☐ The first day of the month after the court order date
- ☐ Permanent relocation with access to new plans
- ☐ Changes in employer health coverage making you eligible for a premium tax credit
- ☐ Determination by the health benefit exchange of exceptional circumstances
- ☐ Eligibility to purchase an individual health plan through an individual coverage health reimbursement arrangement (ICHRA) or a qualified small employer health reimbursement arrangement (QSEHRA)
- ☐ Domestic violence or spousal abandonment occurring within the household

Please write the date of your qualifying life event. ☐☐ / ☐☐ / ☐☐☐☐ (mm/dd/yyyy)

*If your qualifying life event is loss of Kaiser Permanente coverage, we may review membership records to check when and why you lost coverage. For more about minimum essential coverage, visit **kp.org/specialenrollment**.

STEP 2: Choose your health plan

Choose one health plan. If any family members are applying for different health plans, please submit a separate application for each plan. For more about minimum essential coverage, visit **kp.org/specialenrollment**.

Bronze	Silver	Gold	Platinum
☐ KP HI Bronze 6500/65 Off	☐ KP HI Silver 2500/40 Off	☐ KP HI Gold 0/30 Off	☐ KP HI Platinum 0/10 Off
☐ KP HI Bronze 6500/65 Plus CAM Off	☐ KP HI Silver 2500/40 Plus CAM Off	☐ KP HI Gold 0/30 Plus CAM Off	☐ KP HI Platinum 0/10 Plus CAM Off
☐ KP HI Bronze 7000/30% Off	☐ KP HI Silver 4000/45 Off	☐ KP HI Gold 1000/30 Off	

For information about health and dental benefits and limitations, cost-sharing amounts, and premiums, please review the details in your enrollment materials. To request a copy of the *Kaiser Permanente Hawaii's Guide to Your Health Plan* for a particular plan, please go to **kp.org/plandocuments**, call **1-800-966-5955,** or contact your broker.

STEP 3: Verify your pediatric dental plan (All applicants are required to fill out this section.)

If you enroll in a KPIF plan, then by law you must also enroll in a separate pediatric dental plan. Or, if you already have other pediatric dental coverage that is certified by the health benefit exchange, you must let us know.

☐ I have purchased other pediatric dental coverage certified by the health benefit exchange.

STEP 4: Enter your information

Primary applicant

In an individual plan, the primary applicant is the person who will be covered by the health plan. In a family plan, the primary applicant is the family member on the health plan who is authorized to make changes to the account. If this application is only for a child under 18, the child is the primary applicant.

First name | MI | Date of birth (mm/dd/yyyy)

Last name

Former medical record number (if any) | State (if any) | Gender: ☐ Male ☐ Female ☐ Undeclared | Phone

Home address (no P.O. boxes, please)

City

State | ZIP code | County | Social Security number (if any)

Billing address (if different than home address)

City

State | ZIP code

Preferred language spoken (if not English) | Preferred language read (if not English)

Email address (optional) *I understand that Kaiser Permanente may contact me via email.*

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

Parent or legal guardian (if the primary applicant is a child under 18)

First name | MI

Last name | Social Security number (if any)

Primary applicant

Spouse/domestic partner to be covered

A domestic partner is a person registered and legally recognized as your domestic partner by the state of Hawaii.

First name

MI

Choose one: ☐ Spouse ☐ Domestic partner

Last name

Social Security number (if any) ___ - ___ - ____

Former medical record number (if any) ____ – ___

State (if any)

Gender: ☐ Male ☐ Female ☐ Undeclared

Date of birth (mm/dd/yyyy) __ / __ / ____

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

Dependents to be covered

If you have more than 3 dependents to be covered, please fill out an extra copy of this page and submit it with your application.

1 First name

MI

Last name

Social Security number (if any) ___ - ___ - ____

Former medical record number (if any) ____ – ___

State (if any)

Gender: ☐ Male ☐ Female ☐ Undeclared

Date of birth (mm/dd/yyyy) __ / __ / ____

Relationship to primary applicant

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

2 First name

MI

Last name

Social Security number (if any) ___ - ___ - ____

Former medical record number (if any) ____ – ___

State (if any)

Gender: ☐ Male ☐ Female ☐ Undeclared

Date of birth (mm/dd/yyyy) __ / __ / ____

Relationship to primary applicant

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

3 First name

MI

Last name

Social Security number (if any) ___ - ___ - ____

Former medical record number (if any) ____ – ___

State (if any)

Gender: ☐ Male ☐ Female ☐ Undeclared

Date of birth (mm/dd/yyyy) __ / __ / ____

Relationship to primary applicant

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

STEP 5: Choose an authorized representative (if you have one)

You can give a trusted friend or relative permission to talk about this application with us, see your information, or act for you on matters related to this application only. This person is called an authorized representative.

First name

MI

Last name

Phone

By signing, you've appointed this person as your legally authorized representative to get official information about this application, and to act for you on matters related to this application.

X

Date (mm/dd/yyyy)

Primary applicant (parent or legal guardian for children under 18)

STEP 6: Sign the application agreement

Important: All applicants and dependents 18 and older must read, sign, and date below. If the primary applicant is a child under 18, then their parent or legal guardian must sign. By signing, the parent or legal guardian agrees to be responsible for paying all premiums, copays, coinsurance, and deductibles for all the applicants listed on this application. A copy of your agreement with your signature is as valid as the original. If signatures are missing, we will cancel the application. If there are more than 3 dependents 18 and older signing, please attach a copy of this page with the additional signatures. To be eligible for KPIF coverage, you and any dependent you're applying for can't be entitled to Medicare Part A or enrolled in Medicare Part B.

- I verify that no applicant listed on this form is entitled to Medicare Part A or enrolled in Medicare Part B.
- I understand that Kaiser Permanente for Individuals and Families (KPIF) will rely on the information provided in this application. If any information is found to be fraudulent or intentionally misrepresented, then KPIF may choose to terminate coverage back to the coverage effective date.

X _____ Date (mm/dd/yyyy) __/__/____

Primary applicant (parent or legal guardian for children under 18)

X _____ Date (mm/dd/yyyy) __/__/____

Spouse/domestic partner

X _____ Date (mm/dd/yyyy) __/__/____

Dependent (18 and older)

X _____ Date (mm/dd/yyyy) __/__/____

Dependent (18 and older)

X _____ Date (mm/dd/yyyy) __/__/____

Dependent (18 and older)

STEP 7: Sign the arbitration agreement

A. BINDING ARBITRATION

Except as provided below, any and all claims, disputes, or causes of action arising out of or related to the Kaiser Permanente Hawaii's Guide to Your Health Plan (Guide), its performance or alleged breach, or the relationship or conduct of the parties, including but not limited to any and all claims, disputes, or causes of action based on contract, tort, statutory law, or actions in equity, shall be resolved by binding arbitration as set forth in this Guide.

1. This includes but is not limited to any claim asserted:
   (a) By or against a Member, a patient, the heirs or the personal representative of the estate of the Member or patient, or any other person entitled to bring an action for damages, arising from or related to harm to the Member or patient as permitted by applicable federal or Hawaii state law existing at the time the claim is filed ("Member Parties"). For purposes of this section 8, all family members of the Member or patient who have derivative claims arising from such harm, shall also be deemed "Member Parties" and bound to these arbitration terms;
   (b) On account of death, bodily injury, physical ailment, mental disturbance, or economic loss arising out of the rendering or failure to render medical services or the provision or failure to provide benefits under this Guide, premises liability, or arising out of any other claim of any nature, irrespective of the legal theory upon which the claim is asserted; and
   (c) By or against one or more of the following entities or their employees, officers or directors ("Kaiser Permanente Parties"):
      (i) Kaiser Foundation Health Plan, Inc.,
      (ii) Kaiser Foundation Hospitals,
      (iii) Hawaii Permanente Medical Group, Inc.,
      (iv) The Permanente Federation, LLC,
      (v) Any individual or organization that contracts with an organization named in (i), (ii), (iii), or (iv) above to provide medical services to Health Plan Members, when such contract includes a provision requiring arbitration of the claim made.
2. Notwithstanding any provisions to the contrary in this Guide, the following claims shall not be subject to mandatory arbitration:
   (a) claims for monetary damages within the jurisdictional limit of the Small Claims Division of the District Courts of the State of Hawaii;
   (b) actions for appointment of a legal guardian of a person or property subject to probate laws;
   (c) purely injunctive orders reasonably necessary to protect Kaiser Permanente's ability to safely render medical services under this Guide (such as temporary restraining orders, and emergency court orders).

B. INITIATING ARBITRATION

A demand for arbitration shall be initiated by sending a registered or certified letter to each named party against whom the claim is made, with a notice of the existence and nature of the claim, the amount claimed and a demand for arbitration. Any Kaiser Permanente Parties shall be served by registered or certified letter, postage prepaid, addressed to the Kaiser Permanente Parties as follows: Kaiser Foundation Health Plan, Inc., Member Services Department, 711 Kapiolani Blvd., Honolulu, HI 96813. The arbitrators shall have jurisdiction only over persons and entities actually served.

C. ARBITRATION PROCEEDINGS

1. Within 30 days after the service of the demand for arbitration, the parties shall agree on a panel of arbitrators from which to select arbitrators or shall agree on particular arbitrators who shall serve for the case. If the parties cannot agree on any panel of arbitrators or particular arbitrators within the 30 days, then the panel of arbitrators shall be that of Dispute Prevention and Resolution, Inc. ("DPR"). Unless the parties agree to any other arbitration service and rules, DPR shall administer the arbitration and its arbitration rules shall govern the arbitration (including rules for selection of arbitrators from a panel of arbitrators, if the parties have not already agreed upon particular arbitrators to serve). Kaiser Permanente shall notify DPR (or such other arbitration service as may be chosen by the parties) of the arbitration within 15 days following the expiration of the 30-day period noted above.

Sign the arbitration agreement *(continued)*

2. Within 30 calendar days after notice to Dispute Prevention and Resolution, Inc., the parties shall select a panel of three arbitrators from a list submitted to them by the arbitration service. In all claims seeking a total monetary recovery less than $25,000.00, and in any other case where the parties mutually agree, a panel of one arbitrator selected by both parties from a list submitted to them by the arbitration service will be allowed. The arbitrator(s) will arrange to hold a hearing in Honolulu (or such other location as agreed by the parties) within a reasonable time thereafter.
3. Limited civil discovery shall be permitted only for
   (a) production of documents that are relevant and material,
   (b) taking of brief depositions of treating physicians, expert witnesses and parties (a corporate party shall designate the person to be deposed on behalf of the corporation), and a maximum of three other critical witnesses for each side (i.e., respondents or claimants), and
   (c) independent medical evaluations.
4. The arbitrator(s) will resolve any discovery disputes submitted by any party, including entry of protective orders or other discovery orders as appropriate to protect the parties' rights under this paragraph.
5. Any payment for the fees and expenses of the arbitration service and the arbitrator(s) shall be borne one-third by the Member Parties and two-thirds by the Kaiser Permanente Parties.
6. Each party shall bear their own attorney's fees, witness fees, and discovery costs.
7. The arbitrator(s) may decide a request for summary disposition of a claim or particular issue, upon request of one party to the proceeding with notice to all other parties and a reasonable opportunity for the other parties to respond. The standards applicable to such request shall be those applicable to analogous motions for summary judgment or dismissal under the Federal Rules of Civil Procedure.
8. In claims involving benefits and coverage due under this Guide or disputes involving operation of the Plan, Health Plan's determinations and interpretations, and its decisions on these matters are subject to de novo review.
9. The arbitration award shall be final and binding. The Member Parties and Kaiser Permanente Parties waive their rights to jury or court trial.
10. With respect to any matter not expressly provided for herein, the arbitration will be governed by the Federal Arbitration Act, 9 U.S.C. Chapter 1.

D. GENERAL PROVISIONS

All claims based upon the same incident, transaction, or related circumstances regarding the same Member or same patient shall be arbitrated in one proceeding (for example, all Member Parties asserting claims arising from an injury to the same Health Plan Member, shall be arbitrated in one proceeding).

A claim for arbitration shall be waived and forever barred if on the date notice thereof is received, the claim, if it were then asserted in a civil action, would be barred by the applicable Hawaii statute of limitations. All notices or other papers required to be served or convenient in the conduct of arbitration proceedings following the initial service shall be mailed, postage prepaid, to such address as each party gives for this purpose. If the Federal Arbitration Act or other law applicable to these arbitration terms is deemed to prohibit any term in this Guide in any particular case, then such term(s) shall be severable in that case and the remainder of this Guide shall not be affected thereby. Class actions and consolidation of parties asserting claims regarding multiple Members or patients are prohibited. The arbitration provisions in this Guide shall supercede those in any prior Guide.

E. CONFIDENTIALITY

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

Sign the arbitration agreement *(continued)*

F. SPECIAL CLAIMS

1. Medical Malpractice Claims. Prior to initiating any arbitration proceedings alleging medical malpractice, Member Parties shall first submit the claim to a Medical Inquiry and Conciliation Panel pursuant to Chapter 671, Hawaii Revised Statutes, Sections 11-19. If the claim has not been withdrawn or settled, Member Parties shall serve a demand for arbitration on Kaiser Permanente Parties as specified above.
2. External Appeal of Internal Adverse Benefit Decisions. If Member disagrees with Kaiser Permanente's final internal determination, Member shall request binding arbitration pursuant to the procedures in this Guide.

In addition to the arbitration procedures set forth in this Guide, Hawaii Revised Statutes Chapter 432E also creates certain external review rights to submit a request for external review to the State Insurance Commissioner within one hundred thirty days from the date of Kaiser Permanente's final internal determination. These rights are subject to the limitations noted at the end of this subsection, and subject to the requirements and limitations in Hawaii Revised Statutes Chapter 432E (including exhaustion of Kaiser Permanente's internal claims and appeals procedures before requesting external review, except as specified in Chapter 432E for situations when simultaneous external review is permitted to occur or Kaiser Permanente has failed to comply with federal requirements regarding its claims and appeals process). A complete description of Kaiser Permanente's claims and appeals procedures is described in the Member Handbook.

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

STEP 8: Sign the arbitration agreement and waive right to jury trial

Kaiser Foundation Health Plan Arbitration Agreement: Except as provided in the arbitration agreement, excerpted from your Guide on pages 7, 8, and 9 of this enrollment form, any and all claims, disputes, or causes of action arising out of or related to the Guide, its performance or alleged breach, or the relationship or conduct of the parties, including but not limited to any and all claims, disputes, or causes of action based on contract, tort, statutory law, or actions in equity, shall be resolved by binding arbitration. I, on behalf of myself and all family members, hereby (i) acknowledge that I have read and understood the provisions of the arbitration agreement on pages 7, 8, and 9 of this enrollment form, (ii) agree to binding arbitration, and (iii) give up my constitutional right to a jury trial.

X _____ Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

Primary applicant (parent or legal guardian for children under 18)

Primary applicant

STEP 9: Enter first month's payment details

Payment information

First name of person responsible for payment

MI

Last name of person responsible for payment

Address

City

State

ZIP code

Payment options (choose one) ☐ Credit card ☐ Debit card ☐ Electronic payment ☐ Check ☐ Money order

If electronic payment, select account type: ☐ Checking account ☐ Savings account

I authorize Kaiser Foundation Health Plan, Inc. (KFHP), and the designated financial institution to accept this transfer of the first month's payment amount from my checking or savings account when my application is processed by KFHP.

Bank name

Routing number

Account number

Account holder's first name

MI

Account holder's last name

X

Account holder's signature

Date (mm/dd/yyyy) / /

If check or money order

Write the name of the primary applicant on the check. Mail payment with your application to the address listed on page 1.

To pay with a credit or debit card, please fill out the section below.

Cardholder's first name as it appears on card

MI

Cardholder's last name as it appears on card

Expiration date (mm/yyyy) /

Card number

X

Cardholder's signature

Date (mm/dd/yyyy) / /

Automatic monthly payments (optional)

To cancel or update automatic payments, go to **kp.org/payonline** or call the Member Service Contact Center at **1-800-966-5955.**

Do you want to sign up for automatic monthly payments?

- ☐ Yes
  - ☐ I want to enter a new payment method here. (Please fill out this page.)
  - ☐ Please use the same payment method I provided for my first month's payment. (Skip this page.)
- ☐ No, I don't want automatic monthly payments. (Skip this page)

First name of person responsible for payment

MI

Last name of person responsible for payment

Billing address

City

State

ZIP code

Automatic payment options (choose one)

☐ Credit card (debit cards can't be used) ☐ Electronic payment

If electronic payment, select account type: ☐ Checking account ☐ Savings account

I authorize Kaiser Foundation Health Plan, Inc. (KFHP), and the designated financial institution to accept this transfer from my checking or savings account.

Bank name

Routing number

Account number

Account holder's first name

MI

Account holder's last name

X

Account holder's signature

Date (mm/dd/yyyy)

To pay with a credit card, please fill out the section below.

Cardholder's first name as it appears on card

MI

Cardholder's last name as it appears on card

Expiration date (mm/yyyy)

Card number

CVV number

X

Cardholder's signature

Date (mm/dd/yyyy)

For applicants using a broker or Kaiser Permanente representative

If a broker or Kaiser Permanente representative (employee) helped you decide which plan to enroll in or helped you fill out this application, please make sure they complete this page.

The broker may receive monetary payments or other compensation from Kaiser Permanente in connection with your purchase of this coverage.

Note: Premiums are the same whether or not you use a broker or Kaiser Permanente representative.

To be completed by your broker or representative after you complete this application:

Agency name

Agency ID number

Broker or Kaiser Permanente representative (first, middle, last)

Address

City

State

ZIP code

Kaiser Permanente–appointed ID number

National producer number (NPN)

Phone

Fax

Email address

I (the broker or Kaiser Permanente representative) have not made any representations to the applicant about any provisions, benefits, conditions, or limitations of Kaiser Permanente's Hawaii's Guide to Your Health Plan through written materials furnished by KPIF. The applicant has been informed that the effective date of coverage is assigned by KPIF based on when the application is received.

I assisted the applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information, and the applicant understood the explanation

☐ Yes ☐ No

X

Broker or Kaiser Permanente representative

Date (mm/dd/yyyy)

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan, Inc. (Kaiser Health Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, and accessible electronic formats

- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call **1-800-966-5955** (TTY: **711**)

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail or phone at:

Membership Services
Attn: Kaiser Civil Rights Coordinator
711 Kapiolani Blvd
Honolulu, HI 96813
1-800-966-5955

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HELP IN YOUR LANGUAGE

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

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

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-966-5955**（TTY：**711**）。

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

ʻŌlelo Hawaiʻi (Hawaiian) E NĀNĀ MAI: Inā hoʻopuka ʻoe i ka ʻōlelo Hawaiʻi, hiki iā ʻoe ke loaʻa i ke kōkua manuahi. E kelepona i ka helu **1-800-966-5955** (TTY: **711**).

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

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

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

ລາວ (Laotian) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-800-966-5955** (TTY: **711**).

Kajin Majōḷ (Marshallese) LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaaloḳ **1-800-966-5955** (TTY: **711**).

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

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

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

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

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

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

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

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