SHARP Health Plan

Individual & Family Plans Special Enrollment Period

Application for Health Insurance

Purpose

The purpose of this form is to help you apply for health insurance during special enrollment. Filling out this form means you are applying for an Individual or Family Plan — within 60 days of a qualifying event — with Sharp Health Plan.

Instructions

Fill out this form if you would like to make changes to your benefit plan or update the personal information associated with your account.

You can make changes to the following:

- Your subscriber information
- Your coverage
- Your benefit plan and network

Covered California™ members: To add a dependent or change your benefit plan, please contact Covered California at 1-800-300-1506. You can also change or update your account online by logging in to your Covered California account at **coveredca.com**.

Submit

By mail or in person:*
Sharp Health Plan
Attention: IFP Sales
8520 Tech Way, Suite 200
San Diego, CA 92123

By email:
ifpsales@sharp.com

By fax:
Attention: IFP Sales
1-858-499-8246

Expedite this application by applying online at **sharphealthplan.com/get-a-quote**.

Make a Payment

To pay your premium with your debit or credit card, please visit **sharphealthplan.com/payment**, or mail your check or money order to:

Sharp Health Plan
P.O. Box 57248
Los Angeles, CA 90074-7248

If you need assistance, we're here to help.
You can call our IFP sales team at 1-858-499-8211 or email us at **ifpsales@sharp.com**.
We are available to assist you Monday through Friday, 8 a.m. to 5 p.m.

Preliminary Information

Are you currently enrolled in a Sharp Health Plan Individual or Family Plan? ☐ Yes ☐ No

If yes, please enter your subscriber identifier number (provided on member ID card):

Will you be enrolled in any other health insurance with another carrier? ☐ Yes ☐ No

If yes, please provide insurance company:

How Did You Hear About Us?

☐ Advertisement ☐ Doctor's office ☐ Event ☐ Insurance broker ☐ Previous member ☐ Word of mouth
☐ Other

*Pending safety guidelines.

Step 1a. Subscriber Information (Policyholder) (Please print.)

First name: Middle initial: Last name:

Birth date: MM/DD/YY
/ /

Social Security number:
– –

Marital status: ☐ Single ☐ Married ☐ Widowed
☐ State-registered domestic partner ☐ Child-only application

Sex assigned at birth:
- ☐ Male
- ☐ Female
- ☐ Unknown
- ☐ Choose not to disclose

Gender identity:
- ☐ Man
- ☐ Woman
- ☐ Transgender male/trans man/ female-to-male (FTM)
- ☐ Transgender female/trans woman/male-to-female (MTF)
- ☐ Nonbinary, neither exclusively male nor female
- ☐ Additional gender category or other, please specify: _____
- ☐ Choose not to disclose

Pronouns:
- ☐ He/him/his
- ☐ She/her/hers
- ☐ They/them/theirs
- ☐ Something else, please specify: _____
- ☐ Choose not to disclose

Sexual orientation:
- ☐ Lesbian, gay or homosexual
- ☐ Straight or heterosexual
- ☐ Bisexual
- ☐ Something else, please specify: _____
- ☐ Don't know
- ☐ Choose not to disclose

Which race best represents you? Please select all that apply.
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ Other: _____
- ☐ Unknown
- ☐ Choose not to disclose

Are you of Hispanic, Latino or Spanish origin?
- ☐ No, not of Hispanic, Latino or Spanish origin
- ☐ Yes, Cuban
- ☐ Yes, Mexican, Mexican American or Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, another Hispanic, Latino or Spanish origin
- ☐ Two or more races
- ☐ Yes, other
- ☐ Unknown
- ☐ Choose not to disclose

Home address (P.O. Box is not allowed):

City: State: ZIP code:

Billing address (if different from above):

City: State: ZIP code:

Cell phone number:
( )

Home phone number:
( )

Other phone number:
( )

Email address:

Are you willing to receive information from Sharp Health Plan by email and/or text? For text, message or data rates may apply. ☐ Yes ☐ No

Please note any communication assistance or special needs:

Preferred spoken or written language (if not English):

To find a Sharp Health Plan-affiliated doctor who meets your needs, and their Provider NPI, please visit **sharphealthplan.com** or call Customer Care at 1-800-359-2002.

Primary care physician (If left blank, Sharp Health Plan will assign a PCP.):		Are you an existing patient with this doctor? ☐ Yes ☐ No
Name:	Provider NPI:	

Pediatric Dental

Please note: Applicants under age 19 will automatically be enrolled in a pediatric dental plan with Delta Dental of California. To find a Delta Dental dentist in your network, visit deltadentalins.com, use the "Find a Dentist" lookup and choose a dentist in the DeltaCare USA Network. You must use a dentist in the DeltaCare USA Network to be eligible for dental benefits.

DeltaCare USA is underwritten in these states by these entities: AL — Alpha Dental of Alabama, Inc.; AZ — Alpha Dental of Arizona, Inc.; CA — Delta Dental of California; CO, MA, MI, NC, OK, OR, WA — Dentegra Insurance Company; CT, DC, DE, FL, GA, LA, MS, TN — Delta Dental Insurance Company; ID, KY, MD, MO, NJ, OH, TX — Alpha Dental Programs, Inc.; NY — Delta Dental of New York, Inc.; PA — Delta Dental of Pennsylvania; UT — Alpha Dental of Utah, Inc. Delta Dental Insurance Company acts as the DeltaCare USA administrator in all these states. These companies are financially responsible for their own products.

Pediatric Vision

Please note: Applicants under age 19 will automatically be enrolled in a pediatric vision plan. Services are provided by Vision Service Plan (VSP). To search a list of available eye doctors, go to **vsp.com/advantage**.

Step 1b. Parent or Legal Guardian **(If the subscriber applicant is a child under 18)**

First name: Middle initial: Last name:

Birth date: MM/DD/YY / /	Social Security number: – –

Sex assigned at birth:	Gender identity:	Pronouns:	Sexual orientation:
☐ Male ☐ Female ☐ Unknown ☐ Choose not to disclose	☐ Man ☐ Woman ☐ Transgender male/trans man/ female-to-male (FTM) ☐ Transgender female/trans woman/male-to-female (MTF) ☐ Nonbinary, neither exclusively male nor female ☐ Additional gender category or other, please specify: _____ ☐ Choose not to disclose	☐ He/him/his ☐ She/her/hers ☐ They/them/theirs ☐ Something else, please specify: _____ ☐ Choose not to disclose	☐ Lesbian, gay or homosexual ☐ Straight or heterosexual ☐ Bisexual ☐ Something else, please specify: _____ ☐ Don't know ☐ Choose not to disclose

Home address (P.O. Box is not allowed):

City:	State:	ZIP code:

Cell phone number: ( )	Home phone number: ( )	Other phone number: ( )

Email address:

Step 1c. Second Guardian, Spouse or Domestic Partner

Complete the following information if you wish to add a second guardian/spouse/domestic partner to this policy. Otherwise, skip to Step 2.

First name: Middle initial: Last name:

Birth date: MM/DD/YY / /

Social Security number: – –

Relationship to subscriber:
☐ Guardian ☐ Spouse ☐ State-registered domestic partner

Sex assigned at birth:
☐ Male
☐ Female
☐ Unknown
☐ Choose not to disclose

Gender identity:
☐ Man
☐ Woman
☐ Transgender male/trans man/ female-to-male (FTM)
☐ Transgender female/trans woman/male-to-female (MTF)
☐ Nonbinary, neither exclusively male nor female
☐ Additional gender category or other, please specify:
_____
☐ Choose not to disclose

Pronouns:
☐ He/him/his
☐ She/her/hers
☐ They/them/theirs
☐ Something else, please specify:
_____
☐ Choose not to disclose

Sexual orientation:
☐ Lesbian, gay or homosexual
☐ Straight or heterosexual
☐ Bisexual
☐ Something else, please specify:
_____
☐ Don't know
☐ Choose not to disclose

Cell phone number: ( )

Home phone number: ( )

Other phone number: ( )

Email address:

To find a Sharp Health Plan-affiliated doctor who meets your needs, and their Provider NPI, please visit **sharphealthplan.com** or call Customer Care at 1-800-359-2002.

Primary care physician (If left blank, Sharp Health Plan will assign a PCP.):

Name:

Provider NPI:

Are you an existing patient with this doctor?
☐ Yes
☐ No

Step 1d. Dependents

Complete the following information for each additional dependent, parent dependent or stepparent dependent who meets the definition of a qualifying relative. Otherwise, skip to Step 2.

1. First name: Middle initial: Last name:

Birth date: MM/DD/YY / /

Social Security number: – –

Relationship to subscriber:

Sex: ☐ M ☐ F ☐ Other

Cell phone number: ( )

Home phone number: ( )

Other phone number: ( )

Email address:

To find a Sharp Health Plan-affiliated doctor who meets your needs, and their Provider NPI, please visit **sharphealthplan.com** or call Customer Care at 1-800-359-2002.

Primary care physician (If left blank, Sharp Health Plan will assign a PCP.):

Name:

Provider NPI:

Are you an existing patient with this doctor?
☐ Yes
☐ No

Step 1d. Dependents, continued

Complete the following information for each additional dependent, parent dependent or stepparent dependent who meets the definition of a qualifying relative. Otherwise, skip to Step 2.

2. First name: Middle initial: Last name:

Birth date: MM/DD/YY / /	Social Security number: – –	Relationship to subscriber:	Sex: ☐ M ☐ F ☐ Other

Cell phone number: ( )	Home phone number: ( )	Other phone number: ( )

Email address:

To find a Sharp Health Plan-affiliated doctor who meets your needs, and their Provider NPI, please visit **sharphealthplan.com** or call Customer Care at 1-800-359-2002.

Primary care physician (If left blank, Sharp Health Plan will assign a PCP.):		Are you an existing patient with this doctor?
Name:	Provider NPI:	☐ Yes ☐ No

3. First name: Middle initial: Last name:

Birth date: MM/DD/YY / /	Social Security number: – –	Relationship to subscriber:	Sex: ☐ M ☐ F ☐ Other

Cell phone number: ( )	Home phone number: ( )	Other phone number: ( )

Email address:

To find a Sharp Health Plan-affiliated doctor who meets your needs, and their Provider NPI, please visit **sharphealthplan.com** or call Customer Care at 1-800-359-2002.

Primary care physician (If left blank, Sharp Health Plan will assign a PCP.):		Are you an existing patient with this doctor?
Name:	Provider NPI:	☐ Yes ☐ No

Step 2. Plan Selection

When selecting a plan, you must ensure that you live in a ZIP code that is within that plan's network. Go to **sharphealthplan.com/networks-by-zip** to see which ZIP codes are included in each plan network. Once you have confirmed your network, you must then select one benefit plan from the list below.

Premier Network	
Plan Name	**Metal Tier**
☐ Sharp Platinum 90 Premier HMO	Platinum
☐ Sharp Gold 80 Premier HMO	Gold
☐ Sharp Silver 70 Off Exchange Premier HMO	Silver
☐ Sharp Bronze 60 HDHP Premier HMO	Bronze

Performance Network	
Plan Name	**Metal Tier**
☐ Sharp Platinum 90 Performance HMO	Platinum
☐ Sharp Gold 80 Performance HMO	Gold
☐ Sharp Silver 70 Off Exchange Performance HMO	Silver
☐ Sharp Bronze 60 Performance HMO	Bronze
☐ Sharp Minimum Coverage Performance HMO*	Minimum Coverage

Verification of residency is required for all applicants.
This application requires a verification of residency for the subscriber. If the applicant is a minor applying for coverage as a subscriber, the parent(s) or legal guardian(s) must provide proof of residency. In the case of surrogacy, the residence of the legal guardian is required. Surrogate mother proof of residency is not required. Approval for a Sharp Health Plan Individual or Family Plan requires proof that you live in Sharp Health Plan's service area. Proof of residency documents must be received within 10 business days of the receipt of your application.

- Sharp Health Plan requires two documents clearly stating your full name and the address at which you currently reside.
- Proof of residency documents should be the most recent version of the document available.

Examples of acceptable residency documents: gas, electricity, water or internet billing statement; bank statement; California driver's license; rental agreement; school records; pay stub; tax return; or property tax statement.

Sharp Health Plan may accept other types of documents on a case-by-case basis. No handwritten or expired documents will be accepted.

Additionally, each plan has a designated group of physicians and hospitals associated with it, known as a plan medical group (PMG). The Sharp Health Plan you select will determine the doctors that are available to you. To find a Sharp Health Plan-affiliated doctor who meets your needs, and their provider ID, please visit **sharphealthplan.com** or call Customer Care at 1-800-359-2002. Please be sure to select a doctor who is affiliated with Sharp Health Plan network for the benefit plan you would like to enroll in. **If you leave the primary care physician (PCP) field blank in Step 1, then Sharp Health Plan will assign a PCP to you automatically.**

*Minimum coverage plans are available to individuals under the age of 30, as of the effective date of coverage. They are also available to those who have been granted a hardship exemption from the federal government due to affordability or hardship. If an applicant is 30 years of age or older, the certificate of exemption must be provided to Sharp Health Plan in order to process the application. Please visit **healthcare.gov** for additional details.

Effective Date of Coverage

What is the requested effective date of your medical policy? _____

Qualifying Event for Applying Outside of the Open Enrollment Period

Request for enrollment must be submitted within 60 days of a qualifying event. Attach proof of the qualifying event to the application.

All required supporting documentation and your first month's premium payment must be submitted to Sharp Health Plan before your coverage effective date.

- ☐ Loss of coverage
- ☐ Marriage
- ☐ Birth/Adoption
- ☐ Divorce
- ☐ Other _____

In the event of terminations limited to subscribers only, any dependents retaining their coverage will need to submit a new application. The review process will follow underwriting guidelines, and additional documentation may be requested.

Your coverage starts on your effective date

Your effective date will depend on the kind of qualifying event you have.

Unsure how it works? Here's an example:
Ron lost his minimum essential coverage on March 31. After looking at his options for health insurance, Ron sent his completed special enrollment application to Sharp Health Plan on April 11. In order for Ron's new health coverage to start on May 1, Sharp Health Plan must receive Ron's required documentation and first payment no later than April 30.

Use the chart below to see which effective date applies to your situation.

My qualifying event involves ...	If I apply ...	My coverage will start on ...
Birth, adoption, placement for adoption or foster care	Any day of the month	Date of birth, adoption, placement for adoption, foster care OR the 1st day of the month after your qualifying event if you request a later effective date
Marriage or domestic partnership registration	Any day of the month	The 1st of the month after we receive your application or Account Change Form
Dependent parents or stepparents	Any day of the month	The 1st of the month after we receive your application or Account Change Form
Child support order or other court order to cover a dependent	Any day of the month	Date the court order is effective
Loss of health care coverage	Any day of the month	The 1st of the month after we receive your application or Account Change Form
Change in eligibility for employer coverage	Any day of the month	The 1st of the month after we receive your application or Account Change Form
Loss of minimum essential coverage due to the death of the subscriber	Any day of the month	The 1st of the month after we receive your application or Account Change Form
Divorce, legal separation or dissolution of domestic partnership	Any day of the month	The 1st of the month after we receive your application or Account Change Form
Termination of non-calendar-year plan	Any day of the month	The 1st of the month after we receive your application
ICHRA or QSEHRA	Any day of the month	The 1st of the month after we receive your application or Account Change Form
Paid penalty for not having health coverage	Any day of the month	The 1st of the month after we receive your application or Account Change Form
Newly qualifies for app-based driver stipend	Any day of the month	The 1st of the month after we receive your application or Account Change Form
All other qualifying events	Between the 1st and the 15th day of the month	The 1st of the following month
	Between the 16th and the last day of the month	The 1st of the second following month

Step 3. Broker/Agent/Staff Member

Did you work with a broker/agent/staff member? ☐ Yes ☐ No
If an agent, broker or Sharp Health Plan staff member helped you with this application, please make sure they complete this section. Otherwise, skip to Step 4.

Broker/agent/staff member name:	Agency name:	License number:

Notice to broker/agent/staff member: If you have assisted the applicant in submitting this application, the law requires that you attest to this assistance. If you state any material fact you know to be false, you are subject to a civil penalty of up to ten thousand dollars ($10,000), as authorized under Federal Government and Safety Code section 1389.8(c) or Insurance Code section 10119.3.

Select one:

☐ 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.

☐ I did not assist the applicant in any way in completing or submitting this application. All information was completed by the applicant with no assistance or advice from me.

Broker/agent/staff member signature:	Date:
x	

Step 4. Disclosures and Signatures

Please read the following carefully. Keep a copy of this application for your records.

Dental Disclosures

I understand that if I have indicated that coverage under Sharp Health Plan is to be provided only for the dependent child on this form, I am responsible for payment of the required Premium and compliance with all of the provisions and conditions of the Disclosure Form/Contract.

RIGHT OF REIMBURSEMENT: I, on behalf of my Dependent(s) listed on this Enrollment Application, hereby agree that in the event any dental services provided to me or my Dependent(s) covered by Delta Dental of California are the primary financial responsibility of another party because of other dental coverage, I will fully inform Delta Dental of California and will execute such assignments, liens or other documents that may be necessary to enable Delta Dental of California to recover the value of services and supplies provided.

NOTICE: Any person who, with intent to defraud or knowing that they are facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud and may be subject to fines and confinement in prison.

Sharp Health Plan Disclosures

- I alone am responsible for the accuracy and completeness of the information provided on this application. I have personally reviewed all information provided on this application, even if I did not fill out the application myself. To the best of my knowledge and belief, all information on this application is accurate, true and complete. If Sharp Health Plan determines that there is fraud (by act, practice or omission) or an intentional misrepresentation of material fact in the information on this application, I understand that coverage may be rescinded as allowed by law.
- Any person who, with intent to defraud or knowing that they are facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud and may be subject to fines and confinement in prison.
- In accordance with the disclosure requirements of California Health and Safety Code Section 1363 (h), this is to advise you that Sharp Health Plan's ratio of health care expenses to premiums received for the last fiscal year with respect to Sharp Health Plan Individual & Family Plans was 88.3%.
- Sharp Health Plan's 2024 broker compensation commission schedule is 5% of the premium for initial enrollments and 4% of the premium for renewals. This amount is based on the gross premium and includes consideration of both direct and indirect compensation.

(continued on next page)

Step 4. Disclosure and Signatures, continued

- I understand that I may be subject to an audit by Sharp Health Plan, at which time I will need to provide proof of residency, date of birth and Dependent eligibility (if applicable). I further understand that I must provide Sharp Health Plan with any new information that arises after the submission of this application but before my enrollment with Sharp Health Plan begins.
- I understand that this plan will only cover services provided through my plan's network of providers and facilities, unless I receive prior written authorization from Sharp Health Plan or unless the services are emergency care services or out-of-area urgent care.
- If I indicated in Step 1 that I have a language preference other than English and have completed the English version of this application (or version other than in my language preference), I confirm that I understand the questions on this application.
- I understand that California law prohibits an HIV test from being required or used by health care plans as a condition of obtaining coverage.
- Depending on income level and family size, I understand that I may be eligible for financial assistance to help pay for health coverage if I purchase my coverage through Covered California. Sharp Health Plan benefit plans are available through Covered California. I must apply during an open or special enrollment period. Open enrollment is from Nov. 1 through Jan. 31. However, I understand that in order for coverage to begin on Jan. 1, I must submit my application on or before Dec. 15 of the preceding calendar year. If I have a life change such as marriage, divorce, a new child or loss of a job, I can apply at the time the life change occurs ("special enrollment period").
- I understand that I have the right to use Sharp Health Plan's internal dispute resolution process if any dispute or controversy arises regarding the performance, interpretation or breach of the agreement between myself (and/or enrolled dependent) and Sharp Health Plan, whether in contract, tort or otherwise. If I am unsatisfied with the result of the dispute resolution process, I understand that I have the right to voluntary binding arbitration, which is the final step for resolving complaints. Upon receipt of a demand for arbitration, Sharp Health Plan agrees to utilize a neutral arbiter from an appropriate entity. Arbitration will be conducted in accordance with the rules and regulations of the chosen entity.
- Sharp Health Plan provides privacy protection that manages access to and use of race, ethnicity and language (REAL) and sexual orientation and gender identity (SOGI) data. Sharp Health Plan will utilize data to address disparities and focus quality improvement efforts toward providing appropriate services for REAL, SOGI and disability status services. Impermissible use of this data includes use of the data for underwriting and denial of coverage and benefits.
- The undersigned expressly consents and agrees that Sharp Health Plan, its business associates and other third parties, including debt collectors, may send periodic electronic communications for any lawful purpose, including routine business and/or marketing purposes, to any email address or phone number he/she provides. Messages may be sent by text (SMS), email, automatic telephone dialing systems (auto-dialer), prerecorded messages or live operator calls. Message frequency will vary. Message and data rates apply. The undersigned may opt out of receiving further automated, electronic communications at any time by texting STOP or calling 1-800-827-4277. Whether the undersigned agrees to receive these messages will not affect care or coverage in any way. Visit **sharphealthplan.com/terms** for complete Terms of Use.

HICAP Notice

- If you or your dependent parent or stepparent is eligible for or enrolled in Medicare, you have the right to be informed of and understand your specific rights and options before enrolling. The Health Insurance Counseling and Advocacy Program (HICAP) provides insurance counseling to senior California residents free of charge.
  - Statewide HICAP Program Telephone: 1-800-434-0222
  - Local HICAP Program:
    Address: 5151 Murphy Canyon Road, Suite 110
    San Diego, CA 92123
    Telephone: 1-858-565-8772

Subscriber (parent or legal guardian for subscriber if under 18)

Name:	Signature: **x**	Date:

Nondiscrimination Notice

Sharp Health Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. Sharp Health Plan does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability.

Sharp Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Information in other formats (such as large print, audio, accessible electronic formats or other formats) free of charge
- 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 Customer Care at 1-800-359-2002.

If you believe that Sharp Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability, you can file a grievance with our Civil Rights Coordinator at:

- Address: Sharp Health Plan Appeal/Grievance Department, 8520 Tech Way, Suite 200, San Diego, CA 92123-1450
- Telephone: 1-800-359-2002 (TTY 711); Fax: 1-619-740-8572

You can file a grievance in person or by mail or fax, or you can complete the online Grievance/Appeal form on Sharp Health Plan's website, **sharphealthplan.com**. Please call our Customer Care team at 1-800-359-2002 if you need help filing a grievance. You can also file a discrimination complaint if there is a concern of discrimination based on race, color, national origin, age, disability or sex 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 **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 **hhs.gov/ocr/office/file/index.html**.

The California Department of Managed Health Care is responsible for regulating health care service plans. If your grievance has not been satisfactorily resolved by Sharp Health Plan or your grievance has remained unresolved for more than 30 days, you may call toll-free the Department of Managed Health Care for assistance:

- 1-888-466-2219 Voice
- 1-877-688-9891 TDD

The Department of Managed Health Care's website has complaint forms and instructions online: **www.dmhc.ca.gov**.

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call Sharp Health Plan right away at 1-858-499-8300 or 1-800-359-2002.

IMPORTANTE: ¿Puede leer esta carta? Si no le es posible, podemos ofrecerle ayuda para que alguien se la lea. Además, usted también puede obtener esta carta en su idioma. Para ayuda gratuita, por favor llame a Sharp Health Plan inmediatamente al 1-858-499-8300 o 1-800-359-2002.

Language Assistance Services

English:
ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-359-2002 (TTY:711).

Español (Spanish):
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-359-2002 (TTY:711).

繁體中文 (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 1-800-359-2002 (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 1-800-359-2002 (TTY:711).

Tagalog (Tagalog – Filipino):
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-359-2002 (TTY:711).

한국어 **(Korean):**
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-359-2002 (TTY:711) 번으로 전화해 주십시오.

Հայերեն **(Armenian):**
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-359-2002 (TTY (հեռատիպ)՝ 711).

فارسی (Farsi):

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما
فراهم می باشد. با (TTY:711) 1-800-359-2002 تماس بگیرید.

Русский (Russian):
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-359-2002 (телетайп: 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。1-800-359-2002 (TTY:711) まで、お電話にてご連絡ください。

العربية (Arabic):

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-359-2002 (رقم
هاتف الصم والبكم :711).

ਪੰਜਾਬੀ (Punjabi):
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-359-2002 (TTY:711) 'ਤੇ ਕਾਲ ਕਰੋ।

ខ្មែរ (Mon Khmer, Cambodian):
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-359-2002 (TTY:711)។

Hmoob (Hmong):
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-359-2002 (TTY:711).

हिंदी (Hindi):
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-359-2002 (TTY:711) पर कॉल करें।

ภาษาไทย **(Thai):**
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-359-2002 (TTY:711).