Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

Clear Form

2019 PEBB Continuation Coverage (COBRA) Election/Change

- **Type or print clearly in dark ink.** Inaccurate, incomplete, or illegible information may delay coverage.
- We must receive this form **no later than 60 days** from the date your PEBB health plan coverage ends or from the postmark date on the *PEBB Continuation Coverage Election Notice* packet sent to you, whichever is later.
- Your first premium payment and applicable premium surcharges (if any) are due to the Health Care Authority (HCA) **no later than 45 days** after your 60-day election period ends as described above. Premiums and applicable premium surcharges are due back to the date your other coverage ended.
- List eligible dependents you wish to cover or remove from coverage. This form replaces all *PEBB Continuation Coverage (COBRA) Election/Change* forms previously submitted.
- If adding a dependent with a disability age 26 or older, or an extended dependent, you must also include the required dependent certification form.

All forms and documents are available at **www.hca.wa.gov/erb** or by calling 1-800-200-1004 (TRS: 711).

Employee or retiree information only	Employee or retiree name	
	Employee or retiree Social Security number	Date PEBB health plan coverage ended (mm/dd/yyyy)

Section 1: Subscriber Information

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

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

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

☐ **Continue coverage:** *(select one)* ☐ Medical and dental ☐ Medical only ☐ Dental only

You may elect to continue coverage you were enrolled in on the day your PEBB health plan coverage ended. If you have life insurance and wish to port or convert, contact MetLife at 1-866-548-7139.

If you are enrolled in a Medical Flexible Spending Arrangement and would like to continue it, contact Navia Benefit Solutions at 1-800-660-3539. Your election to continue enrollment must be received by Navia Benefit Solutions **no later than 60 days** from the date your PEBB health plan coverage ended or from the postmark date on the election notice sent by Navia, whichever is later.

☐ **Terminate coverage:** *(select one)* ☐ Medical and dental ☐ Medical only ☐ Dental only

If terminating coverage, include reason _____ Terminate date _____

If I terminate my coverage, I understand that I am forfeiting all further rights to enroll in PEBB benefits terminated above unless I regain eligibility.

Are you covered by another group medical plan? ☐ Yes ☐ No If yes, effective date _____

Are you covered by another group dental plan? ☐ Yes ☐ No If yes, effective date _____

Are you disabled under Title II (OASDI) of the Social Security Act? ☐ Yes ☐ No If yes, effective date _____

Are you disabled under Title XVI (SSI) of the Social Security Act? ☐ Yes ☐ No If yes, effective date _____

If yes, you must send a copy of your Social Security Disability Award letter.
You and your enrolled dependents may be eligible for additional months of coverage.

Enrolled in Medicare Part(s) A and/or B? **Part A (hospital)** ☐ Yes ☐ No If yes, effective date _____

Part B (medical) ☐ Yes ☐ No If yes, effective date _____

If yes, proof is required. Attach a copy of your Medicare card to this form.
Write your full name and the last four digits of your Social Security number on the copy.

(continued)

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

Section 1: Subscriber Information *(continued)*

Tobacco Use Premium Surcharge

The PEBB Program requires a monthly $25-per-account surcharge in addition to your monthly premium if you are not enrolled in Medicare Part A and Part B, and you or a dependent (age 13 or older) enrolled on your PEBB medical coverage uses a tobacco product. Tobacco use is defined as any use of tobacco products within the past two months except for religious or ceremonial use. See the 2019 Premium Surcharge Help Sheet *at* **www.hca.wa.gov/erb** *for instructions on how to respond. If you check YES below or leave this section blank, you will be charged the monthly $25 premium surcharge.*

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

☐ I am enrolled in Medicare Part A and Part B. The premium surcharge does not apply.
☐ YES, I am subject to the $25 premium surcharge. I have used tobacco products in the past two months.
☐ NO, I am not subject to the $25 premium surcharge. I have not used tobacco products in the past two months, or I have enrolled in or accessed the tobacco cessation resources noted in the *2019 Premium Surcharge Help Sheet*.

Section 2: Spouse or State-Registered Domestic Partner Information

List an eligible spouse or state-registered domestic partner, as defined by Washington Administrative Code 182-12-260(2), you wish to cover or remove from coverage. Dependents cannot be enrolled in two PEBB medical or dental accounts at the same time.
If adding a state-registered domestic partner, you must provide proof of dependent eligibility within PEBB Program enrollment timelines, or the state-registered domestic partner will not be enrolled. *A list of documents we will accept to verify dependent eligibility is available at* **www.hca.wa.gov/erb.**

Relationship to subscriber ☐ Spouse: date of marriage_____ ☐ State-registered domestic partner: date registered _____	Date of birth (mm/dd/yyyy)

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

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

☐ **Continue coverage:** *(select one)*	☐ Medical and dental	☐ Medical only	☐ Dental only
☐ **Add coverage:** *(select one)*	☐ Medical and dental	☐ Medical only	☐ Dental only
☐ **Terminate coverage:** *(select one)*	☐ Medical and dental	☐ Medical only	☐ Dental only

If terminating coverage, include reason _____ Termination date _____
If removing a spouse or state-registered domestic partner due to a divorce or dissolution of state-registered domestic partnership, attach a copy of the divorce decree or dissolution of state-registered domestic partnership.

Covered by another group medical plan?	☐ Yes ☐ No	If yes, effective date _____
Covered by another group dental plan?	☐ Yes ☐ No	If yes, effective date _____
Disabled under Title II (OASDI) of the Social Security Act?	☐ Yes ☐ No	If yes, effective date _____
Disabled under Title XVI (SSI) of the Social Security Act?	☐ Yes ☐ No	If yes, effective date _____

If yes, you must send a copy of your spouse's or state-registered domestic partner's Social Security Disability Award letter. You and your enrolled dependents may be eligible for additional months of coverage.

Enrolled in Part(s) A and/or B of Medicare?	**Part A (hospital)**	☐ Yes ☐ No	If yes, effective date _____
	Part B (medical)	☐ Yes ☐ No	If yes, effective date _____

If yes, proof is required. Include a copy of your spouse's or state-registered domestic partner's Medicare card with this form. Write your full name and the last four digits of your Social Security number on the copy.

Tobacco Use Premium Surcharge—if enrolling in medical coverage

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

☐ The subscriber listed in Section 1 is enrolled in Medicare Part A and Part B. The $25 premium surcharge does not apply.
☐ YES, I am subject to the $25 premium surcharge. My spouse or state-registered domestic partner has used tobacco products in the past two months.
☐ NO, I am not subject to the $25 premium surcharge. My spouse or state-registered domestic partner has not used tobacco products in the past two months, or has enrolled in or accessed the tobacco cessation resources noted in the *2019 Premium Surcharge Help Sheet*.

(continued)

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

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

Spouse or State-Registered Domestic Partner Coverage Premium Surcharge

The PEBB Program requires a monthly $50 surcharge in addition to your premium if you are not enrolled in Medicare Part A and Part B, and your spouse or state-registered domestic partner is enrolling in PEBB medical coverage and has elected not to enroll in another employer-based group medical that is comparable to Uniform Medical Plan Classic. See the 2019 Premium Surcharge Help Sheet *and the* 2019 Spousal Plan Calculator *at* **www.hca.wa.gov/erb**. *To change your attestation, use the* 2019 Premium Surcharge Change Form. **If you check YES below or leave this section blank, you will be charged the monthly $50 premium surcharge.**

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

- ☐ The subscriber listed in Section 1 is enrolled in Medicare Part A and Part B. The premium surcharge does not apply.
- ☐ YES, I am subject to the $50 premium surcharge. I used the *2019 Premium Surcharge Help Sheet* and completed the *2019 Spousal Plan Calculator* online.
- ☐ NO, I am not subject to the $50 premium surcharge. I used the *2019 Premium Surcharge Help Sheet* and, if needed, completed the *2019 Spousal Plan Calculator* online.

Which questions, if any, on the *2019 Premium Surcharge Help Sheet* did you check NO? Check all that apply. Question 1 is not applicable. ☐ Question 2 ☐ Question 3 ☐ Question 4 ☐ Question 5 ☐ Question 6

☐ I am completing and submitting the printed *2019 Spousal Plan Calculator* for the PEBB Program to determine.

Section 3: Dependent Information (such as child as defined by WAC 182-12-260(3))

Use additional forms for more dependents.

List eligible dependents you wish to cover or remove from coverage. Dependents cannot be enrolled in two PEBB medical or dental accounts at the same time. Attach a completed Extended Dependent Certification *form if enrolling an extended dependent. If enrolling a dependent with a disability age 26 or older, submit a completed* Certification of Dependent With a Disability *form and return as instructed on the form.*

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

Relationship to subscriber	☐ Child ☐ Stepchild *(not legally adopted)* ☐ Extended dependent *(attach copy of court order)*	☐ Disabled *(check only if age 26 or older)*	Date of birth (mm/dd/yyyy)

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

☐ **Continue coverage:** *(select one)*	☐ Medical and dental	☐ Medical only	☐ Dental only	
☐ **Add coverage:** *(select one)*	☐ Medical and dental	☐ Medical only	☐ Dental only	
☐ **Terminate coverage:** *(select one)*	☐ Medical and dental	☐ Medical only	☐ Dental only	

If terminating coverage, include reason _____ Termination date _____

Covered by another group medical plan?	☐ Yes ☐ No	If yes, effective date _____
Covered by another group dental plan?	☐ Yes ☐ No	If yes, effective date _____
Disabled under Title II (OASDI) of the Social Security Act?	☐ Yes ☐ No	If yes, effective date _____
Disabled under Title XVI (SSI) of the Social Security Act?	☐ Yes ☐ No	If yes, effective date _____

If yes, you must send a copy of your dependent's Social Security Disability Award letter. You and your enrolled dependents may be eligible for additional months of coverage.

Enrolled in Medicare Part(s) A and/or B?	**Part A (hospital)**	☐ Yes ☐ No	If yes, effective date _____
	Part B (medical)	☐ Yes ☐ No	If yes, effective date _____

If yes, proof is required. Attach a copy of your dependent's Medicare card to this form. Write your full name and the last four digits of your Social Security number on the copy.

Tobacco Use Premium Surcharge—if enrolling in medical coverage

Does the tobacco use premium surcharge apply to this dependent? *(Response required for dependents ages 13 or older enrolling in medical coverage.)* Check one:

- ☐ The subscriber listed in Section 1 is enrolled in Medicare Part A and Part B. The $25 premium surcharge does not apply.
- ☐ YES, I am subject to the $25 premium surcharge. This dependent has used tobacco products in the past two months.
- ☐ NO, I am not subject to the $25 premium surcharge. This dependent has not used tobacco products in the past two months, or has enrolled in or accessed the tobacco cessation resources noted in the *2019 Premium Surcharge Help Sheet*.

(continued)

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

Section 3: Dependent Information *(continued)*

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

Relationship to subscriber	☐ Child ☐ Stepchild *(not legally adopted)* ☐ Extended dependent *(attach copy of court order)*	☐ Disabled *(check only if age 26 or older)*	Date of birth (mm/dd/yyyy)

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

☐ **Continue coverage:** *(select one)* ☐ Medical and dental ☐ Medical only ☐ Dental only
☐ **Add coverage:** *(select one)* ☐ Medical and dental ☐ Medical only ☐ Dental only
☐ **Terminate coverage:** *(select one)* ☐ Medical and dental ☐ Medical only ☐ Dental only

If terminating coverage, include reason _____ Termination date _____

Covered by another group medical plan? ☐ Yes ☐ No If yes, effective date _____

Covered by another group dental plan? ☐ Yes ☐ No If yes, effective date _____

Disabled under Title II (OASDI) of the Social Security Act? ☐ Yes ☐ No If yes, effective date _____

Disabled under Title XVI (SSI) of the Social Security Act? ☐ Yes ☐ No If yes, effective date _____

If yes, you must send a copy of your dependent's Social Security Disability Award letter.
You and your enrolled dependents may be eligible for additional months of coverage.

Enrolled in Medicare Part(s) A and/or B? **Part A (hospital)** ☐ Yes ☐ No If yes, effective date _____

Part B (medical) ☐ Yes ☐ No If yes, effective date _____

If yes, proof is required. Attach a copy of your dependent's Medicare card to this form. Write your full name and the last four digits of your Social Security number on the copy.

Tobacco Use Premium Surcharge—if enrolling in medical coverage

Does the tobacco use premium surcharge apply to this dependent? *(Response required for dependents ages 13 or older enrolling in medical coverage.)* Check one:

☐ The subscriber listed in Section 1 is enrolled in Medicare Part A and Part B. The $25 premium surcharge does not apply.
☐ YES, I am subject to the $25 premium surcharge. This dependent has used tobacco products in the past two months.
☐ NO, I am not subject to the $25 premium surcharge. This dependent has not used tobacco products in the past two months, or has enrolled in or accessed the tobacco cessation resources noted in the *2019 Premium Surcharge Help Sheet*.

Section 4: Changes to an Existing Account

Are you making changes to an existing account?

☐ **Yes** If yes, what changes? *(Check all that apply in the sections below.)*
☐ **No** If no, go to Section 5.

Changes you can make anytime

Give date of event/change _____

☐ Name change ☐ Address change ☐ Terminate medical coverage ☐ Terminate dental coverage

☐ Remove dependent(s) from coverage. In most cases, when removing a dependent from coverage, the change will occur prospectively. If removing due to loss of eligibility (divorce, dissolution of state-registered domestic partnership, death, or other loss of eligibility under PEBB Program rules), **we must receive this form no later than 60 days after the dependent is no longer eligible**. Coverage will be terminated the last day of the month of loss of eligibility. If applicable, provide former dependent's new address below.

Dependent's new address: _____

Additional changes you can make during annual open enrollment (November 1–30)

All changes become effective January 1 of the following year.

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

☐ Add dependent(s) ☐ Change medical plan ☐ Change dental plan

(continued)

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

Section 4: Changes to an Existing Account *(continued)*

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

The PEBB Program only allows changes outside of annual open enrollment when an event creates a special open enrollment.

The PEBB Program must receive this form and proof of the event no later than 60 days after the event occurs. However, if adding a newborn or adopted child increases your premium, this form must be received no later than 12 months after the birth or adoption.

In most cases, the enrollment or change will be effective the first day of the month after the event date or the date the form is received, whichever is later.

Give date of event _____

Check the box next to the corresponding event(s) below.

Add dependent(s), change medical plan, and/or change dental plan:

- ☐ Marriage, registering a state-registered domestic partnership, birth, adoption, or assuming a legal obligation for total or partial support in anticipation of adoption.
- ☐ Child becomes eligible as an extended dependent through legal custody or legal guardianship. Also complete an *Extended Dependent Certification* form available at **www.hca.wa.gov/erb**.
- ☐ Subscriber or dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act.
- ☐ Subscriber has a change in employment status that affects the subscriber's eligibility for their employer contribution toward their employer-based group health plan.
- ☐ Subscriber's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan.
- ☐ A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber.
- ☐ Subscriber or dependent becomes entitled to or loses eligibility for Medicaid or a state Children's Health Insurance Program (CHIP).
- ☐ Subscriber or dependent becomes eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.

Add dependent(s):

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

Change medical plan and/or change dental plan:

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

Are you or any eligible dependents enrolled in PEBB insurance coverage under another account? ☐ Yes ☐ No

(continued)

2019 PEBB Continuation Coverage (COBRA) Election/Change

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

Section 5: Medical Plan Selection *Check appropriate box(es).*

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

Kaiser Foundation Health Plan of the Northwest[1]

- ☐ Kaiser Permanente NW Classic[2]
- ☐ Kaiser Permanente NW Consumer-Directed Health Plan [2,3]
- ☐ Kaiser Permanente NW Senior Advantage[4]

Kaiser Foundation Health Plan of Washington[1]

- ☐ Kaiser Permanente WA Classic
- ☐ Kaiser Permanente WA Consumer-Directed Health Plan[3]
- ☐ Kaiser Permanente WA Medicare Plan[4,5]
- ☐ Kaiser Permanente WA SoundChoice[6,9]
- ☐ Kaiser Permanente WA Value[6]

- ☐ **Medicare Supplement Plan F, administered by Premera Blue Cross[7]**

Uniform Medical Plan, administered by Regence BlueShield

- ☐ UMP Classic
- ☐ UMP Consumer-Directed Health Plan[3]
- ☐ UMP Plus–Puget Sound High Value Network[1,3,8]
- ☐ UMP Plus–UW Medicine Accountable Care Network [1,3]

[1] These plans have a specific service area. If you move out of the service area, you may need to change your plan. You must notify the PEBB Program no later than 60 days after you move.

[2] Kaiser Foundation Health Plan of the Northwest, with plans offered in Clark and Cowlitz counties in Washington and select counties in Oregon.

[3] These plans are available only to members not enrolled in Medicare. If you cover a dependent enrolled in Medicare, you must terminate your dependent's PEBB insurance coverage to enroll in this plan. Your dependent will not be eligible for COBRA or other continuation coverage options.

[4] These Medicare Advantage plans are available in certain counties to Medicare members. Also complete and attach the *Medicare Advantage Plan Election Form* (form C) if you live in a county where Medicare Advantage is available. (See www.hca.wa.gov/erb for medical plans available by county.)

[5] If you cover members not enrolled in Medicare Part A and Part B, also select Kaiser Permanente WA Classic, SoundChoice, or Value for these members.

[6] This plan is available only if at least one covered member is not enrolled in Medicare Part A and Part B. Members enrolled in Medicare Part A and Part B will be enrolled in Kaiser Permanente WA's Medicare Plan.

[7] Also complete and return the *Group Medicare Supplement Enrollment Application* (form B) to enroll in Medicare Supplement Plan F. The PEBB Program does not offer the high-deductible Plan F.

[8] This plan does not have network primary care providers for adults in Thurston County.

[9] Not all contracted providers in Spokane County are in the SoundChoice network. Please make sure your provider is in-network before your visit.

Section 6: Dental Plan Selection *Check only one.*

Before you select a dental plan, be sure your provider(s) participate with that plan. Contact the plans, not your dentist, for benefits information.

Preferred Provider Organization (PPO)	☐ **Uniform Dental Plan** (Group #3000), administered by Delta Dental of Washington. You can choose any dental provider and change providers at any time.
Managed-Care Plans (limited network)	☐ **DeltaCare** (Group #3100), administered by Delta Dental of Washington. You will select and receive care from a primary care dental provider in the DeltaCare network. Before you enroll, call DeltaCare at 1-800-650-1583 to verify your provider accepts the specific plan network and plan group. ☐ **Willamette Dental of Washington, Inc.** (Group WA82) You will select and receive care from a primary care dental provider in the Willamette Dental Group Plan. Before you enroll, call 1-855-433-6825 to verify your provider is in the Willamette Dental Group network.

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2019 PEBB Continuation Coverage (COBRA) Election/Change

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

Section 7: Signature *Required*

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

If I send payment, this does not mean that I will be automatically enrolled in PEBB coverage. The PEBB Program will verify eligibility for me and my dependents. If we do not qualify, I will receive a refund.

I understand I am responsible for paying any applicable tobacco use premium surcharge and spouse or state-registered domestic partner coverage premium surcharge in addition to my monthly premium.

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

This form replaces all *PEBB Continuation Coverage (COBRA) Election/Change* forms previously submitted to the PEBB Program.

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

Subscriber's signature_____ **Date** _____

Please sign and date this form.

Mail to:	**If payment is enclosed, make it payable to Health Care Authority and mail to:**	**Or hand-deliver to:**
Washington State Health Care Authority PO Box 42684 Olympia, WA 98504-2684	Washington State Health Care Authority PO Box 42691 Olympia, WA 98504-2691	Washington State Health Care Authority 626 8th Ave. SE Olympia, WA 98501

Note: Do not send forms to the addresses below. They are only for your reference.

2019 PEBB Program Medical Contractors

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

Kaiser Foundation Health Plan of Washington
601 Union Street, Suite 3100, Seattle, WA 98101
In 2018: 1-888-901-4636 In 2019: 1-866-648-1928
or TTY 1-800-833-6388

Premera Blue Cross
PO Box 327, Seattle, WA 98111-0327
1-800-817-3049 or TTY 1-800-842-5357

Uniform Medical Plan, administered by Regence BlueShield
1800 Ninth Ave., Suite 235, Seattle, WA 98101
1-888-849-3681 or TRS 711

2019 PEBB Program Dental Contractors

DeltaCare, administered by Delta Dental of Washington
400 Fairview Ave. N, Suite 800, Seattle, WA 98109-5371
1-800-650-1583

Uniform Dental Plan
administered by Delta Dental of Washington
400 Fairview Ave. N, Suite 800, Seattle, WA 98109-5371
1-800-537-3406

Willamette Dental of Washington, Inc.
6950 NE Campus Way, Hillsboro, OR 97124-5611
1-855-433-6825

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