aetna®

Enrollment/Change Request

Aetna International
Coverage underwritten by Aetna Life Insurance Company and Aetna Life & Casualty (Bermuda) Ltd. ("Aetna")
visit us at www.aetnainternational.com

A. Transaction Information **EFFECTIVE DATE OF TRANSACTION (MM/DD/YYYY):** ____/____/____

1. Enrollment (Check One):
- ☐ New Enrollee
  Hire Date (MM/DD/YYYY) ____/____/____
- ☐ Rehired/Reinstatement
  Date (MM/DD/YYYY): ____/____/____
- ☐ Return to Work
  Date (MM/DD/YYYY): ____/____/____
- ☐ New Dependent(s) See Section D (below)

2. Change: (Check All That Apply) **From:** **To:**
- ☐ U.S. Social Security/ID Number ____-____-____ ____-____-____
- ☐ Control/Suffix-Account Number ____-____ (Enter in B.2.)
- ☐ Plan Number ____ (Enter in B.3.)
- ☐ Employee Name ☐ Dependent Name(s) (Enter New Name(s) Below)
- ☐ Beneficiary Designation (Enter in C. 11a-c)
- ☐ Stop Continuation of Health Coverage (i.e. COBRA)
- ☐ Other: ____

3. Termination: (Check All That Apply)
- ☐ Termination of Employment – Reason: ____
- ☐ Canceling Coverage– Reason: ____
- ☐ Canceling All Dependent Coverage*– Reason: ____
- ☐ Canceling Specific Dependents' Coverage*– Reason: ____
- ☐ Continue Employee Health Coverage (i.e. COBRA)
- ☐ Continue Dependent Health Coverage (i.e. COBRA)

* (indicate individuals for which coverage has been cancelled in Section D)

B. Employer Information (Shaded Areas in Section B Are Assigned By Aetna)

1. Employer Name – Full Name of Business or Organization	2. Control	Suffix	Account	3. Plan Number	4. SFO
Reliant Mission, Inc.	0142986	10	001	001	

5. Employer Address (Street, City, State, ZIP/Postal Code, Country – Primary Business Location of Business or Organization	6. Employer Telephone Number (Include Area &/or Country Code, as applicable)	7. Customer Code (Optional)
11002 Lake Hart Dr Ste 100	407-986-5530	

C. Employee Information Please Print All Information (Shaded Areas in Section C Are Assigned By Employer)

1. Employee U.S. Social Security/ID Number	2a. Employee Name (Last, First, Middle Initial) – Please provide Employee's Legal Name Last: ____ First: ____ Middle Initial: ___	3. Salutation ☐Mr. ☐ Mrs. ☐ Miss ☐Ms.	4. Employee Status ☐ Active ☐ Retired
5. Country of Citizenship	2b. Employee Name – to appear on ID Card and Explanation of Benefits (If Legal Name exceeds allowable 24 characters) ____ Last Name (16 Characters) , ____ First Name (7 Characters) ____ Middle Initial (1 Character)	6. Gender ☐ Male ☐ Female	7. Birthdate (MM/DD/YYY)

8. Employee's Mailing Address:
Address Line 1: ____
Address Line 2: ____
Address Line 3: ____
City: ____ State: ____ Province: ____
ZIP/Postal Code: ____ Country: ____

9. Employee Residence Information
☐ Same as Mailing Address OR ☐ Resident Address Different from Mailing Address. (See Below)
City: ____ State/Province: ____ Country: ____

10. Additional Employee Contact Option(s) – include Area &/or Country Code(s), as applicable:
E-mail Address: ____ Home Telephone Number: ____
Work Telephone Number: ____ Fax Number: ____

11a. Beneficiary Designation – Full Beneficiary Name (Last, First, Middle Initial) – if more than one Beneficiary, use Special Remarks	11b. U.S. Social Security Number (as applicable) of Beneficiary	11c. Relationship of Beneficiary to Employee	12. Earnings (in US$) $ ☐ Annually ☐ Monthly ☐ Weekly

13. Insurance Amounts (in US$)	14. Prior Insurance Plan	15. Other Health Coverage	16. Currently Covered by Medicare
☐ Life Insurance $ ____ ☐ AD&D Amount $ ____ ☐ Supplemental Life $ ____	☐ Yes*	☐ Yes*	☐ Yes

D. Individuals Covered (List individuals – including yourself – for whom you are electing/changing coverage) ☐ **Check this box if you are refusing coverage for your dependents**

While the U.S. Federal Patient Protection and Affordable Care Act (PPACA) generally mandates coverage of dependent children up to age 26, your Plan may allow coverage beyond age 26. Some exceptions apply. Please refer to your plan documents or contact your benefits administrator to confirm your Plan's eligibility definition and whether or not PPACA applies to your Plan.

(A)dd/New (C) hange (R) emove	Relation. Code	Name (Last, First, Middle Initial) – explain any differences in last names in Special Remarks	U.S. Social Security Number (if dep has no U.S. SSN, write "None")	Birthdate (MM/DD/YYYY)	Dep Address (if different than employee's)	Prior Insurance Plan	Other Health Coverage	Currently Covered By Medicare	Handi-capped	Student Age 19 or Older	Primary Country of Citizenship	Residence (Indicate if Same or Different than employee; Enter details, if Different)
						Yes* ☐	Yes* ☐	Yes ☐	Yes* ☐	Yes* ☐		☐ Same ☐ Different (enter below) City ____ Country ____ State/Province ____
						☐	☐	☐	☐	☐		☐ Same ☐ Different (enter below) City ____ Country ____ State/Province ____
						☐	☐	☐	☐	☐		☐ Same ☐ Different (enter below) City ____ Country ____ State/Province ____
						☐	☐	☐	☐	☐		☐ Same ☐ Different (enter below) City ____ Country ____ State/Province ____

*** See the applicable category in Section C & D of the Instructions page for additional information that may require reporting in the Special Remarks field.**

Special Remarks ***(Include the school name and expected graduation date for Students age 19+; prior insurance; and other health coverage, as applicable.)*****:**

E. Acknowledgements – Signatures Required: I have read and agree to the terms of the authorization on **Page 2** of this Enrollment/Change Request form. I understand that, in the event I fail to sign this form within 31 days after the above transaction request or that for any reason Aetna does not receive notice of the above transaction within a reasonable time following the event, my and my dependents' eligibility may be affected.
I authorize deductions of the required contributions for the plan elections I have selected. I understand that my elections can only be changed during the next annual open enrollment period or if I have a qualifying status change during the year and understand that I must request such changes within 31 calendar days of the qualifying event. You may elect to use an electronic form of signature on this enrollment / change request form confirming your verification and declaration to the details given above. For the avoidance of doubt, such electronic signature will be valid and binding as if you had provided your original signature. We may rely on such electronic signature as a binding verification and declaration confirming that the information above is accurate and not misleading in all respects. The Employer affirms that it has conducted the appropriate validation regarding the authenticity of the employee's signature (electronic or otherwise) and the source of the submitted form.

Employee Signature: X____ **Date:** ____ **Employer Signature:** X____ **Date:** ____

Please Retain A Copy of the Completed Form For Your Files

Authorization/Declaration of Applicant(s):

Disclosure of Healthcare Information	My spouse, competent adult dependents, and I (those who are applying for coverage under this Application) authorize any physician, healthcare professional, hospital, other healthcare institution (“Providers”), and my employer to disclose, to the extent allowed by applicable law, to Aetna or an affiliated entity ("Aetna"), information concerning the medical history, services, supplies, or treatment provided to anyone listed on this Application, including those services involving dental, behavioral health, substance abuse and HIV/AIDS ("healthcare information").
Redisclosure of Healthcare Information	I confirm and agree that personal information and/or healthcare information collected or held by Aetna, whether contained in this Application form or otherwise obtained, may be disclosed worldwide to my employer, Aetna affiliates, Providers, payors, other insurers, third party administrators, vendors, consultants, and governmental authorities with appropriate jurisdiction, when necessary for care or treatment, payment for services, and activities related to the operation of my health plan.
Purpose of Disclosure/ Redisclosure	I understand that Aetna may rely on such information to: 1) underwrite this application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations for all of the applicants; 2) administer claims and determine or fulfill responsibility for coverage and provisions of benefits; 3) administer coverage; and 4) conduct other insurance operations, like marketing and publicity, according to applicable laws and regulations.
Authorization of Enrollee	I have discussed the terms of this authorization with my spouse and competent adult dependents, and I have obtained their consent to the release of their healthcare information pursuant to this authorization. I understand that I may decline to provide Aetna with consent to process my personal or healthcare information; however, this may result in declination of coverage.
Covered Member's Rights	I understand that I may review and offer corrections to my personal or healthcare information, to the extent allowed by law, receive a copy of this authorization upon request, and that a photocopy is as valid as the original; and I may revoke this authorization at any time, to the extent it has not been relied upon by Aetna or other party. I also have the right to opt out of any direct marketing campaigns.
Duration of Authorization	This authorization shall remain valid for the term of this coverage or for so long as allowed by law.
Payroll Deductions and Other Payments	I request the coverage which I have indicated and for which I am eligible. I authorize deductions from my earnings for any contributions required for healthcare coverage, and I agree to make any necessary payments as required for coverage.
Independent Contractors	I acknowledge that Aetna's participating providers are independent contractors and are not agents or employees of Aetna or any affiliated Aetna Entity.

Instructions - Instructions are provided only for those fields which are not self-explanatory or for which you may need additional information.

A. Transaction Information

*Make sure you complete the **Effective Date of Transaction** in the upper right corner of the form, above Section A2.*

*Make sure you read Section E. **Sign name and date.***

To Enroll

- Complete **Effective Date of Transaction** and check appropriate box in Section **A**, Number **1.**
- Complete blank fields in Section **B** (if applicable).
- Complete Section **C**, Numbers **1** through **16.**
- Complete Section **D** for all dependents for whom you are electing coverage. Complete **ALL** items for each dependent listed.

To Change

- Complete **Effective Date of Transaction** and check appropriate box in Section **A**, Number **2**.
- Complete blank fields in Section B (if applicable) [If the Change impacts the U.S. Social Security/ID Number, Control Suffix Account or Plan Number, the existing/impacted Number should be identified in Section B. The 'new' Number should be entered in the "To" field in the Change section, for the U.S. Social Security/ID Number or in fields B2 or B3, as applicable].
- Complete Section **C**, Numbers **1, 2, and 3.**
- Indicate change(s) in appropriate Section(s) (**B, C, D**) and *circle*.

To Terminate

- Complete **Effective Date of Transaction** and check appropriate box in Section **A**, Number **3**.
- Indicate reason for Termination or Cancellation.
- Check "All" or "Specific" cancellation of dependent coverage and indicate specific individual(s) in Section **D**.
- Check appropriate box for individuals continuing health coverage. **Note:** Section D must be completed for all individuals continuing coverage.

B. Employer Information

The Servicing Field Office (B4) is assigned by Aetna.

B2. **Control, Suffix and Account** - If this information is not preprinted, provide the complete Control, Suffix and Account numbers.
B3. **Plan Number** - If this information is not preprinted, refer to the Plan Sheet to determine the correct Plan Number.
B7. **Customer Code (Optional)** - Provide an identifying Customer Code for the employee only if you had elected to provide this information.
NOTE: Employer/Benefits Administrator must also complete items C12 and 13 (below).

C. Employee Information

To be completed by the Enrollee; except, items Earnings (C12) and Insurance Amounts (C13) are completed by the Employer/Benefits Administrator.

C*11.* **Beneficiary Designation** - *Full Beneficiary Name (First, Middle and Last)*, U.S. Social Security Number (as applicable, otherwise enter "None"), and relationship of the person to whom benefits will be paid in the event of your death.
C*12.* **Earnings** - Your Benefits Administrator will identify if earnings amounts need to be reported, check the appropriate box, and enter the rounded dollar amount.
C*13.* **Insurance Amounts** - Your Benefits Administrator will identify if earnings/insurance amounts need to be reported, check the appropriate box, and enter the rounded dollar amount.
C14. * **Prior Insurance Plan** - Check "Yes" if you are covered under your employer's or other prior insurance plan. NOTE: You must provide the following in Special Remarks: **Carrier/Plan Name, effective date of prior coverage, policy/group number, and prior coverage type (i.e., individual or group)**.
C15. * **Other Health Coverage** - Check "Yes" if you are currently covered by another health insurance plan. NOTE: You must provide the following in Special Remarks: **Carrier Name**. **Please Note**: For grandfathered group plans subject to U.S. Federal Patient Protection and Affordable Care Act (PPACA) mandates, if your child (under age 26) is eligible for employer based coverage other than through a parent's plan, then that child may not be eligible to enroll in this Plan. Contact your policyholder for further information.
C16. **Currently Covered by Medicare** - Check "Yes" based on employee age or disabled status.

D. Dependents Covered

To be completed by the Enrollee.

List only those individuals for whom you are electing/ changing coverage and complete ALL items for each individual.

Dependent eligibility may vary if a Plan is subject to U.S. federal Patient Protection and Affordable Care Act (PPACA). See your plan documents or Benefits Administrator.

- **Add/Change/Remove** - Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- **Relationship Code** - Use **ONLY**: H=Husband, W=Wife, N=Divorced Spouse, S=Son, D=Daughter, Y=Sponsored Male, X=Sponsored Female. **If the dependent is NOT a biological or legally adopted child, please indicate relationship to employee in Special Remarks.**
- **Name** - This **must** be completed for all individuals for whom you are electing or changing coverage. Please complete **ALL** items in Section **D** for each individual listed. Attach another form if you are requesting coverage for additional dependents.
- **Birthdate** - Date of birth should include **four digit year of birth**.

* **Prior Insurance Plan** - Check "Yes" if you are covered under your employer's or other prior insurance plan. NOTE: You must provide the following in Special Remarks: **Carrier/Plan Name, effective date of prior coverage, policy/group number, and prior coverage type (i.e., individual or group)**.
* **Other Health Coverage** - Check "Yes" if you are currently covered by another health insurance plan. NOTE: You must provide the following in Special Remarks: **Carrier Name**. **Please Note**: For grandfathered group plans subject to U.S. Federal Patient Protection and Affordable Care Act (PPACA) mandates, if your child (under age 26) is eligible for employer based coverage other than through a parent's plan, then that child may not be eligible to enroll in this Plan. Contact your policyholder for further information.

- **Currently Covered by Medicare** - Check "Yes" based on dependent(s) age or disabled status.

* **Handicapped** - Check "Yes" if handicapped and financially dependent, provide proof of handicapped status from the attending physician.
* **Student Age 19 or Older** - Please report the school name & expected graduation date in the Special Remarks field for dependent students age 19 years or older if U.S. Federal Patient Protection and Affordable Care Act (PPACA) mandates do **not** apply to your Plan and your Plan includes an age 19 years/full-time student eligibility qualification. Refer to your plan documents or contact your benefits administrator for the eligibility and any regulatory provisions that apply to your Plan**. Thereafter**, Member Services may request that you provide proof from the educational institution.

E. Acknowledgements

Signature required.

- Read the information contained above the space provided for your signature and the **Authorization of Enrollee** on **Page 2** of this form.
- **Sign and date the form. Both the Employer and Employee Signature areas support the ability to use an electronic form of signature to confirm your verification and declaration of the details provided.**

Misrepresentations

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

United States Fraud Statements Below:

Attention Alabama Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof. **Attention Arkansas, District of Columbia, Rhode Island and West Virginia Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Attention California Residents: For your protection California law requires notice of the following to appear on this form:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. **Attention Colorado Residents:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. **Attention Florida Residents:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. **Attention Kansas Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Attention Kentucky Residents:** Any person who knowingly and with intent to **defraud** any insurance company or other person files a statement of claim containing any materially **false** information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a **crime**. **Attention Louisiana Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application is guilty of a crime and may be subject to fines and confinement in prison. **Attention Maine and Tennessee Residents:** 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, or denial of insurance benefits. **Attention Maryland Residents:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Attention Missouri Residents:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, denial of insurance and civil damages, as determined by a court of law. Any person who knowingly and with intent to injure, defraud or deceive an insurance company may be guilty of fraud as determined by a court of law. **Attention New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. **Attention New York Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation. **Attention North Carolina Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties. **Attention Ohio Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **Attention Oklahoma Residents:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **Attention Oregon Residents:** Any person who with intent to injure, defraud, or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Attention Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **Attention Puerto Rico Residents:** Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years. **Attention Texas Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any intentional misrepresentation of material fact or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **Attention Vermont Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **Attention Virginia Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties. **Attention Washington Residents:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

For Plan Compliant with United States Federal Affordable Care Act (ACA) legislation
Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

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

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

TTY: 711

For language assistance in your language call the number listed on your ID card at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al número que figura en su tarjeta de identificación. (Spanish)

欲取得繁體中文語言協助，請撥打您 ID 卡上所列的號碼，無需付費。(Chinese)

Pour une assistance linguistique en français appeler le numéro indiqué sur votre carte d'identité sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang nakalistang numero sa iyong ID card nang walang bayad. (Tagalog)

Benötigen Sie Hilfe oder Informationen auf Deutsch? Rufen Sie kostenlos die auf Ihrer Versicherungskarte aufgeführte Nummer an. (German)

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني المذكور في بطاقتك التعريفية. (Arabic)

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo a yo endike nan kat idantifikasyon ou gratis. (French Creole)

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente il numero riportato sulla Sua scheda identificativa. (Italian)

日本語で援助をご希望の方は、IDカードに記載されている番号まで無料でお電話ください。(Japanese)

한국어로 언어 지원을 받고 싶으시면 보험 ID 카드에 수록된 무료 통화번호로 전화해 주십시오. (Korean)

برای راهنمایی به زبان فارسی، بدون هیچ هزینه ای با شماره ای که بر روی کارت شناسایی شما آمده است تماس بگیرید. (Persian) انگلیسی

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer podany na karcie ID. (Polish)

Para obter assistência linguística em português ligue para o número grátis listado no seu cartão de identificação. (Portuguese)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру, указанному в вашей ID-карте удостоверения личности. (Russian)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số được ghi trên thẻ ID của quý vị. (Vietnamese)