Covered California
PO BOX 989725
West Sacramento, CA 95798-9725

Your destination for affordable healthcare, including Medi-Cal

{FIRST_NAME} {LAST_NAME}
{ADDRESS_LINE1}
{ADDRESS_LINE2}
{CITY}, {STATE_CD (FK)} {ZIPCODE}

Your state tax form for {Tax Year}

{CURRENT_DATE}

Case Number: {AHBX_CASE_ID}

Dear {FIRST_NAME} {LAST_NAME},

Form FTB 3895, California Health Insurance Marketplace Statement
Your Form FTB 3895 is at the end of this letter. You need this form to file your California income tax return with the Franchise Tax Board (FTB).

The form shows:

- Members of your household who were enrolled in a Covered California health plan in {Tax Year}
- How much California premium subsidy you used during the year

If you got the California premium subsidy or want to claim it now, you must:

- File a **state** tax return. You must file even if you don't usually file a state tax return or have not filed in the past.
- File **Form FTB 3849, Premium Assistance Subsidy** with your **state** tax return to report the California premium subsidy amount you got each month. Use the information on your Form FTB 3895 to fill out Form FTB 3849.

Note: If you are married or have a Registered Domestic Partner, you may be required to file your taxes as Married Filing Jointly. There are some exceptions. If you have questions about your tax filing status, talk to your tax preparer.

If you need help with your taxes
Covered California may be able to answer questions but **cannot** give tax advice. For help with your taxes:

- Talk to a tax adviser

- Contact the IRS Volunteer Income Tax Assistance (VITA) or the Tax Counseling for the Elderly (TCE) programs for free tax help. VITA helps people who make $58,000 or less per year, persons with disabilities, and limited English-speaking taxpayers. TCE helps people 60 years of age or older. To find free help near you:
    - Go online to irs.treasury.gov/freetaxprep
    - Call 1-800-906-9887

- Visit the Franchise Tax Board's website at FTB.ca.gov. You can learn more about filing your state tax return, the California premium subsidy, and the California Individual Shared Responsibility Penalty.

If you need a digital copy
Log in to your account at CoveredCA.com. On the homepage, click "View {Tax Year} California Tax Form 3895." To create an online account, follow the instructions at CoveredCA.com/create-account.

Questions?
Read the **Frequently Asked Questions** in this letter. If you have other questions or think there is a mistake on your form:

- Go online to CoveredCA.com/3895
- Call Covered California, Monday – Friday, 8 a.m. to 6 p.m. at **{SERVICE_CENTER_PHONE}** (TTY: 1-888-889-4500)

Remember: You will get two tax forms this year. Your letters may be mailed days or weeks apart in separate envelopes. Please wait until **after** January 31 to report a missing form.

Thank you,

Covered California

This notice was sent to you in compliance with Section 61005 of the Revenue and Taxation Code.

TAXABLE YEAR 2021

California Health Insurance Marketplace Statement

CALIFORNIA FORM 3895

☐ VOID ☐ CORRECTED

Recipient's name	Initial	Last name	Suffix	Recipient's SSN	Recipient's date of birth

Spouse's first name	Initial	Last name	Suffix	Spouse's SSN	Spouse's date of birth

Address (apt./ste., room, PO box, or PMB no.)

City	State	ZIP code

Marketplace identifier	Marketplace-assigned policy number	Policy issuer's name

Policy start date	Policy termination date	☐ Repayment cap may not apply

Part I Covered Individuals

	(a) Covered individual name		(b) Covered individual SSN	(c) Covered individual date of birth	(d) Coverage start date	(e) Coverage termination date
	First name	Last name				
1						
2						
3						
4						
5						

Part II Coverage Information

Month	(a) Monthly enrollment premiums	(b) Monthly second lowest cost silver plan (SLCSP) premium	(c) Monthly advance payment of premium assistance subsidy
6 January			
7 February			
8 March			
9 April			
10 May			
11 June			
12 July			
13 August			
14 September			
15 October			
16 November			
17 December			
18 Annual Totals			

2021 Instructions for Form FTB 3895

California Health Insurance Marketplace Statement

General Information

Minimum Essential Coverage Individual Mandate – For taxable years beginning on or after January 1, 2020, California law requires residents and their dependents to obtain and maintain minimum essential coverage (MEC), also referred to as qualifying health care coverage. Individuals who fail to maintain qualifying health care coverage for any month during the taxable year will be subject to a penalty unless they qualify for an exemption. For more information, get the following health care forms, instructions, and publications:

- Form FTB 3849, Premium Assistance Subsidy
- Form FTB 3853, Health Coverage Exemptions and Individual Shared Responsibility Penalty
- Form FTB 3895, California Health Insurance Marketplace Statement
- Publication 3849A, Premium Assistance Subsidy (PAS)
- Publication 3895B, California Instructions for Filing Federal Forms 1094-B and 1095-B
- Publication 3895C, California Instructions for Filing Federal Forms 1094-C and 1095-C

Purpose

Form FTB 3895 is used to report certain information to the Franchise Tax Board (FTB) about individuals who enroll in a qualified health plan through the California Health Insurance Marketplace (Marketplace). The term "Marketplace" refers to the California state Marketplace, also known as Covered California. Form FTB 3895, is also furnished to individuals to allow them to take the premium assistance subsidy, to reconcile any advanced premium assistance subsidies, and to file an accurate tax return.

Who Must File

The Marketplace must file form FTB 3895 to report information on all enrollments in qualified health plans in the individual market through the Marketplace. **Do not** file a form FTB 3895 for a catastrophic health plan or a separate dental policy (called a "stand-alone dental plan" in these instructions).

When To File

File the annual report with the FTB and furnish the statements to individuals on or before January 31, 2022, for coverage in calendar year 2021.

How To File

Electronic filing. You must submit the information to the FTB electronically. For more information, get FTB File Exchange System – Technical Specifications (3895).

Statements to Individuals

Furnishing required information to the individual.
The Marketplace uses form FTB 3895 to furnish the required statement to recipients. A separate form FTB 3895 must be furnished for each policy and the information on the form FTB 3895 should relate only to that policy. If two or more tax filers are enrolled in one policy, each tax filer receives a statement reporting coverage of only the members of that tax filer's applicable household (an applicable household may include the tax filer, the tax filer's spouse if the tax filer is filing a joint return with their spouse, and the tax filer's dependents). See the instructions for "Recipient's name" for more information about who is a recipient. **Do not** furnish a form FTB 3895 for a catastrophic health plan or a stand-alone dental plan. See the instructions for Part II, column (a).

On form FTB 3895 statements furnished to recipients, filers of form FTB 3895 may truncate the social security number (SSN) of an individual receiving coverage by showing only the last four digits of the SSN and replacing the first five digits with asterisks (*) or Xs. Truncation is not allowed on forms filed with the FTB.

Statements must be furnished to recipients on paper by mail, unless a recipient affirmatively consents to receive the statement in an electronic format.

If mailed, the statement must be sent to the recipient's last known permanent address, or if no permanent address is known, to the recipient's temporary address.

Consent to furnish statement electronically.
The requirement to obtain affirmative consent to furnish a statement electronically ensures that statements are sent electronically only to individuals who are able to access them. A recipient may provide their consent on paper or electronically, such as by email. If consent is provided on paper, the recipient must confirm the consent electronically. An electronic statement may be furnished by email or by informing the recipient how to access the statement on the Marketplace website (for example, in the recipient's Marketplace account).

Specific Instructions

Recipient Information

Recipient's name – Enter the name of the recipient of the statement. This should be the person identified at enrollment as the tax filer (the person who is expected to file a tax return, to claim other applicable household members as dependents, and who, if qualified, would take the premium assistance subsidy for the year of coverage for their applicable household). If the tax filer cannot be identified from the information provided at enrollment (for example, because no financial assistance was requested), enter the name of the primary applicant for the coverage.

Recipient's SSN – Enter the SSN for the recipient shown on the recipient's name line.

Recipient's date of birth – Enter the recipient's date of birth.

Spouse's name/SSN/date of birth – Enter information about the recipient's spouse, if enrolled under the same policy. Enter this information even if the advance subsidy payments were not made for the spouse's coverage.

Address/City/State/ZIP code – Enter the recipient's address.

Marketplace identifier – Enter California or abbreviation.

Marketplace-assigned policy number – Enter the number the Marketplace assigned to the policy. Enter the full policy number.

Policy issuer's name – Enter the name of the issuer of the policy.

Policy start date – Enter the date that coverage under the policy started. If the policy was in effect at the start of the year, enter 1/1/2021.

Policy termination date – Enter the date of termination if the policy was terminated during the year. If the policy was in effect at the end of the year, enter 12/31/2021.

Repayment cap may not apply – Check this box for individuals who indicate a household income above 400% of the federal poverty line for the entire year.

Part I – Covered Individuals

Enter on line 1 through line 5 and columns (a) through (e) information for each individual covered under the policy, including the recipient and the recipient's spouse, if covered. If advance subsidy payments were not made for any coverage under the policy and an applicable household cannot be identified, enter in Part I information for all covered individuals. If advance subsidy payments were made for the coverage or an applicable household can be identified, enter in Part I information only for covered individuals whom the tax filer certified at enrollment would be a part of the tax filer's applicable household. Information about individuals enrolled in the same policy as the tax filer's applicable household who are not members of that applicable household, including children, must be reported on a separate form FTB 3895.

For each line, enter a date of birth in column (c) whenever available. If no SSN is provided in column (b), a date of birth must be provided. Enter in column (d) the date the coverage started for the individual. Enter in column (e) the date of termination if the individual's coverage was terminated during the year. If the coverage was in effect at the end of the year, enter 12/31/2021.

If there are more than 5 covered individuals, complete one or more additional forms FTB 3895, Part I.

Part II – Coverage Information

Enter information in Part II, line 6 through line 17, for each month of coverage. This information is determined on a monthly basis and may change during the year if there is a change in enrollment or other circumstances that affect eligibility for, or the amount of, the premium assistance subsidy. Total the amounts on line 6 through line 17 and enter on line 18.

Column (a). Enter the total monthly enrollment premiums for the policy in which the covered individuals enrolled. Include only the premiums allocable to essential health benefits. If a covered individual is enrolled in a stand-alone dental plan, include the portion of the premiums for the stand-alone dental plan that is allocable to pediatric dental coverage in the total monthly enrollment premiums. If more than one form FTB 3895 is filed for coverage of the recipient's applicable household for the same months because, for example, an applicable household member enrolled in a separate policy, include the portion of the premium for pediatric dental coverage in the amount in column (a) on only one form FTB 3895. If more than one tax filer is enrolled in a policy, report on each tax filer's form FTB 3895 only those enrollment premiums allocated to that tax filer.

If a policy is terminated by an issuer for nonpayment of premiums, enter -0- for a month in which the covered individuals have coverage but the premiums are not fully paid (generally, the first month of a grace period). Premiums and subsidy amounts are automatically prorated based on the number of days covered per that month.

Column (b). Enter the premiums for the applicable second lowest cost silver plan (SLCSP) that was used as a benchmark to compute monthly advance subsidy payments. If advance subsidy payments were made, the applicable SLCSP for a month is the SLCSP that applies to individuals in Part I who were identified at enrollment as members of the tax filer's applicable household (the tax filer, the tax filer's spouse if the tax filer is filing a joint return with their spouse and any dependents of the tax filer) and who are enrolled in the coverage on the first day of the month and are not eligible for other health coverage for that month. However, if an individual enrolls in coverage and the enrollment is effective on the date of the individual's birth, adoption, placement in foster care, or on the effective date of a court order, the individual should be considered to have enrolled on the first day of the month for purposes of the applicable SLCSP premium reported in column (b). If all covered individuals enroll after the first of the month, and no individual's coverage is effective on the date of the individual's birth, adoption, placement in foster care, or on the effective date of a court order, enter -0- in column (b) for that month. If more than one form FTB 3895 is filed for coverage of a tax filer's applicable household for the same month (for example, because members of the applicable household were split among several policies), enter the SLCSP premium that applies to all the applicable household members who were enrolled in any policy on the first of the month and who were not eligible for other health coverage for that month. Enter this SLCSP premium in column (b) on each form FTB 3895.

In some cases, the information provided at enrollment may not indicate which covered individuals are members of the recipient's applicable household and are not eligible for other health coverage. (Such information may not be provided, for example, because no financial assistance was requested.) If this is the case, and if the Marketplace has provided a tool for determining the applicable SLCSP premium for the year of coverage at the time of filing the tax return, leave column (b) blank. If the Marketplace has not provided a tool for determining the applicable SLCSP premium, enter the premiums for the SLCSP that would apply to all individuals identified in Part I as covered for the month.

If a policy is terminated by an issuer for nonpayment of premiums and advance subsidy payments are made, enter -0- for a month in which the covered individuals have coverage but the premiums are not paid (generally, the first month of a grace period). However, if an individual enrolled on the first day of a month terminates coverage before the last day of the month, the individual should be considered to have been enrolled for the entire month for purposes of the applicable SLCSP premium reported in column (b).

Column (c). Enter the amount of advance subsidy payments for the month. If more than one form FTB 3895 is filed for coverage of a tax filer's applicable household for the same months, enter only the advance subsidy payment amount allocated to the policy reported on this form FTB 3895. If the tax filer's applicable household is also enrolled in a stand-alone dental plan, any advance subsidy payments allocated to the stand-alone dental plan should be added to the advance subsidy payments allocated to one of the policies reported on a form FTB 3895.

Void Statements

If a form FTB 3895 was sent for a policy that should not be reported on a form FTB 3895, such as a stand-alone dental plan or a catastrophic health plan, send a duplicate of that form FTB 3895 and check the void box at the top of the form. Provide this information to the FTB and to the recipient of the statement as soon as possible after discovering that the statement was sent in error.

Correction to Information Reported

Report corrected information on the form FTB 3895 to the FTB and to the recipient as soon as possible after discovering that information reported is incorrect. Check the corrected box on the top of the form.

Frequently Asked Questions

Q: What is the California premium subsidy?

A: In 2020 and 2021, Covered California offered a new type of financial help. The California premium subsidy lowered the premium (monthly cost) of a qualified health plan through Covered California. Covered California used the information on your application to decide if you qualified.

Q: How does taking the California premium subsidy in advance (during the year) impact my taxes?

A: When you file **state** taxes at the end of the year, the Franchise Tax Board uses the actual income and family size you report on your state tax return to decide the amount of your subsidy. Based on your specific situation, you may have to **pay back** some or all of the subsidy you got during the year. Or you may qualify for more subsidy and get the rest as a refund. If you owe other state taxes, your unused subsidy may lower the amount you owe.

To avoid having to pay back California premium subsidy next year, report any changes to Covered California right away. Report changes in income; family size; and eligibility for other health coverage such as Medicare, Medi-Cal, or employer coverage.

Q: Why am I getting Form FTB 3895?

A: We send Form FTB 3895 to everyone who got health insurance through Covered California in {Tax Year}. You need this form to file your **state** taxes. We also send Form FTB 3895 to the Franchise Tax Board. It shows:

- Who was enrolled and how many months they had health insurance
- How much was paid in monthly premiums
- How much California premium subsidy was paid to the health insurance company

Q: Why did I get more than one Form FTB 3895?

A: This could happen if members of your household were enrolled in different health plans. Or, someone changed health plans or benefit levels during the year, such as changing from a Silver to a Gold plan.

Q: How do I use Form FTB 3895 to file my state taxes?

A: Use your Form FTB 3895 to fill out **Form FTB 3849, Premium Assistance Subsidy.** You must file Form FTB 3849 with your state tax return**.** You can get a blank copy on the Franchise Tax Board's website at ftb.ca.gov/forms/index.html. Your tax preparer or online tax service should also have the form.

Q: Why is there a zero (0) in Part III – Column A on my Form FTB 3895?

A: If you did not pay your premium (monthly cost) and your health plan ended, then a zero (0) will appear for each month you did not pay. This will happen even if you got the California premium subsidy (Part III – Column C) during those months.

Q: Why does my Form FTB 3895 say I did not get any California premium subsidy during the year? Part III – Column C is blank or has all zeroes.

A: This could happen because you did not ask for help paying for your health insurance. Or, you did **not** qualify when you applied. For example, your income did not meet the program rules or you were eligible for other health insurance.

Q: How can I correct a mistake on my Form FTB 3895?

A: If you find a mistake on your Form FTB 3895, you can call Covered California. Or you can file a dispute online at CoveredCA.com/3895. Click "Errors on your forms?" Then fill out the Request to Correct or Dispute Tax Forms.

Q: Why do I need two different tax forms (Form FTB 3895 and IRS Form 1095-A) this year?

A: Starting in tax year 2020, both state **and** federal financial help are available through Covered California. These are reported on two different tax forms:

- Use **Form FTB 3895** to report **state** financial help you got and show proof of coverage when you file California state taxes
- Use **IRS Form 1095-A** to report **federa**l financial help you got when you file federal taxes

Q: Will I get a tax form for a family member who had other health insurance?

A: You might get IRS Form 1095-B or 1095-C if someone in your household had health insurance other than through Covered California. For example:

- **IRS Form 1095-B** shows if someone had insurance through Medi-Cal, Medicare, Veteran's Administration, a small employer, or other health insurance not purchased through Covered California

- **IRS Form 1095-C** shows if someone had insurance through a large employer with 50 or more full-time equivalent employees

You can use these forms as proof of health insurance when you file your state taxes.

Note: The Department of Health Care Services (DHCS) will send IRS Form 1095-B to everyone who had Medi-Cal in {Tax Year}. You will get more than one form if some people in your family had Medi-Cal and others had Covered California. If you have questions, visit the DHCS website at dhcs.ca.gov/1095. Or call **1-844-253-0883.**

Section 1557 of the Patient Protection and Affordable Care Act (ACA)

Covered California complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity or sexual orientation. Covered California does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity or sexual orientation.

Covered California provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats and other formats). Covered California also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact the Civil Rights Coordinator at 916-228-8764 or by email at CivilRights@covered.ca.gov.

If you believe that Covered California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity or sexual orientation, you can file a grievance with the Civil Rights Coordinator.

You can file a grievance in the following ways:

Mail: Civil Rights Coordinator
P.O. Box 989725
West Sacramento, CA 95798-9725

Phone: 916-228-8764

Fax: 916-228-8909

Email: CivilRights@covered.ca.gov

You can also file a civil rights complaint with the Office for Civil Rights at the U.S. Department of Health and Human Services.

Mail: U.S. Department of Health and Human Services
200 Independence Ave. SW, Room 509F, HHH Building
Washington, DC 20201

Phone: 1-800-368-1019 or TTY: 1-800-537-7697

Online: Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available on the U.S. Department of Health and Human Services Office for Civil Rights website.

Getting Help in a Language Other than English

IMPORTANT: Can you read this letter? You can call 1-800-300-1506 and ask for this letter translated to your language or in another format such as large print. For TTY call 1-888-889-4500 where you can also request this letter in alternate format.

Español IMPORTANTE: ¿Puede leer esta carta? Usted puede llamar al 1-800-300-0213 y pedir esta carta traducida en su idioma o en otro formato como en letras grandes. Para TTY, llame al 1-888-889-4500, donde también puede pedir esta carta en algún formato diferente. **(Spanish)**

中文/繁體字 重要事项：您能讀懂這封信嗎？您可以致电 **1-800-300-1533** 並要求將這封信翻譯成您的語言或者索要其他格式如大字版本的信件。對於 TTY ，请致电

1-888-889-4500, 您也可以在那里索取其他格式的信件。

(Chinese)

Tiếng Việt QUAN TRỌNG: Quý vị có thể đọc được bức thư này không? Quý vị có thể gọi điện đến số **1-800-652-9528** và yêu cầu được dịch bức thư này sang ngôn ngữ của quý vị hoặc chuyển sang định dạng khác như bản in khổ lớn. Người dùng TTY, hãy gọi số **1-888-889-4500** quý vị cũng có thể yêu cầu định dạng thay thế khác cho bức thư này. **(Vietnamese)**

한국어 중요: 이 편지를 읽을 수 있습니까? **1-800-738-9116** 으로 연락하여 귀하의 언어로 번역되거나 큰 활자와 같은 다른 형식으로 요청하십시오. **TTY 1-888-889-4500** 에서도 이 편지의 다른 포맷을 요청할 수도 있습니다. **(Korean)**

Tagalog MAHALAGA: Maaari ba ninyong basahin ang sulat na ito? Maaari kang tumawag sa **1-800-983-8816** at humiling na isalin ang sulat na ito sa iyong wika o sa iba pang format katulad ng malalaking titik. Para sa TTY, tumawag sa **1-888-889-4500** kung saan maaari kang humiling ng alternatibong format ng sulat na ito. **(Tagalog)**

العربية هام: هل يمكنك قراءة هذا الخطاب؟ يمكنك الاتصال بـ **1-800-826-6317** وطلب هذا الخطاب مترجماً إلى لغتك أو بصيغة أخرى، بخط كبير مثلاً. للصم والبكم، اتصل بـ **1-888-889-4500** حيث يمكنك أيضاً أن تطلب هذا الخطاب بصيغة مختلفة. **(Arabic)**

հայերեն ԿԱՐԵՎՈՐ է: Դուք կարո՞ղ եք կարդալ այս նամակը: Դուք կարող եք զանգահարել **1-800-996-1009** և խնդրել, որ այս նամակը թարգմանվի Ձեր լեզվով կամ Ձեզ տրվի մեկ այլ ձևաչափով, օրինակ՝ խոշորատառ: TTY-ի համար զանգահարեք **1-888-889-4500,** որտեղ կարող եք նաև այլընտրանքային ձևաչափով խնդրել այս նամակը: **(Armenian)**

ភាសាខ្មែរ សំខាន់៖ តើលោកអ្នកអាចអានលិខិតនេះបានដែរឬទេ? លោកអ្នកអាចទូរស័ព្ទមកលេខ **1-800-906-8528** និងស្នើសុំឲ្យគេបកប្រែលិខិតនេះជាភាសារបស់លោកអ្នក ឬជាទម្រង់មួយផ្សេងទៀតដូចជាអក្សរពុម្ពធំៗ។ សម្រាប់ TTY ទូរស័ព្ទមកលេខ **1-888-889-4500** ដែលលោកអ្នកក៏អាចស្នើសុំលិខិតនេះជាទម្រង់ផ្សេងទៀតបានផងដែរ។ **(Khmer)**

Русский ВАЖНАЯ ИНФОРМАЦИЯ: Вы можете прочитать это письмо? Вы можете позвонить по телефону **1-800-778-7695** и запросить получение этого письма, переведенного на Ваш родной язык, или распечатанного крупным шрифтом. Лица со сниженным слухом могут позвонить по телефону **1-888-889-4500**, чтобы запросить это письмо в ином формате. **(Russian)**

فارسی مهم: آیا می توانید این نامه را بخوانید؟ می توانید با شماره **1-800-921-8879** تماس بگیرید و تقاضا کنید که این نامه به زبان شما ترجمه شود یا به فرمت دیگری مانند حروف درشت به شما ارسال شود. برای TTY با شماره **1-888-889-4500** تماس بگیرید و از طریق همان شماره همچنین می توانید درخواست کنید که این نامه به فرمت دیگری به شما ارسال شود. **(Farsi)**

Hmoob TSEEM CEEB: Koj nyeem puas tau tsab ntawv no? Koj hu tau rau **1-800-771-2156** thiab nug kom daim ntawv txais ua yog koj cov lus los sis yog lwm hom xws lis luam tus ntawv loj. Hu tau TTY ntawm **1-800-889-4500** ua koj thov hloov tau lwm hom. **(Hmong)**

महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? इस पत्र को अपनी भाषा में अनुवाद करने के लिए या बड़े प्रिंट की तरह किसी अन्य प्रारूप में प्राप्त करने के लिए 1-800-300-1506 पर कॉल करके अनुरोध कर सकते हैं। TTY के लिए 1-888-889-4500 पर कॉल करें जहाँ आप इस पत्र को किसी अन्य प्रारूप में प्राप्त करने का अनुरोध कर सकते हैं। (Hindi)

重要：この文書を読むことができますか？希望の言語に翻訳された文書、または大きな文字など別の形式の文書をご希望の場合、1-800-300-1506 までお電話ください。TTY の場合、1-888-889-4500 にお電話いただければ、その他の形式の文書をリクエストすることもできます。(Japanese)

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਨੂੰ ਪੜ ਸਕਦੇ ਹੋ? ਤੁਸੀਂ 1-800-300-1506 'ਤੇ ਕਾਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਇਸ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਜਾਂ ਕਿਸੇ ਹੋਰ ਸਰੂਪ ਵਿਚ, ਜਿਵੇਂ ਕਿ ਵੱਡੇ ਪਰਿੰਟ ਲਈ ਪੁੱਛ ਸਕਦੇ ਹੋ। ਟੀਟੀਵਾਇ ਲਈ 1-888-889-4500 'ਤੇ ਕਾਲ ਕਰੋ ਜਿੱਥੇ ਕਿ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਦੇ ਵਿਕਲਪਕ ਰੂਪ ਵਿਚ ਸਰੂਪ ਲਈ ਬੇਨਤੀ ਵੀ ਕਰ ਸਕਦੇ ਹੋ। **(Punjabi)**

สำคัญ: คุณสามารถอ่านจดหมายฉบับนี้ได้หรือไม่ คุณสามารถติดต่อได้ที่เบอร์ 1-800-300-1506 เพื่อขอให้แปลจดหมายฉบับนี้เป็นภาษาของคุณ หรือขอเปลี่ยนแปลงรูปแบบตัวอักษรให้เป็นรูปแบบอื่น เช่นตัวอักษรขนาดใหญ่ สำหรับระบบ TTY คุณสามารถติดต่อได้ที่เบอร์ 1-888-889-4500 ซึ่งคุณสามารถขอจดหมายฉบับนี้ในรูปแบบอื่น ๆ ได้ (Thai)