DROP Exit Checklist

**** PLEASE BE SURE TO CAREFULLY COMPLETE ALL REQUIRED FIELDS. FAILURE TO DO SO WILL CAUSE A DELAY IN PROCESSING YOUR BENEFIT ****

☐ Complete all Retirement System forms, including:

1. **DROP Exit Notification Form:** Indicate how you want to receive payment of your DROP balance and when your last day worked/DROP exit date is. You have the following options for your DROP lump sum:

    - **Refund:** Lump sum distribution minus taxes will be direct deposited into the checking account used for your direct deposit (unless otherwise requested).
    - **Rollover:** If you have elected to rollover your entire balance will be directly rolled to pre-tax retirement fund (ex: Traditional IRA). A designated official of the receiving financial institution must complete the "Rollover Information" field on the back of the form.
    - **Refund/Rollover:** Your balance will be divided between refund and rollover based on percentage or dollar amount of your choice.
    - **100% Increase to Base Benefit:** Your entire lump sum is used towards an increase in your base benefit (no lump sum distribution).
    - **50% Increase to Base Benefit**: 50% of lump-sum is used to increase base benefit. The remaining 50% is a lump-sum benefit paid to you as you elect (refund, rollover, or a combination refund/rollover)

2. **Deduction Authorization Form:** Mark your elections to have Federal and/or Virginia State taxes withheld from your retirement check.

3. **Direct Deposit Form:** Please either attach a VOIDED check or have a bank representative complete the bottom portion of the form.

☐ Return completed forms to your Retirement Analyst via

- E-mail: SCDavis@fcps.edu or Stephanie.Davis2@fairfaxcounty.gov
- Fax: 703-653-9543
- Mail (please do not send through courier)
- Locked drop box

All questions regarding health, life or dental insurance processes should be directed to FCPS Benefits at HRConnection@fcps.edu or (571) 423-3200, option 3, option 2. An HR-461 form is attached for your convenience. This form is <u>not</u> processed by FCERS and should be sent directly to FCPS Human Resources at:

8115 Gatehouse Road, Falls Church, VA 22042

Form EMPLOYEES' RETIREMENT SYSTEM

#E043 _7/15/2019

DROP Exit Notification

Last Name:	First Name:		Middle Initial:
Address:	City:	State:	Zip:
Social Security #:	Phone #:	Date of Birth: *Month Day Year*	
Non-county email:	Department and position:		
Address your retirement pay advices/other information will mailed, if different from above:			
Last Day Worked/DROP Exit Date:			

This form MUST be completed when you terminate the Deferred Retirement Option Program (DROP). This form must be received by the Retirement Systems NO LESS than 60 days prior to DROP exit date. **If you do NOTHING with this form**, and do not choose elections for your DROP account disbursement, your DROP account balance will be used to increase your monthly retirement benefit. The amount of the increase will be determined based on the actuarial equivalent of your DROP account balance.

After you have returned a completed form and you have been paid for final hours worked, your disbursement will be processed no later than the last business day of the following month.

This form MUST be received by the Retirement Systems Office NO LESS THAN 60 days prior to DROP Exit date!

Indicate below, how you want to receive payment of your DROP balance. SELECT ONLY ONE BOX

A. ☐ **Lump Sum Refund**

B. ☐ **Rollover*** **Any post-tax portion of your account balance will be paid directly to you in the form of a check as that portion of your balance can **NOT** be rolled over since you have already paid taxes on those dollars.*

C. ☐ _____$ or % **Rolled Over and** _____$ or % **Lump Sum Refund**

D. ☐ **Use 100% of your DROP balance to *increase* your retirement benefit**

E. ☐ **Use 50% of your DROP balance to *increase* your retirement benefit and 50% distribution in the following manner:**
_____$ or % Rolled Over and _____$ or % Lump Sum Refund

~ Please complete the front and back of this form and retain a copy for your records ~

Please return this original form to:

FAIRFAX COUNTY Retirement SYSTEMS
EMPLOYEES' POLICE Officers UNIFORMED

Fairfax County Retirement Systems
12015 Lee Jackson Memorial Hwy. ∗ Suite 350 ∗ Fairfax, VA 22033
703-279-8200 ∗ TTY: 711 ∗ 1-800-333-1633 ∗ Fax: 703-653-9543
www.fairfaxcounty.gov/retirement/

Form EMPLOYEES' RETIREMENT SYSTEM

Refunds and Taxes

You will receive your lump sum refund by direct deposit. You may also choose to have all or part of your refund rolled over via a check into an Individual Retirement Account (IRA) or to an employer's Plan that will accept the funds. This "direct rollover" or "eligible rollover distribution" is explained on the attached sheets.

The amount or percentage of any lump sum refund is subject to a mandatory 20% federal tax-withholding. In addition, it is subject to Virginia state tax withholding at the rate of 4% unless you indicate below that you are not subject to paying those taxes because: (1) you are not a resident of Virginia; (2) you incurred no income tax liability for last year and do not expect to incur a liability for this year; or (3) you expect your Virginia adjusted gross income to be less than $5,000 if single; $8,000 if married filing a joint return; or $4,000 if married filing a separate return. If under the age of 55, you may also be subject to a penalty from the IRS.

I certify that I am **not** subject to Virginia tax withholding for one of the reasons listed above. _____
Initial here

PLEASE NOTE: For a rollover by direct transfer of funds, the box below MUST be completed and signed by a designated official AND **you must sign below** in addition to signing in the other required signature spots. The box does not need to be completed if you are requesting a **refund** be paid to you.

★ ***Signature***_____***Date***_____

(Your signature above authorizes the distribution of your DROP balance and interest according to the election on the reverse)

ROLLOVER INFORMATION

Please have an official of the financial institution or employer's plan, which will be receiving a direct rollover of a portion of your refund complete and sign the section below. Please note that only one such rollover will be permitted. All requested information must be supplied before any funds are transferred.

I certify that the account below is eligible to receive the direct rollover of the taxable portion of this distribution.

_____ _____
Name of Financial Institution/Fund — Financial Institution Phone Number

_____
Address of Financial Institution — City — State — Zip

_____ _____
Rollover Account Number — Date

_____ _____
Printed Name and Title of Official — Signature of Official

Note: Any taxable DROP exit lump sum payment (not a rollover) that you receive directly may be subject to a 10% IRS penalty when you file your taxes. For example: in 2016, if you are under age 55, you may be subject to a 10% penalty.

**This information is provided only as general information and should not be considered as legal or tax advice. Please consult a tax professional before taking a distribution from your DROP Account.*

FAIRFAX COUNTY Retirement SYSTEMS
EMPLOYEES' POLICE Officers UNIFORMED

Fairfax County Retirement Systems
12015 Lee Jackson Memorial Hwy. ∗ Suite 350 ∗ Fairfax, VA 22033
703-279-8200 ∗ TTY: 711 ∗ 1-800-333-1633 ∗ Fax: 703-653-9543
www.fairfaxcounty.gov/retirement/

Form EMPLOYEES' RETIREMENT SYSTEM

#E007_5/7/2019

Authorized Payroll Deductions

Type of Request	Type of Payment
☐ New Request	☐ Retiree
☐ Change to current tax withholding	☐ Survivor

PART A: MEMBER INFORMATION

Last Name:	First Name:		Middle Initial:
Email:	Phone #:	SSN:	
Address:	City:	State:	Zip:

PART B: FEDERAL INCOME TAX WITHHOLDING

Choose one option below.

#1 ☐ Do not withhold federal income tax from my monthly benefit. I understand I am liable for paying federal income tax on the taxable portion of my benefit and I may be subject to tax penalties under the estimated tax payment rules if my payment(s) of estimated tax and withholding are not adequate. (If I am a U.S. Citizen or resident alien whose benefit payments are delivered outside of the U.S. or its possessions, I *must* have federal income tax withheld.)

#2a ☐ Using the marital status and exemptions below, calculate my federal income tax withholding (if any) in accordance with the tax formula as published in IRS Publication 15.

Marital Status: ☐ Married ☐ Single ☐ Married at Single Rate Total Exemptions _____

#2b Additional amount, if any, in addition to amount calculated in *2a* $ _____

#3 ☐ Flat amount $ _____ **OR** ☐ Percent _____%

PART C: STATE OF VIRGINIA INCOME TAX WITHHOLDING

Choose one option below. (You are not required to have Virginia state income tax withheld from your benefit if you do not reside in Virginia.)

#1 ☐ Do not withhold state income tax from my monthly benefit. I understand I am liable for paying state income tax on the taxable portion of my benefit and I may be subject to tax penalties under the estimated tax payment rules if my payment(s) of estimated tax and withholding are not adequate.

#2a ☐ Using the exemptions below, calculate my state income tax withholding (if any) in accordance with the tax formula as published in the Virginia Income Tax publication.

Personal Exemptions _____ Age and Blindness Exemptions _____ Total Exemptions _____

#2b Additional amount, if any, in addition to amount calculated in *2a* $ _____

#3 ☐ Flat amount $ _____ **OR** ☐ Percent _____%

Service-Connected Disability Retirees do not have taxes withheld from their retirement benefit checks.
Monthly credit union deductions are available by completing a secondary direct deposit form.

I hereby acknowledge receipt of the **"Preparing for Retirement"**, **"Preparing for Disability Retirement" or "DROP EXIT"** Guide and I am aware of the provisions explained therein. I request for the above deductions to be taken from my monthly retirement benefit.

Signature _____ Date _____

Please return this form to:

FAIRFAX COUNTY Retirement SYSTEMS
EMPLOYEES' POLICE Officers UNIFORMED

Fairfax County Retirement Systems
12015 Lee Jackson Memorial Hwy. ∗ Suite 350 ∗ Fairfax, VA 22033
703-279-8200 ∗ TTY: 711 ∗ 1-800-333-1633 ∗ Fax: 703-653-9543
www.fairfaxcounty.gov/retirement

Form EMPLOYEES' RETIREMENT SYSTEM | POLICE Officers RETIREMENT SYSTEM | UNIFORMED RETIREMENT SYSTEM

Direct Deposit Authorization Agreement

INSTRUCTIONS: Before you submit this application please have a representative of your banking institution **verify your account number and bank transit/ABA routing number** or attach a blank check marked "VOID". Completed forms should be mailed to the **Fairfax County Retirement Systems Office**, 12015 Lee Jackson Memorial Highway, Suite 350, Fairfax, VA 22033.

Last Name:	First Name:		Middle Initial:
Address:	City:	State:	Zip:
Social Security #:	Phone #:		
Type of Account: ☐ Checking ☐ Savings			

I authorize the County of Fairfax, Virginia to initiate credit entries to my account indicated above in the depository named below. This includes my authorization to correct entries made in error.

Since there is a slight possibility that my account will not be credited in a timely manner, I understand that I must check with my depository to verify that my account has in fact been credited before engaging in any financial transaction that is dependent on the existence of the credit entry.

This authority is to remain in effect until the County of Fairfax has received written notification from me of its termination in such time and in such manner as to afford the County of Fairfax a reasonable opportunity to act on it. I also understand that should my bank change any of its account or routing numbers I will have to submit a new form with the updated information to the Retirement Systems so the correct account will continue to be credited.

Benefit payments will be sent electronically to the account and routing number provided on the Direct Deposit Authorization. Please ensure accurate information is provided to ensure timely receipt of funds.

Signature:_____ Date:_____

To Be Verified By Banking Institution – OR attach a blank check marked "VOID"

This form must be signed by a bank representative before it can be processed **OR ATTACH A CHECK MARKED "VOID"**.

Name of Depository/Bank: _____

Address: _____

BK/TRANSIT/ABA Routing Number: __ __ __ __ __ __ __ __ __ Account #_____

Financial Institution Certification: I confirm the transit/routing number and account number for the individual named above. As representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210.

Signature of Representative:_____ Date:_____ Phone:_____

FAIRFAX COUNTY Retirement SYSTEMS
EMPLOYEES' POLICE Officers UNIFORMED

Fairfax County Retirement Systems
12015 Lee Jackson Memorial Hwy. ∗ Suite 350 ∗ Fairfax, VA 22033
703-279-8200 ∗ TTY: 711 ∗ 1-800-333-1633 ∗ Fax: 703-653-9543
www.fairfaxcounty.gov/retirement/

Fairfax County PUBLIC SCHOOLS
ENGAGE • INSPIRE • THRIVE

The following form will NOT be processed by FCERS and should be returned directly to FCPS Human Resources at:

8115 Gatehouse Road
Falls Church, VA 22042

You may also email this form to:

HRBenefitsDocumentation@fcps.edu

*** this form will **NOT** be processed by FCERS and should be returned directly to FCPS Human Resources at 8115 Gatehouse Rd, Falls Church, VA 22042

Retiree Medical & Dental Enrollment and Change Form

Fairfax County PUBLIC SCHOOLS
ENGAGE • INSPIRE • THRIVE

Action requested due to: (check all that apply)

☐ Retirement: Retirement date: _____	☐ Adding or Dropping Dependents (complete Sections 5 or 6) Effective date: _____	☐ Changing plans due to Medicare Eligibility or Moving Outside the Service Area Effective date: _____
☐ Re-employed Retiree Terminating Active Employment: Effective date: _____	☐ Cancelling Coverage (also select "No Coverage" in Sections 2 and/or 3 below) Effective date: _____	☐ Utilizing One Time Re-Entry Right Effective date: _____
☐ Open Enrollment	☐ Other (describe): _____	

To ensure your request is processed as quickly as possible, please read the instructions and important information below:

Requested elections/changes to your coverage must be made **within 30 calendar days** of the event. See page 2 for the effective date of change. If you are requesting to add dependents not currently covered on your FCPS plan, you must supply required supporting documentation. Find a complete list of documentation requirements at www.fcps.edu; search keywords "Dependent eligibility".

1. Your Information (Please print clearly)

Your Name (Last, First, Middle) _____

Date of Birth _____

Your Home Address (street and apt. number) _____

Social Security Number (SSN) or Employee ID Number _____

City, State, Zip Code _____

Home Phone _____

Email Address _____

Alternate Phone _____

Are you the surviving spouse of an FCPS employee/retiree? ☐ Yes ☐ No
If yes, please provide the name and SSN of the employee/retiree: _____

2a. Select your medical plan - or - ☐ No medical coverage

☐ Aetna/Innovation Health/ Aetna Medicare Advantage	☐ CareFirst Blue Choice Advantage (not available for retirees/dependents eligible for Medicare)	☐ Kaiser Permanente/ Kaiser Permanente Medicare (Additional form required for Medicare)

2b. Select your level of coverage

Coverage for yourself only	Coverage for yourself + 1 dependent	Coverage for yourself and 2+ dependents
☐ Individual (no Medicare) ☐ Individual (Medicare)	☐ Mini-family (no one has Medicare) ☐ 1 Individual + 1 Medicare (one has Medicare/one does not) ☐ Medicare Mini-family (both have Medicare)	☐ Family (no one has Medicare) ☐ Family with Medicare ☐ Mini-family + 1 Medicare

3a. Select your dental plan - or - ☐ No dental coverage

☐ Aetna Dental PPO	☐ Aetna Dental DNO If electing the DNO plan, you MUST contact Aetna Dental to designate a primary care dentist (PCD).

3b. Select your level of coverage (note: separate premium structures apply to retirees/dependents age 65+)

Coverage for yourself only	Coverage for yourself + 1 dependent	Coverage for yourself and 2+ dependents
☐ Individual	☐ Mini-family	☐ Family

For Benefits Office Use Only:

Coverage Dates **5 Continuous Years?**

☐ Direct Bill HL ☐ Annuity Deduction HL HL Deduction Amount _____ Medical _____ to _____ yes no

☐ Direct Bill DN ☐ Annuity Deduction DN DN Deduction Amount _____ Dental _____ to _____ yes no

Last 4 digits of SSN ________________________

4. If you are electing FCPS Medical coverage, are you eligible for Medicare due to age or disability?
Note: If not enrolling in FCPS medical coverage, go to Section 5 (if electing dental) or Section 7.

☐ Yes If Yes, please provide your Medicare Beneficiary Identifier (MBI): ________________

☐ No Part A Effective Date: ____________ Part B Effective Date: ____________

Please attach a copy of your card to this form.

____
Retiree Initials

I understand that it is my responsibility (and the responsibility of my covered dependents) to apply for Medicare when first eligible and provide a copy of my Medicare card to the Office of Benefit Services within 30 calendar days of receipt. Failure to apply for Medicare, including eligibility due to disability, will result in cancellation of medical coverage.

5. Dependent Enrollment Information

List only the names of those individuals you wish to ADD to coverage. To drop dependents use box 6. Skip to section 7 if no dependents.

Name (Last, First, MI) **and Social Security Number** (see box 9)	**Gender, Relationship, and D.O.B.**	**Plans to Enroll In**	**Medicare Info** (Attach copy of Medicare card. If you are not enrolled in Medicare, please skip this section.)
Dependent Name SSN (Required)	☐ Female ☐ Male ☐ Spouse ☐ Child Date of Birth (MM/DD/YYYY)	☐ Medical Only ☐ Dental Only ☐ Both Medical & Dental	**Medicare Effective Date:** Part A ________ Part B ________ MBI# ________
Dependent Name SSN (Required)	☐ Female ☐ Male ☐ Spouse ☐ Child Date of Birth (MM/DD/YYYY)	☐ Medical Only ☐ Dental Only ☐ Both Medical & Dental	**Medicare Effective Date:** Part A ________ Part B ________ MBI# ________
Dependent Name SSN (Required)	☐ Female ☐ Male ☐ Spouse ☐ Child Date of Birth (MM/DD/YYYY)	☐ Medical Only ☐ Dental Only ☐ Both Medical & Dental	**Medicare Effective Date:** Part A ________ Part B ________ MBI# ________

6. Remove Dependents

Complete only if YOU, the retiree, are retaining coverage and are requesting to remove the dependent(s) listed below from FCPS medical and/or dental coverage.

Name (Last, First, MI)	**Relationship**	**Remove from**
	☐ Spouse ☐ Child Date of Birth (MM/DD/YYYY)	☐ Medical ☐ Dental ☐ Medical & Dental
	☐ Spouse ☐ Child Date of Birth (MM/DD/YYYY)	☐ Medical ☐ Dental ☐ Medical & Dental
	☐ Spouse ☐ Child Date of Birth (MM/DD/YYYY)	☐ Medical ☐ Dental ☐ Medical & Dental

Coverage Effective Dates:

- If enrolling for coverage as a newly retired employee, you must submit this form **within 30 calendar days of your date of retirement**. Coverage will then take effect on the first day of the month following your date of retirement. If your date of retirement is the first day of the month, retiree coverage will become effective on that date.
- If requesting a change in enrollment due to a family status change or qualifying event, your request must be submitted **within 30 calendar days of the status change or qualifying event**, with changes in coverage effective the first day of the month after the qualifying event. You will need to supply the required supporting documentation. Find a complete list of documentation requirements at www.fcps.edu; search keywords **"Dependent eligibility"**.

Last 4 digits of SSN _____

7. Acceptance or Opt Out

I hereby elect (or decline) coverage under the FCPS health plan on behalf of myself and each eligible dependent. I understand that coverage will be provided according to the terms and conditions of the contract between the insurance carrier(s) and Fairfax County Public Schools (FCPS), and applicable FCPS directives. I understand the following provisions apply:

- I must notify the Office of Benefit Services of any change in status which would cause me – or my enrolled dependents - to cease to be eligible for benefits under the FCPS health and/or dental plans. This includes the death of a covered dependent, divorce, or a dependent child reaching the maximum age limit.
- If I am the surviving spouse of a deceased employee/retiree, I must notify the Office of Benefit Services **within 30 calendar days** if I remarry.
- If I fail to notify the Office of Benefit Services by filing the appropriate forms, I will be responsible for any claims and/or premiums paid on behalf of any individual who ceased to be eligible for benefits under the policy.
- If I elect coverage for myself but choose not to cover my eligible dependent(s), I may only add dependents during Open Enrollment or **within 30 calendar days** of a qualifying event. Examples of qualifying events include eligibility for Medicare, termination of spouse's employment, significant increase in my dependent's cost of coverage, and/or loss of eligibility under spouse's health and/or dental plan. See the *FCPS Retiree Benefits Handbook* for more information.
- I have the ability to cancel FCPS coverage and re-enter the plan(s) at a later date if I meet all of the following criteria:
  - I was enrolled in an FCPS medical and/or dental plan or DHO coverage on the date immediately prior to my retirement, **and**
  - I am enrolled in Medicare Parts A & B. If I wish to cover my dependents, all dependents must be enrolled in Medicare; **and**
  - I apply for coverage within 30 days of a qualifying event (or during Open Enrollment), **and**
  - I provide proof of continuous health coverage for the preceding 12 or more consecutive months, **and**
  - I have not previously utilized my re-entry right.
- It is my responsibility to keep my address up to date with my Retirement Agency (or the Office of Benefit Services, if no longer receiving a retirement benefit) and remain informed of any changes to the plan that might affect my eligibility or my dependent(s) eligibility.
- By completing and signing this enrollment form, I am making a binding election with regard to my benefits. I authorize FCPS to take the necessary deduction from my retirement annuity to pay my share of the cost of coverage, including any retroactive deductions if required. This authorization applies to future plan years unless I modify or cancel my coverage. If my retirement annuity will not accommodate the deduction, I will be invoiced by OptumFinancial Services.

Retiree Name (Last, First, M):_____

Retiree Signature: _____ **Date:**_____

8. Submission

Scan and email form to: HRBenefitsDocumentation@fcps.edu

Or fax to: Office of Benefit Services at 571-423-5000

Or mail to: Department of Human Resources
Office of Benefit Services, Suite 2700
8115 Gatehouse Road
Falls Church, VA 22042

Questions?

Contact the HR Client Service Center at 571-423-3000 or 1-800-831-4331 or email your questions to HRConnection@fcps.edu.

Remember to keep a copy of this form for your records. If you fax this form, also keep a copy of your fax machine's transmission report as documentation that we received the form by the deadline. Forms that are received after applicable deadlines cannot be accepted.

9. Notes

Patient Protection and Affordable Care Act:
Reporting requirements of the Patient Protection and Affordable Care Act require employers to file an annual report with the IRS that includes Social Security numbers (SSNs) for all individuals, including spouses, and dependent children enrolled in employer-sponsored medical plans (IRC Section 6055). You are required to provide FCPS with the SSNs of all covered dependents to comply with this requirement.

Medicare, Medicaid and SCHIP Extension Act of 2007:
Medicare, Medicaid and SCHIP Extension Act of 2007, 42 U.S.C. 1395y (b) (7) & (8), mandates employers to submit SSNs of all medical plan enrollees who are age 45 and over or are Medicare eligible regardless of age to the Center for Medicare and Medicaid Services.

Nondiscrimination and Foreign Language Assistance
FCPS health plans comply with applicable Federal civil rights laws, including Section 1557 of the Affordable Care Act (Nondiscrimination in Health Programs and Activities). In compliance with the Act, FCPS health plans do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. FCPS health plans also prohibit denial of health care or health coverage based on an individual's sex, including discrimination based on pregnancy, gender identity, and sex stereotyping. The Plan also provides important protections for individuals with disabilities and enhances language assistance for people with limited English proficiency. Each tagline listed below reads, "If you speak [native language], language assistance services, free of charge, are available to you. Call 571-423-3200."

ENGLISH
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 571-423-3200.

AMHARIC (አማርኛ)
አጻምጥ : አማርኛ, ከከፍያ ነፃ የድንቋ እርዳታ አገልግሎቶች , የሚናንሩ ከሆነ , ለእርስዎ የሚገኙ ናቸው . 571-423-3200 ይደውሱ .

ARABIC (العربية)
تنبيه: إذا كنت تتكلم العربية ، وخدمات المساعدة اللغوية ، مجانا ، تتوفر لك . قم571-423-3200.

BENGALI (বাংলা)
দৃষ্টি আকর্ষণ: আপনি বাংলা , ভাষা সহায়তা সেবা, নিখরচা কথা বলতে পারেন, আপনার জন্য উপলব্ধ . 571-423-3200 কল .

CHINESE (繁體中文)
注意：如果你说中国话，语言协助服务，免费的，都可以给你。拨打571-423-3200 。

FRENCH (Français)
ATTENTION : Si vous parlez français , les services d'assistance de langues, gratuitement , sont à votre disposition. Appelez 571-423-3200 .

GERMAN (Deutsch)
ACHTUNG: Wenn Sie Deutsch sprechen , Sprachassistenzdienste sind kostenlos, zur Verfügung. Rufen Sie 571-423-3200 .

HINDI (हिंदी)
ध्यान दें: आप हिंदी , भाषा सहायता सेवाओं, नि: शुल्क बोलते हैं, तो आप के लिए उपलब्ध हैं । 571-423-3200 बुलाओ।

IBO (Igbo asusu)
Ntị : Ọ bụrụ na ị na-ekwu okwu n'ala Igbo , asụsụ aka ọrụ , n'efu , dị ka gị. Akpọ 571-423-3200 .

KOREAN (한국어)
주의 : 당신이 한국어, 무료 언어 지원 서비스를 말하는 경우 사용할 수 있습니다. 571-423-3200 를 호출합니다.

KRU (Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀)
Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Đá 571-423-3200.

PERSIAN FARSI (فارسی)
توجه: اگر شما فارسی صحبت می کنند ، خدمات کمک زبان رایگان در دسترس شما هستند . پاسخ 571-423-3200 .

RUSSIAN (Русский)
ВНИМАНИЕ : Если вы говорите России , переводческие услуги , бесплатно , доступны для вас . Звоните 571-423-3200 .

SPANISH (Español)
ATENCIÓN : Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame a 571-423-3200.

TAGALOG (Tagalog)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 571-423-3200.

URDU (اُردُو)
توجہ: اگر آپ اردو بولتے ہیں تو ، مفت زبان کی مدد کی خدمات آپ کو دستیاب ہیں . 571-423-3200 پر کال کریں .

VIETNAMESE (Tiếng Việt)
Chú ý : Nếu bạn nói tiếng Việt , các dịch vụ hỗ trợ ngôn ngữ , miễn phí, có sẵn cho bạn . Gọi 571-423-3200 .

YORUBA (èdè Yorùbá)
AKIYESI: Bi o ba nsọ èdè Yorùbú ọfé ni iranlọwọ lori èdè wa fun yin o. Ẹ pe ẹrọ-ibanisọrọ yi 571-423-3200.