Moda Health Enrollment

Questions? Call us at 1.888.957.5001

Tips for completing the application:

- Please read everything carefully and answer all questions honestly. This document becomes part of your health insurance contract.
- Please complete all sections to the best of your ability.
- The section about your health information is to make sure that you get all the support care you may need. It is not required to complete this section.

Payment Options:

- **Monthly Bank Draft:** Please complete Authorization section carefully and attach a voided check. (deposit slip does not work!)
- **Direct Bill:** Simply do nothing, you are done.

Final check list before mailing:

- ✓ All sections completed?
- ✓ Signed and Dated
- ✓ Voided check if selecting the automated monthly withdrawal

Send Completed Application to:

First Choice Health Insurance, Inc.
2000 W Harvard Ave – Ste 100
Roseburg, Oregon 97471
FAX: 1.541-440-6944
Email: aprilm@ehealthlink.com

Changing Plans?

You may change plans only during the Open Enrollment period or if you are eligible for a Special Enrollment. This application must be received by the end of the Open Enrollment period or the end of the Special Enrollment period.

If you're changing plans, your new plan will take effect on the first of the month following receipt of this application.

DELTA DENTAL®

Apply online by visiting shopmodaplans.com.
Questions? We're here to help. Call us at 855-718-1767.

2017 | Individual dental plan application

for Oregon individuals and families

Please complete all sections of this application and send it to us. If the application is incomplete or we need more information, your effective date may be delayed. Be sure information is clearly written. If we can't read something, we will return your application to you.

Section 1 › Application type

☐ New policy/subscriber ☐ Add dependent to existing plan ☐ Plan change only*

Existing Delta Dental subscriber name	Existing subscriber ID

**Plan change is only available during open enrollment or special enrollment.*

Section 2 › Eligibility and residency

To be eligible to apply for one of our Oregon individual dental plans, you must be an Oregon resident and live in our service area for six months out of the year. If you terminated from Delta Dental individual dental coverage during the past two years, you won't be eligible unless you have had continuous group dental coverage since leaving Delta Dental.

☐ **I confirm I meet the eligibility and residency requirements.**

Section 3 › Plan selection

I select the following dental plan and deductible for the requested effective date of ____ / ____ / _____ :

☐ Delta Dental PPO – $0 deductible
☐ Delta Dental Exclusive – $0 deductible
☐ Delta Dental PPO Bright Smiles – $0 deductible
☐ Delta Dental Premier – $50 deductible

Section 4 › Subscriber information

Is this a child- or children-only plan? ☐ No ☐ Yes. If yes, please list the youngest child as the subscriber. Children age 26 or older must be on their own policy.

Last name	First name	M.I.

Date of birth *(mm/dd/yyyy)*	Social Security number	Gender ☐ M ☐ F

Race

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Caucasian ☐ Hispanic or Latino ☐ Native Hawaiian or other Pacific Islander
☐ Other (please specify) _____

Language preference

☐ English ☐ Spanish ☐ Other (please specify) _____

Residence address	City	State	ZIP

Mailing address (if different)	City	State	ZIP

Email address (required to go paperless)	Primary phone	Secondary phone

Section 5 › Dependent Information — spouse or registered domestic partner (RDP)

Please complete this section for spouse or RDP to be covered on this dental plan.

Relationship ☐ Spouse ☐ RDP	Last name	First name	M.I.

Date of birth *(mm/dd/yyyy)*	Social Security number	Gender ☐ M ☐ F

Race

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Caucasian ☐ Hispanic or Latino ☐ Native Hawaiian or other Pacific Islander
☐ Other (please specify) _____

Language preference

☐ English ☐ Spanish ☐ Other (please specify) _____

Section 6 > Dependent Information — children

Please list all children to be covered on this dental plan (children must be under age 26 years old). Attach additional copies of this page, if necessary, to list other family members to be included on this application.

Last name	First name	
Date of birth *(mm/dd/yyyy)*	Social Security number	Gender ☐ M ☐ F

Last name	First name	
Date of birth *(mm/dd/yyyy)*	Social Security number	Gender ☐ M ☐ F

Last name	First name	
Date of birth *(mm/dd/yyyy)*	Social Security number	Gender ☐ M ☐ F

Last name	First name	
Date of birth *(mm/dd/yyyy)*	Social Security number	Gender ☐ M ☐ F

Last name	First name	
Date of birth *(mm/dd/yyyy)*	Social Security number	Gender ☐ M ☐ F

Please explain relationship to the applicant for any member listed above whose last name is different from the applicant or is not a natural or adopted child of the applicant.

If any children listed above have a different race or primary language than the applicant, please list their name, race and primary language here.

Section 7 › Other insurance

Will you have other dental insurance?

☐ Yes ☐ No

Section 8 › Credit toward benefit waiting period (for new dental coverage)

For applicants and dependents age 19 and over:
Do you have 12 months of prior dental insurance with no more than a 90-day break in coverage?

☐ No ☐ Yes. If yes, please provide the following:

Name of individual(s) enrolled in prior dental plan		
Prior insurance company	Prior insurance company phone	Prior subscriber ID
Coverage effective date *(mm/dd/yyyy)*	Coverage end date *(mm/dd/yyyy)*	

Section 9 › Payment method

We offer three payment options for you to choose from.

1. Electronic fund transfer (EFT), see authorization agreement below.
2. Automatic eBill payment through MyModa.
3. Personal check, money order or cashier's check.

EFT authorization agreement

EFT initiates around the fifth of the month and typically takes one or two days to post to your account. Your initial payment may initiate on a later date in the event that the enrollment is processed after the 5th of the month. Your premium invoice will be paperless and located in the eBill section of myModa.

1. Complete and sign below as the account holder for monthly automatic premium deductions from your bank.
2. Attach a photocopy of a voided personal check from the account, or provide the bank routing and account numbers below.

Applicant		Account holder
Name of bank	Routing number	Account number

I authorize Delta Dental of Oregon to charge my checking account for monthly premiums for the above named individual. I also authorize my bank, named here, to honor these monthly charges. This authority will remain in effect until I give my bank a reasonable chance to act upon it. I can stop payment by notifying my bank before my account has been charged.

Account holder signature	Signature date
X	

Section 10 > Billing options

If you are set up for EFT your premium invoice will be paperless. If you are not set up for EFT you will be set up for paper invoices. You may change your billing preference to paperless by going to the eBill section of myModa.

If the bill needs to go to an address other than your mailing address, please note the billing address below.

Billing address	City	State	ZIP

Section 11 > Agent of record (to be completed by agent only)

I (the agent) certify that I have explained the eligibility provisions to the applicant. I have not made any statements about benefits, conditions or limitations of the contract except through written material furnished by Delta Dental. I have informed the applicant that the effective date of coverage is assigned only by Delta Dental.

For you to become the agent of record, you must be actively appointed with Moda Health/Delta Dental. Please sign and date below.

Agent name	Agency name	Phone	Agent/Agency NPN
John Gridley First	Choice Health Ins.,Inc.	541-957-5000	

Address	City	State	ZIP
2000 W Harvard Avenue #100	Roseburg	OR	97471

I certify that the information supplied to me by the applicant has been truly and accurately recorded.

Agent signature (required)	Signature date
X	

Note to agent: Payment does not have to be included with the application, but the first payment is required to activate coverage.

Section 12 > Basic terms of enrollment

- I understand and agree that this application is not an offer of coverage, and coverage does not begin until this application is received and reviewed by Delta Dental and an effective date of coverage is assigned.
- I understand and agree that this application becomes a part of my plan.
- I understand that no benefits are available under this plan for services or supplies that were received prior to the effective date of coverage.
- I understand that acceptance for coverage requires that individuals listed on this application must be residents of the state of Oregon to apply for and maintain coverage under this plan.
- "Resident" means a person who lives in the state of Oregon and intends to live in the state permanently or indefinitely. Delta Dental may require proof of residency from time to time. Such proof shall include, but not be limited to, the street address of the individual's residence and not a post office box.
- I understand that I may receive benefits that are less than the amount billed by my provider when treatment is not received from a contracted provider.
- I have the right to examine and return the policy within 10 days of receipt.
- Potential changes due to state or federal mandates, effective in January, may alter the benefits or rates of my current plan.
- Regardless of my enrollment date, my plan rate will renew January 1.

Section 13 › Go paperless!

You can view your explanation of benefits (EOBs) online by logging in to myModa. After your application is approved, you will receive a welcome letter with your Moda member ID number. With this ID number, simply set up a myModa account by visiting modahealth.com and opt to receive electronic EOBs.

Section 14 › Certification of completion and correctness

Be sure to sign and date the application below. Your spouse, RDP and any dependents over age 18 are required to sign the application.

I affirm that the answers given on this application are complete and correct to the best of my knowledge. I have provided these answers as part of the application procedure required by Delta Dental to enroll in its insurance coverage. I understand that if this application contains any intentional misrepresentations of material fact that Delta Dental may deny coverage, modify or cancel the contract, rescind the contract or take other legal action. I will promptly inform Delta Dental in writing if anything happens before my coverage takes effect that makes this application incomplete or incorrect. I understand and agree that no coverage will be in force until approved by Delta Dental. If approved, coverage will be in force as of the effective date determined by Delta Dental. Delta Dental may contact me to clarify answers on this application. As the applicant, I understand I have the right to inspect the information in my file.

I acknowledge that I have read and agree to the terms of this application.

Print name of responsible party[1] if child- or children-only policy X	Relationship[2]
Signature of applicant *(if applicant is under age 18, signature of parent/guardian)* X	Signature date
Signature of applicant's legal spouse or RDP, if applying for coverage X	Signature date
Signature of dependent(s), age 18 and older, if applying for coverage X	Signature date
Signature of dependent(s), age 18 and older, if applying for coverage X	Signature date

1 *Responsible party: If you are an adult not covered by this plan and you bear financial responsibility or act as the primary caregiver for the subscriber and others covered by this plan, then you are the responsible party*

2 *If not a parent, please attach legal documentation if you are the legal guardian or holder of Power of Attorney.*

Ready to submit? Mail, fax or email this form to Delta Dental.

Mail: Delta Dental/Moda, Billing and Eligibility, 601 SW Second Ave., Portland, OR 97204-3156

Fax: 503-219-3696 **Email:** Scan and send to individualapp@modahealth.com.

New to Delta Dental of Oregon? Visit modahealth.com to log in to myModa and view your member handbook and bill. Once you sign up for myModa and go paperless (see Section 9), you'll receive an email when your first bill is ready.

Questions? Contact us at 855-718-1767.

modahealth.com

Dental plans in Oregon provided by
Oregon Dental Service, dba Delta Dental Plan of Oregon.

Moda Health nondiscrimination notice

Moda, Inc. complies with applicable federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability or sex.

Moda provides free, timely aids and services to people with disabilities to help them communicate with us effectively. These accommodations include sign language interpreters and written information in other formats.

If your primary language is not English, Moda also provides free, timely interpretation services and/or materials written in other languages.

If you need any of the services listed above, contact:

Customer Service,
888-217-2363 (TDD/TTY 711)

If you believe that Moda has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a written grievance by mailing or faxing it to:

Moda, Inc.
Attention: Appeal Unit
601 SW Second Ave.
Portland, OR 97204
Fax: 503-412-4003

Moda's efforts to assure nondiscrimination are coordinated by:

Tom Bikales, VP Legal Affairs
601 SW Second Ave.
Portland, OR 97204
855-232-9111
compliance@modahealth.com

If you need assistance filing a grievance, please call Customer Service.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone to:

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

800-868-1019, 800-537-7697 (TDD).

Office for Civil Rights complaint forms are available at hhs.gov/ocr/office/file/index.html.

14884271 (7/16) BE-1463

ATENCIÓN: Si habla español, hay disponibles servicios de ayuda con el idioma sin costo alguno para usted. Llame al 1-877-605-3229 (TTY: 711).

注意：如果您說中文，可得到免費語言幫助服務。
請致電1-877-605-3229（聾啞人專用：711）

CHÚ Ý: Nếu bạn nói tiếng Việt, có dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Gọi 1-877-605-3229 (TTY:711)

주의: 한국어로 무료 언어 지원 서비스를 이용하시려면 다음 연락처로 연락해주시기 바랍니다. 전화 1-877-605-3229 (TTY: 711)

PAUNAWA: Kung nagsasalita ka ng Tagalog, ang mga serbisyong tulong sa wika, ay walang bayad, at magagamit mo. Tumawag sa numerong 1-877-605-3229 (TTY: 711)

ВНИМАНИЕ! Если Вы говорите по-русски, воспользуйтесь бесплатной языковой поддержкой. Позвоните по тел. 1-877-605-3229 (текстовый телефон: 711).

تنبيه: إذا كنت تتحدث العربية، فهناك خدمات مساعدة لغوية متاحة لك مجانًا. اتصل برقم 1-877-605-3229 (الهاتف النصي: 711)

ATANSYON: Si ou pale Kreyòl Ayisyen, nou ofri sèvis gratis pou ede w nan lang ou pale a. Rele nan 1-877-605-3229 (moun ki itilize sistèm TTY rele : 711)

ATTENTION : si vous êtes locuteurs francophones, le service d'assistance linguistique gratuit est disponible. Appelez au 1-877-605-3229 (TTY : 711)

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń: 1-877-605-3229 (obsługa TTY: 711)

ATENÇÃO: Caso fale português, estão disponíveis serviços gratuitos de ajuda linguística. Telefone para 1-877-605-3229 (TERMINAL: 711)

ATTENZIONE: Se parla italiano, sono disponibili per lei servizi gratuiti di assistenza linguistica. Chiamare il numero 1-877-605-3229 (TTY: 711)

注意：日本語をご希望の方には、日本語サービスを無料で提供しております。
1-877-605-3229（TYY、テレタイプライターをご利用の方は711）までお電話ください。

Achtung: Falls Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistenzdienste zur Verfügung. Rufen sie 1-877-605-3229 (TTY: 711)

توجه: در صورتی که به فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما موجود است. با 1-877-605-3229 (TTY: 711) تماس بگیرید.

УВАГА! Якщо ви говорите українською, для вас доступні безкоштовні консультації рідною мовою. Зателефонуйте 1-877-605-3229 (TTY: 711)

ATENȚIE: Dacă vorbiți limba română, vă punem la dispoziție serviciul de asistență lingvistică în mod gratuit. Sunați la 1-877-605-3229 (TTY 711)

THOV CEEB TOOM: Yog hais tias koj hais lus Hmoob, muaj cov kev pab cuam txhais lus, pub dawb rau koj. Hu rau 1-877-605-3229 (TTY: 711)

โปรดทราบ: หากคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี โทร 1-877-605-3229 (TTY: 711)

ត្រូវចងចាំ៖ បើអ្នកនិយាយភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដោយឥតគិតថ្លៃ គឺមានផ្តល់ជូនលោកអ្នក។ សូមទូរស័ព្ទទៅកាន់លេខ 1-877-605-3229 (TTY: 711)

HUBACHIISA: Yoo afaan Kshtik kan dubbattan ta'e tajaajiloonni gargaarsaa isiniif jira 1-877-605-3229(TTY:711) tiin bilbilaa.

DELTA DENTAL
Delta Dental of Oregon & Alaska

moda HEALTH