DELTA DENTAL

Delta Dental of Oregon & Alaska

2022 CareAssist | Individual dental plan application

Please fill out all sections of this application. If the application is incomplete or additional information is required, your effective date may be delayed. Illegible and incomplete applications will be returned. We must receive your complete application before the requested effective date. To expedite your application, please complete the fillable form and include your electronic signature or your Adobe digital ID signature. You also have the option to complete this application form using black or blue ink and include your handwritten signature.

Section 1: Eligibility and residency

To be eligible to apply for our Oregon individual dental plans, you must be an Oregon resident and reside in our service area for at least 6 months out of the year. If it is determined you are not CareAssist qualified, you may still be able to enroll on a Delta Dental individual plan if you are eligible for a special enrollment. Documentation will be required in order to demonstrate your eligibility for a special enrollment based on certain life events you may have experienced.

Section 2: Plan selection

☑ Delta Dental PPO $0 deductible

Section 3: Application type

☑ New dental policy due to meeting CareAssist qualifications

Section 4: Subscriber information

Last name	First name	M.I.	Suffix

Date of birth *(mm/dd/yyyy)*	Social Security no.	Gender ☐ Male ☐ Female ☐ Prefer not to answer

Gender identity
☐ Female ☐ Male ☐ Transgender ☐ Cisgender ☐ Gender non-conforming
☐ Non-binary / Third gender ☐ Questioning ☐ Prefer not to answer ☐ Another

These fields are optional. We are committed to understanding and valuing diversity among our members. We are seeking this information so our staff can refer to and communicate with you in the most appropriate and respectful way.

Race (optional)	Language preference
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Caucasian ☐ Hispanic or Latino ☐ Native Hawaiian or other Pacific Islander ☐ Other (please specify) _____	☐ English ☐ Spanish ☐ Other (please specify) _____

Residence address	City	State	ZIP

Mailing address (if different)	City	State	ZIP

Email address	Home phone	Mobile phone

Section 5: Other insurance

Will you have other dental insurance? ☐ Yes ☐ No

Section 6: Credit toward benefit exclusion period (for new dental coverage)

For subscribers age 19 and over:
Do you have 12 continuous months of prior dental coverage with no more than a 90-day break in coverage from the end of the old policy to the expected effective date of the new policy?

☐ No ☐ Yes Was this coverage through Delta Dental of Oregon? If yes, we'll automatically waive the exclusion period on your dental coverage. If this coverage was through a different carrier, please provide a letter from your prior carrier or employer documenting the start and end dates of your prior dental coverage. This documentation of prior coverage is required for credit to be applied toward the benefit exclusion period. Please email, fax or mail documentation.

E-mail: CustomerSupportOR@DeltaDentalOR.com **Fax:** 503-219-3696

Standard mail: Delta Dental Plan of Oregon, 601 SW 2nd Avenue, Portland, OR 97204

Section 7: Basic terms of enrollment

> **I understand that I may receive benefits that are less than the amount billed by my provider when treatment is not received from a participating provider.**

> 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 the individual listed on this application must be a resident 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 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 Jan. 1.

> I have read the Delta Dental privacy statement that is available on DeltaDentalOR.com.

Section 8: Go paperless!

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

Section 9: Certification of completion and correctness

Be sure to sign and date the application within this section.

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 process required by Delta Dental to enroll in its insurance coverage. I understand that if this application contains any intentional misrepresentations of material fact, 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 subscriber, 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 policy	Relationship[2]
Signature of subscriber *(if subscriber is under age 18, signature of responsible party)* *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 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.*

By providing your contact information, you are consenting to receive communications from Moda Health Plan, Inc, Delta Dental Plan of Oregon, and their affiliates and business partners regarding your health plan benefits, payments, and treatment. Please keep in mind that communications via email over the internet may not be secure. Although it is unlikely, there is a possibility that information included in an email could be obtained by other parties besides the person to whom it is addressed. We recommend that you do not include personal identifying information such as your birth date, or personal medical information in any emails you send to us. There is no requirement to provide your email address or phone number as a condition to purchasing any goods or services.

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

Mail: Delta Dental, Membership Accounting, 601 SW Second Ave., Portland, OR 97204-3156

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

New to Delta Dental of Oregon? Visit DeltaDentalOR.com to log in to your Member Dashboard and view your member handbook and bill. Once you sign up for your Member Dashboard and go paperless (see Section 11), you'll receive an email when your first bill is ready.

Questions? Contact us at 855-718-1767.

DeltaDentalOR.com

Nondiscrimination notice

We follow federal civil rights laws. We do not discriminate based on race, color, national origin, age, disability, gender identity, sex or sexual orientation.

We provide free services to people with disabilities so that they can communicate with us. These include sign language interpreters and other forms of communication.

If your first language is not English, we will give you free interpretation services and/or materials in other languages.

If you need any of the above, call Customer Service at:

888-217-2365 (TDD/TTY 711)

If you think we did not offer these services or discriminated, you can file a written complaint. Please mail or fax it to:

Delta Dental of Oregon and Alaska
Attention: Appeal Unit
601 SW Second Ave.
Portland, OR 97204
Fax: 503-412-4003

Dave Nesseler-Cass coordinates our nondiscrimination work:

Dave Nesseler-Cass,
Chief Compliance Officer
601 SW Second Ave.
Portland, OR 97204
855-232-9111
compliance@modahealth.com

If you need help filing a complaint, 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:

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

800-368-1019, 800-537-7697 (TDD)

You can get Office for Civil Rights complaint forms at hhs.gov/ocr/office/file/index.html.

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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).

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)

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）

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)

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

توجہ دیں: اگر آپ اردو (URDU) بولتے ہیں تو لسانی اعانت آپ کے لیے بلا معاوضہ دستیاب ہے۔ 1-877-605-3229 (TTY: 711) پر کال کریں

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

ATTENTION : si vous êtes locuteurs francophones, le service d'assistance linguistique gratuit est disponible. Appelez au 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.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपको भाषाई सहायता बिना कोई पैसा दिए उपलब्ध है। 1-877-605-3229 पर कॉल करें (TTY: 711)

Achtung: Falls Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistenzdienste zur Verfügung. Rufen sie 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。

DeltaDentalAK.com | DeltaDentalOR.com

અગત્યનું:જોતમે(ભાષાંતરકરેલભાષાઅહીંદશાર્વો)બોલો છોતોતેભાષામાંતમારેમાટેવિનામૂલ્યેસહાયઉપલબ્ધછે. 1-877-605-3229 (TTY: 711) પર કૉલ કરો

ໂປດຊາບ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການຊ່ວຍເຫຼືອດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສັຍຄ່າ. ໂທ 1-877-605-3229 (TTY: 711)

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)

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.

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

FA'AUTAGIA: Afai e te tautala i le gagana Samoa, o loo avanoa fesoasoani tau gagana mo oe e le totogia. Vala'au i le 1-877-605-3229 (TTY: 711)

IPANGAG: Nu agsasaoka iti Ilocano, sidadaan ti tulong iti lengguahe para kenka nga awan bayadna. Umawag iti 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)

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