

Delta Dental of Oregon & Alaska

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.

### Section 1 ▶ Eligibility and residency

To be eligible to apply for one of our Oregon individual dental plans, you must be an Oregon resident and reside in our service area for six 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.	
Date of birth (mm/dd/yyyy)		Social Security no.		Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Other (please specify) _____				Language preference <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (please specify) _____	
Residence address		City		State	ZIP
Mailing address (if different)		City		State	ZIP
Email address		Primary phone		Secondary 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. If yes, 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. In addition, please provide the following information:

Name of individual enrolled in prior dental plan		
Carrier name	Carrier subscriber ID	Carrier telephone number
Effective (mm/dd/yyyy)	Termed (mm/dd/yyyy)	

## Section 7 ▶ 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 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 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 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 Moda privacy statement that is available on modahealth.com.

## Section 8 ▶ 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 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 <sup>1</sup> if child policy	Relationship <sup>2</sup>
Signature of subscriber (or parent or legal guardian if subscriber is under age 18) X	Signature date

1 *Responsible party: If you are an adult not covered by this plan and you 1) bear financial responsibility and/or 2) 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.*

**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 8), you’ll receive an email when your first bill is ready.

**Questions?** Contact us at 855-718-1767.

**modahealth.com**

# Moda does not discriminate

**Moda, Inc. follows 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.

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## **If you need any of the above, call:**

**Medicare Customer Service,**  
877-299-9062 (TDD/TTY 711)

**Medicaid Customer Service,**  
888-788-9821 (TDD/TTY 711)

**Customer Service for all other plans**  
888-217-2363 (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:**

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

## **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](http://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](http://hhs.gov/ocr/office/file/index.html).

## **Dave Nessler-Cass coordinates our nondiscrimination work:**

Dave Nessler-Cass,  
Chief Compliance Officer  
601 SW Second Ave.  
Portland, OR 97204  
855-232-9111  
[compliance@modahealth.com](mailto:compliance@modahealth.com)

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 مجاناً. اتصل برقم (الهاتف النصي: 711) 1-877-605-3229

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（TTY、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 Sprachassistenzen 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.