



2020 CareAssist – Individual dental plan application

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 our Oregon individual dental plans, you must be an Oregon resident and reside in our service area for at least 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.	Suffix
Date of birth (mm/dd/yyyy)	Social Security no.	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
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	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 waiting period. Please email, fax or mail documentation.

E-mail: indunit@modahealth.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 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 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 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 <i>(if subscriber is under age 18, signature of responsible party)</i> 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.*

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

Mail: Membership Accounting, 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 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 8), you'll receive an email when your first bill is ready. **Questions?** Contact us at 855-718-1767.

DeltaDentalOR.com

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

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:

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 Partners, Inc.
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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