



Delta Dental of Oregon & Alaska

Apply online by visiting [shopmodaplans.com](http://shopmodaplans.com).  
Questions? We're here to help. Call us at 855-718-1767.

Moda Assurance Company and Delta Dental of Alaska

## 2021 | Individual health plan application – Pioneer service area

for Alaska individuals and families in Municipality of Anchorage, Fairbanks North Star, Kenai Peninsula, Ketchikan Gateway and Matanuska-Susitna boroughs and Prince of Wales-Hyder Census Area.

Note: To be eligible to enroll, subscriber and dependents must reside in the Pioneer service area.

Please fill out all sections of this application and submit 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. For most enrollments, we must receive your complete application no later than the 15th of the month before the requested effective date. For special enrollment, we must receive this application and supporting documentation within 60 days of the special enrollment event date. Your application process could be delayed or denied if supporting documentation is not provided. 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 ▶ Application type

The reason I am applying or making a change is:

#### Open enrollment

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

If this is a special enrollment application, you must include proof of the life event that made you eligible. **A list of acceptable documentation to support your life event and the available effective dates for coverage can be found at [modahealth.com/shop/special-enrollment](http://modahealth.com/shop/special-enrollment).**

You will need a special enrollment event for changes or new policies made outside of the open enrollment period.

#### Special enrollment

- Marriage or domestic partnership (DP)
- Birth, adoption or placement for adoption
- Placement of foster child
- Loss of coverage because I turned 26
- Loss of coverage due to end of marriage or DP
- Loss of eligibility for group coverage
- COBRA ended due to expiration of coverage
- Loss of Dental coverage due to Medicare coverage
- Other \_\_\_\_\_

## Section 2 › Eligibility and residency

### Medical plans:

To be eligible to apply for our Alaska individual health plans, you must be an Alaska resident, intend to reside in our service area permanently or indefinitely, and continue to reside in our service area for at least 6 months out of the year. You must not be enrolled in Medicare or reside in the service area for the primary purpose of obtaining health coverage or other temporary purpose such as obtaining treatment. Treatment received in a residential care facility is not considered an eligibility qualification for this Residency Requirement provision.

I confirm I meet these requirements.

### Dental plans:

To apply and remain eligible for one of our Alaska individual dental plans, you must be an Alaska resident and currently reside in the service area for the plan selected, and continue to reside in the service area for at least 6 months out of the year. If you had Delta Dental individual dental coverage that ended during the past 12 months, you won't be eligible unless you have a special enrollment qualifying event or have had continuous group dental coverage since leaving Delta Dental.

The service area for PPO dental plans is limited to the following zip codes:

Anchorage Municipality		Fairbanks North Star Borough				Matanuska-Susitna Borough (Mat-Su Valley)		
99501-99511	99577	99701	99706	99710	99716	99623	99654	99683
99513-99524	99587	99702	99707	99711	99725	99629	99667	99687
99529-99530	99599	99703	99708	99712	99775	99645	99674	99688
99540	99695	99705	99709	99714	99790	99652	99676	99694
99567								

I confirm I meet these requirements.

## Section 3 › Plan selection

I select the following medical and/or dental plan(s) for the requested effective date \_\_\_/\_\_\_/\_\_\_\_:

- |   |  |
|---|--|
| <input type="checkbox"/> Pioneer Gold 1500 - \$1,500 deductible   | <input type="checkbox"/> Pioneer Bronze 6500 - \$6,500 deductible      |
| <input type="checkbox"/> Pioneer Silver 4500 - \$4,500 deductible | <input type="checkbox"/> Pioneer Bronze HDHP 5500 - \$5,500 deductible |

### Plans available throughout Alaska

- Delta Dental Premier – \$1,000 annual maximum plan payment limit
- Delta Dental Premier Healthy Smiles – No annual maximum plan payment limit
- Delta Dental Premier Preventive Alaska Mandated Plan – \$25 per person/\$75 family deductible, \$500 annual maximum plan payment limit for all ages and no out-of-pocket maximum

### Plans available only in Anchorage, Fairbanks North Star Borough, and Mat-Su Valley

- Delta Dental PPO 1000 - \$1,000 annual maximum plan payment limit
- Delta Dental PPO 1500 - \$1,500 annual maximum plan payment limit

Most dental plans have \$0 deductible and the annual maximum plan payment limit does not apply under age 19. Members under age 19 are subject to an annual out-of-pocket maximum. For PPO plans, the out-of-pocket maximum applies in-network only. If you are changing from one Delta Dental of Alaska individual plan to another outside of open enrollment, any amount applied to the annual maximum plan payment limit will be transferred to your new plan.

The Delta Dental Premier Preventive Alaska Mandated Plan has some exceptions. Please refer to the plan details listed above.

## Section 4 ▶ Subscriber information

This section must be completed with **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.	Suffix
Date of birth (mm/dd/yyyy)		Social Security number		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) _____					
Preferred spoken and written language <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 ▶ Dependent Information – spouse or domestic partner (DP)

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

Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> DP		Last name		First name		M.I.	Suffix
Date of birth (mm/dd/yyyy)		Social Security number		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) _____							
Preferred spoken and written language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (please specify) _____							

Dependent address same as subscriber (If no please fill out the below information)

Yes  No

Residence address		City		State	ZIP
Mailing address (if different)		City		State	ZIP
Email address			Phone		

**Section 6 > Dependent Information – children living in the service area only  
(no dependent coverage outside the service area)**

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

Last name	First name	M.I.	Suffix
Date of birth ( <i>mm/dd/yyyy</i> )	Social Security number	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	

Dependent address same as subscriber (If no please fill out the below information)

Yes  No

Residence address	City	State	ZIP
Mailing address (if different)	City	State	ZIP
Email address	Phone		

Last name	First name	M.I.	Suffix
Date of birth ( <i>mm/dd/yyyy</i> )	Social Security number	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	

Dependent address same as subscriber (If no please fill out the below information)

Yes  No

Residence address	City	State	ZIP
Mailing address (if different)	City	State	ZIP
Email address	Phone		

Last name	First name	M.I.	Suffix
Date of birth ( <i>mm/dd/yyyy</i> )	Social Security number	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	

Dependent address same as subscriber (If no please fill out the below information)

Yes  No

Residence address	City	State	ZIP
Mailing address (if different)	City	State	ZIP
Email address	Phone		

If any dependent children have a different race or primary language than the subscriber, please list their name, race, and primary language below.

### Section 7 > Other insurance

Will you have other medical and/or dental insurance?

Yes  No

If yes on other insurance, what type?

Medical  Dental  Medical and dental

### Section 8 > Credit toward benefit exclusion period (for new dental coverage)

For subscribers and dependents age 19 and over:

Do you have 12 continuous months of prior dental insurance 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 Alaska? 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: CustomerSupportAK@DeltaDentalAK.com

Standard mail: Delta Dental of Alaska

Fax: 503-219-3696

601 SW 2nd Avenue  
Portland, OR 97204

### Section 9 > Payment method

We offer several payment options for you to choose from, including:

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

#### EFT authorization agreement

EFT initiates around the 5th of the month and usually takes one or two days to post to your account. Your first payment may initiate on a later date if your enrollment is processed after the 5th of the month. Your premium invoice will be paperless and located in the eBill section of your Member Dashboard.

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.

Subscriber		Account holder	
Name of bank	Routing number	Account number	Account type <input type="checkbox"/> Checking <input type="checkbox"/> Savings

I authorize Moda Health or Delta Dental to charge my 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 X	Signature date
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## 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 receive paper invoices in the mail. You may change your billing preference to paperless by going to the eBill section of your Member Dashboard.

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
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## Section 11 › Agent (to be completed by agent only)

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

For you to become the agent, you must be actively appointed with Moda Health/Delta Dental of Alaska.

Please sign and date below.

Agent name	Agency name	Phone	Agent NPN
Address	City	State	ZIP

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

Agent signature (required) X	Signature date
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*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

- > **Medical:** I understand that I must use providers in Alaska. There is no out-of-Alaska coverage except for emergency services, coverage through the travel network or medical travel support, coverage through out-of-state contracted providers or services prior authorized by Moda Health.
- Dental:** 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 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 Moda Health and Delta Dental and an effective date of coverage is assigned.
- > I understand if my previous Moda Health or Delta Dental policy ended because I did not pay premiums when due, this new coverage may not begin until I have paid my past-due premium amounts from the last 12 months in addition to the first month's premium for this new policy.
- > I understand and agree that this application becomes a part of my plan.
- > I understand that no benefits are available under a Moda Health or Delta Dental plan for services or supplies, including those related to an inpatient confinement, that were received prior to the effective date of coverage.
- > I understand that acceptance for coverage has the following requirements:
  - A. Individuals listed on this application must be Alaska residents living in the service area to apply for and maintain coverage under a Moda Health or Delta Dental plan. Moda Health and Delta Dental reserve the right to request documentation at any time.
  - B. No one listed on this application who is applying for medical coverage can be 65 years of age or older and enrolled in Medicare on the date coverage would begin.
  - C. Members cannot be covered by more than one Moda Health and Delta Dental individual medical and dental plan at any time.
- > If I am eligible for premium-free Medicare (Part A) but not enrolled in Medicare Part A and B, Moda Health will estimate what Medicare would have paid and reduce my benefits by that amount.
- > **“Resident”** means a person who lives in the plan's service area and intends to live in the service area permanently or indefinitely. Moda Health and 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 premium will renew January 1.
- > I have read the Moda Health/Delta Dental privacy statement that is available on [modahealth.com](http://modahealth.com) and [deltadentalak.com](http://deltadentalak.com).

## Section 13 > 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 [modahealth.com](http://modahealth.com) or [deltadentalak.com](http://deltadentalak.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, DP and any children 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 process required by Moda Health and Delta Dental to enroll in insurance coverage. I understand that if this application contains any intentional misrepresentations of material fact that Moda Health and Delta Dental may deny coverage, modify or cancel the contract, rescind the contract or take other legal action. I will promptly inform Moda Health and 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 Moda Health and Delta Dental. If approved, coverage will be in force as of the effective date determined by Moda Health and Delta Dental. Moda Health and 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 understand this application, terms and certification and privacy statement.

Print name of responsible party <sup>1</sup> if child- or children-only policy X	Relationship <sup>2</sup>
Signature of subscriber (if subscriber is under age 18, signature of responsible party) X	Signature date
Signature of subscriber's legal spouse or DP, 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 Moda Health/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 Moda Health/Delta Dental? Visit [modahealth.com](http://modahealth.com) or [deltadentalak.com](http://deltadentalak.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 13), you'll receive an email when your first bill is ready.

**Questions?** Contact us at 855-718-1767 [modahealth.com/deltadentalak.com](http://modahealth.com/deltadentalak.com)

*To view the summary of benefits and coverage (SBC) for the medical plans, please visit [shopmodaplans.com](http://shopmodaplans.com). A uniform glossary is available to help you understand the most common healthcare terms at <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf>. For free print copies of the SBC or uniform glossary, contact Moda Health at 855-718-1767.*

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# 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.

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

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

**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](https://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](https://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)

Dental plans in Oregon provided by Oregon Dental Service, dba Delta Dental Plan of Oregon. Dental plans in Alaska provided by Delta Dental of Alaska. Health plans provided by Moda Health Plan, Inc. Individual medical plans in Alaska provided by Moda Assurance Company.



Delta Dental of Oregon & Alaska

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 (الهاتف النصي): 1-877-605-3229 (711)

بولتے ہیں تو سانی (URDU) توجہ دیں: اگر آپ اردو 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)

توجہ: در صورتی کہ بہ فارسی صحبت می کنید، خدمات ترجمہ بہ صورت رایگان برای شما موجود است. با تماس بگیرد. (TTY: 711) 1-877-605-3229

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 Sprachassistentendienste 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 (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。

အကူအညီ: ဤတမ်း (အမျိုးအနွယ် အမျိုးအနွယ်) အလိုအလျောက် ဖြစ်တိုက် အမျိုးအနွယ် တစ်ခုခုကို မိမိ၏ မူလမှ အထောက်အကူ ပေးပါမည်။ 1-877-605-3229 (TTY: 711) ပါ အသံ အသံ

ໂປດຊາຍ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການຊ່ວຍເຫຼືອດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. 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 คุณจะสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี 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 llocano, 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)