Enrollment application & change of information form

Medical, Dental and Vision

Moda use only

Group number _____ Subscriber number _____

To expedite your application, please print legibly in black or blue ink and return as instructed. Please complete all sections of this application. *If the application is incomplete or additional information is required, your effective date may be delayed.*

Section 1 › Application type

Outside of the open enrollment period, you would need a special enrollment reason to enroll or make changes (for example, add dependents or switch plans). If you are enrolling or making changes due to a special enrollment event, please specify the event below and provide documentation of your life event. The reason I am applying or making a change is:

Open enrollment

Date of event: _____

- ☐ New policy/subscriber
- ☐ Add dependent on existing plan
- ☐ Plan change only
- ☐ *Waiver of coverage*

Changes *(these can be made outside of open enrollment)*

- ☐ Name change
  New name: _____
  Old name: _____
- ☐ New address
  (please write new address in Section 3)

Special enrollment

Date of event: _____

- ☐ Marriage
- ☐ Registration of domestic partner (RDP)
- ☐ Birth, adoption or placement for adoption
- ☐ Loss of coverage because I turned 26
- ☐ Loss of coverage due to end of marriage or registered domestic partnership (RDP)
- ☐ Involuntary loss of group coverage
- ☐ COBRA/continuation ended due to exhausting benefit
- ☐ Other _____

Group name	Subgroup	Group no.	Class

Section 2 › Coverage

- ☐ **Medical coverage** _____
- ☐ **Dental coverage** _____
- ☐ **Vision coverage** _____

Bundled coverages: ☐ **Medical** ☐ **Dental** ☐ **Vision** _____

Section 3 › Employee information

First name*	M.I.	Last name*	Social Security no.*	
Mailing address*		City*	State*	ZIP*
Home phone	Date of birth *(mm/dd/yyyy)**	Date of employment *(mm/dd/yyyy)**		
Primary language ☐ English ☐ Spanish ☐ Other _____		Email address		

The following 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.

Gender/sex: ☐ Female ☐ Male ☐ Prefer not to answer

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

** Enrollment will be delayed if fields with an asterisk are not filled out.*

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Section 4 › Dependent children eligibility information

Children are eligible to enroll for coverage through age 25. Please see your Member Handbook for additional eligibility information. The following are eligible dependent children:

- Your or your spouse's natural or adopted child
- Children placed with you for adoption
- Newborns born to a covered dependent, for whom you are financially responsible (legal guardianship is required for coverage after the first 31 days)
- Children related by blood or marriage for whom you are the legal guardian (you will need to attach a signed court order showing legal guardianship)
- Your domestic partner's natural child or adopted child (if domestic partners by affidavit can enroll in your employer's plan)
- Your registered domestic partner's natural child or adopted child

Section 5 › Dependents

Relationship code: **SP** = spouse, **DP** = domestic partner, **RDP** = registered domestic partner *(DP and RDP only if applicable to your plan)*
Please use additional form if needed.

Add Term	Med Den Vis	Relationship*	Dependent first name*	Dependent last name*	Social Security no.*	Date of birth* *(mm/dd/yyyy)*	Primary language *(if different from employee)*
☐ ☐	☐ ☐ ☐	☐ SP ☐ DP ☐ RDP					
Gender/sex: ☐ Female ☐ Male ☐ Prefer not to answer		**Gender identity:** ☐ Female ☐ Male ☐ Transgender ☐ Cisgender ☐ Gender non-conforming ☐ Non-binary / Third gender ☐ Questioning ☐ Prefer not to answer ☐ Another ☐ Undefined / Unspecified					

Add Term	Med Den Vis	Relationship*	Dependent first name*	Dependent last name*	Social Security no.*	Date of birth* *(mm/dd/yyyy)*	Primary language *(if different from employee)*
☐ ☐	☐ ☐ ☐	Child[1]					
Gender/sex: ☐ Female ☐ Male ☐ Prefer not to answer		**Gender identity:** ☐ Female ☐ Male ☐ Transgender ☐ Cisgender ☐ Gender non-conforming ☐ Non-binary / Third gender ☐ Questioning ☐ Prefer not to answer ☐ Another ☐ Undefined / Unspecified					

Add Term	Med Den Vis	Relationship*	Dependent first name*	Dependent last name*	Social Security no.*	Date of birth* *(mm/dd/yyyy)*	Primary language *(if different from employee)*
☐ ☐	☐ ☐ ☐	Child[1]					
Gender/sex: ☐ Female ☐ Male ☐ Prefer not to answer		**Gender identity:** ☐ Female ☐ Male ☐ Transgender ☐ Cisgender ☐ Gender non-conforming ☐ Non-binary / Third gender ☐ Questioning ☐ Prefer not to answer ☐ Another ☐ Undefined / Unspecified					

Add Term	Med Den Vis	Relationship*	Dependent first name*	Dependent last name*	Social Security no.*	Date of birth* *(mm/dd/yyyy)*	Primary language *(if different from employee)*
☐ ☐	☐ ☐ ☐	☐ Child[1] ☐ Ward					
Gender/sex: ☐ Female ☐ Male ☐ Prefer not to answer		**Gender identity:** ☐ Female ☐ Male ☐ Transgender ☐ Cisgender ☐ Gender non-conforming ☐ Non-binary / Third gender ☐ Questioning ☐ Prefer not to answer ☐ Another ☐ Undefined / Unspecified					

Section 6 › Other insurance (coordination of benefits)

Will employee or any dependents have other insurance? ☐ Yes ☐ No

If your Group's size is less than 20 employees, Medicare will be assumed to be the primary payer and we will coordinate benefits as the secondary payer even if you have not elected coverage under Medicare. When your Group's size is 20 employees or more, Medicare will be considered the secondary payer.

** Enrollment will be delayed if fields with an asterisk are not filled out.*

Section 7 › Authorization (please read and sign below)

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (people who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law.[2] Health information requested or disclosed may be related to treatment or services performed by:

- A physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- A clinic, hospital, long term care or other medical facility;
- Any other institution providing care, treatment, consultation, pharmaceuticals or supplies or;
- An insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records or hospital records (including nursing records and progress notes). This acknowledgement does not apply to obtaining information regarding HIV/AIDS, psychotherapy notes, alcohol/drug and genetic testing. A separate authorization will be used for information related to these health conditions.
It is a crime to knowingly provide false, incomplete, or misleading information to a health carrier for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of health coverage.

I certify that the information provided on this form is true and correct to the best of my knowledge. I acknowledge that my enrollment form will be delayed if all fields with an asterisk are not filled out entirely.

Employee signature*	Signature date*
X	

** Enrollment will be delayed if fields with an asterisk are not filled out.*
1 Please list only eligible dependent children. See Section 5 for dependent children qualifications.
2 For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Notice of Privacy Practices. A copy is available by calling the Privacy Office at 503-952-5033.

Nondiscrimination notice

We follow federal civil rights laws. We do not discriminate based on race, religion, 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:

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

Scott White coordinates our nondiscrimination work:

Scott White,
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.

modahealth.com

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

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