

Alaska Large Employer Group Application (51+)



Thank you for choosing Moda Health and Delta Dental.

Please forward the completed copy to:
ModaGroupSales@modahealth.com

New Group Enrollment Checklist for Employers and Agents

Please note, if any of the below items are not completed in full, enrollment will be delayed

Is this an existing Moda Health or Delta Dental group with an active line of coverage? ☐ Yes ☐ No

☐ Group Application (completed and signed by the group and agent)

Does the group have COBRA eligible lines of coverage other than Moda Health (medical coverage)? ☐ Yes ☐ No

☐ Quote sheet for selected plans

☐ Enrollment forms have been reviewed for the following:

- ☐ Enrollment forms/Waiver forms provided for all eligible employees
- ☐ Please include hire dates on all enrollment forms/green enrollment spreadsheet
- ☐ Enrollment forms match census information

☐ First Month's Premium (paid electronically)

☐ Electronic Services Agreement

☐ Late Acknowledgement Agreement (if enrolling past the 10th of the month)

For a first of the month effective date, all new group enrollment materials must be received by Moda Health no later than the 10th of the preceding month.

Health plans provided by Moda Health Plan, Inc. 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.
Delta Dental is a trademark of Delta Dental Plans Association.

Alaska Large Employer Group Application *Group Size 51+*



Effective date: _____

Group information			
Legal name:		Tax ID#:	
DBA name (appears on bills):		NAICS:	
Physical address (no P.O. box):	City:	State:	ZIP:
Group administrator:			
Group administrator phone #:			
Group administrator email address:			
Renewal date:		Notification Month/Year:	
Is the group subject to ERISA (Employee Retirement Income Security Act of 1974)? Note: In general, ERISA does not cover group health plans established or maintained by governmental entities, churches for their employees, or plans which are maintained solely to comply with applicable workers compensation, unemployment or disability laws.			☐ Yes ☐ No
Form of organization (check all that apply):			
☐ Association Filed date: _____ Approval #: _____			
☐ Trust Filed date: _____ Approval #: _____			
☐ Bargaining agreement (union)			
Effective date: _____			
Expiration date: _____			
☐ Corporation ☐ LLC ☐ Non-profit ☐ Partnership ☐ S Corporation ☐ Sole proprietor ☐ Government entity			

Existing coverage	
Please provide the name for the current insurance carrier(s), both medical and dental:	
Medical: _____	Dental: _____
If this plan is replacing an existing plan, will members receive credit from the previous plan? ☐ Yes ☐ No	
If Yes, check the type(s) of report(s) below that will be available for applying credit:	
☐ Medical deductible ☐ Dental deductible ☐ Other: _____	

Group Size Determination Form

This form must be completed for all new and renewing groups to determine whether a group is a large employer.

Employee Count		
Are you a Controlled Group? If you are a controlled or affiliated group of employers as described under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986, Moda Health must treat all employees within the affiliated group as a single group for purposes of determining group size. You must fill out one group profile form for the entire controlled group. If a controlled group is determined as a large employer, each affiliated employer is part of the large employer even if separately the employer would not meet the definition of large employer. Therefore, each affiliated employer is considered a large group for the purposes of group size determination.		☐ Yes ☐ No
Employee Counting Instructions A. Total the number of employees working 130 hours for each month of the preceding calendar year. B. Total the number of hours worked by employees working less than 130 hours for each month of the preceding calendar year, but do not include more than 120 hours per employee in a month and divide by 120. This is your Full Time Equivalent (FTE) count of the preceding calendar year. C. Add the numbers from a and b together and divide by 12. This is your group size. When counting employees to determine group size, do not count a sole proprietor, a partner in a partnership, a 2 percent S corporation shareholder, or the spouse of a person who is a sole proprietor, leased or contracted employee, a retired employee, or former employee on continuation coverage.		
1. On average, how many full time employees did the employer have during the preceding calendar year? Total the number of employees working 130 hours or more for each month of the preceding calendar year and divide by 12.		
2. On average how many Full Time Equivalent (FTE) employees did the employer have during the preceding calendar year. Total the number of hours worked by employees working less than 130 hours for each month of the preceding calendar year, but do not include more than 120 hours per employee in a month and divide by 120. Then divide the total number by 12.		
3. Total employee count (for determining group size) (#1+ #2) If less than 1, no Alaska small group exists. If more than 50, the group is a large group and not eligible as an Alaska small group. If 1 to 50, the group is a small group.		
	Medical	Dental
4. Out of the number of employees indicated in question #3, indicate the number of employees waiving due to other group or individual coverage		
5. Total employee count (for participation requirement) (#3 - #4):		
6. Out of the number of employees indicated in question #5, indicate the number of employees opting out of coverage		
7. Total number of employees enrolling (#5 - #6)		
Comments: 		

Employee Participation		
What percentage of employees participate in the plan(s)? (#7 divided by #5) For Voluntary Dental Plans: a minimum of 25% of eligible employees must participate with a minimum of 10 enrolling.		

Signature

To the best of my knowledge, I certify that all the information contained herein is correct. I understand that the final rates will be based on actual enrollment and may be different than the rates originally quoted and that additional information may be required to verify eligibility of the group.

I am the: ☐ Business Owner ☐ Group Administrator ☐ Authorized Insurance Agent ☐ Other

Name (printed please)

X

Signature

Date

Eligibility and Employer Contribution

1. How many hours per week must employees work to be eligible for benefits? (20 minimum)

2. What is the eligibility period employees must complete before being eligible for benefits?

2a. Time served as a part-time employee will count towards the waiting period when the employee moves to full-time

☐ Yes ☐ No

2b. Is the group subject to ERISA (Employee Retirement Income Security Act of 1974)?

☐ Yes ☐ No

Note: In general, ERISA does not cover group health plans established or maintained by governmental entities, churches for their employees, or plans which are maintained solely to comply with applicable workers compensation, unemployment, or disability laws.

2c. For initial enrollment only, do you want to waive the waiting period for all current eligible employees?

☐ Yes ☐ No

3. Is Domestic Partner coverage available? ☐ Yes - either gender/sex ☐ No

4. What percentage of your medical premium is contributed by the employer?

If choosing multiple plans, the minimum contribution is 50% of the plan with the lowest premium.

Your contribution for employee (minimum is 50%)

Your contribution for dependents

5. What percentage of your dental premium is contributed by the employer?

If Standard Plan: Your contribution for employee (minimum is 50%)
If Voluntary Plan: Your contribution for employee (minimum is 0%)

Your contribution for dependents

Employee participation

1. Medical:

- A minimum of 70% of eligible employees must participate.

2. Non-voluntary Delta Dental Only:

- A minimum of 70% of eligible employees must participate.

3. Voluntary Delta Dental:

- A minimum of 25% of eligible employees must participate.

Group Structure Worksheet

Subgroup setup			
Our standard subgroup setup designates if subscribers are "Active" or have elected "COBRA". Subgroups can be used to categorize your membership by a different billing location or entity. Custom subgroups will create billing statements, separate your members on your invoice and impact reporting (if applicable) for each subgroup defined. If you require additional explanation or assistance with subgroup setup, please speak with your sales representative.			
Subgroup name	Subgroup billing contact name (if different than group administrator)	Subgroup billing address (if different than physical address)	
Active	Name:	Address:	
	Phone number:	City:	
	Email:	State:	Zip:
COBRA	Name:	Address:	
	Phone number:	City:	
	Email:	State:	Zip:
	Name:	Address:	
	Phone number:	City:	
	Email:	State:	Zip:
	Name:	Address:	
	Phone number:	City:	
	Email:	State:	Zip:
Is domestic partner coverage available?		☐ Yes, either gender/sex ☐ No	

Class setup

Our standard setup groups all employees into one single class called "All Employees". If a medical group has out of state employees, we will include an Outside the Service Area plan, so that you can distinguish the plan that uses our local PPO Medical network, and those that will use our National network. Class setup allows you to define the benefits available to a subset of membership. If all of your employees must work the same hours, meet the same probationary period and have the same benefits available to them, our standard setup should work.

If you require additional explanation or assistance with class setup, please speak with your sales representative.

Service area for medical groups

Will employees who reside outside of Alaska be covered by a Moda Health medical plan?

☐ Yes ☐ No

If yes, list state(s): _____

Note: Employees who reside in the state of Hawaii are not eligible to enroll for medical coverage.

How many hours per week must an employee work to be eligible for benefits? (minimum 20): _____

Will the minimum hours apply to all eligible employees? ☐ Yes ☐ No

If no, please describe: _____

What is the waiting period an employee must complete before becoming eligible for benefits?

☐ Date of hire

☐ Date of hire, plus one month orientation period

OR

1st of the month following:

☐ Date of hire

☐ Date of hire, plus one month orientation period

☐ Date of hire or date of hire when 1st of the month

☐ Date of hire or date of hire when 1st of the month, plus one month orientation period

☐ 30 days

☐ 30 days, plus one month orientation period

☐ 60 days

☐ 60 days, plus one month orientation period

☐ 90 days (dental only)

☐ 90 days, plus one month orientation period (dental only)

☐ Other, please describe _____

Will the eligibility period apply to all eligible employees? ☐ Yes ☐ No

If no, please describe: _____

For employer's initial enrollment only, will the waiting period be waived for all current eligible employees?

☐ Yes ☐ No

If a part-time employee becomes eligible for coverage, does part-time employment count towards the waiting period for full-time employees?

☐ Yes ☐ No

Will all plans be available to all employees? ☐ Yes ☐ No

If no, please describe: _____

Will the Medical and Dental plan be integrated (bundled)? ☐ Yes ☐ No

If yes, indicate which lines are integrated:

☐ Medical, Dental, Vision ☐ Medical, Dental

COBRA Administration and Premium Only plan

Moda Health's subsidiary, BenefitHelp Solutions (BHS), provides COBRA administration for Moda Health Medical Groups **at no additional cost.**

Fees will apply when BHS provides administration for product lines outside of Moda Health and Delta Dental.

If a group has COBRA eligible plans outside of Moda, please contact BHS for COBRA administration fees:

BHS-S&Steam@benefithelpsolutions.com

1. Does the group use a third-party administrator (TPA) for COBRA or Retiree Administration?

☐ Yes ☐ No

1a. If yes, enter the TPA Name and contact information:

TPA Name

Address

Phone

1b. If no, will you elect COBRA administration through BenefitHelp Solutions (BHS)?

☐ Yes ☐ No

1c. If yes, should BHS charge an additional 48% administrative fee for COBRA participants that meet the disability requirement and are eligible for an additional 11 months of COBRA?

☐ Yes ☐ No

List all company contacts who should have Online COBRA employer portal access:

☐ Check here if Online COBRA broker portal access should be granted.

Broker's tax ID number

2. Who will be paying the COBRA premiums?

☐ Employer ☐ TPA – Do not print bill ☐ TPA – Print bill

Health Savings Account (HSA)

Health Savings Account (HSA)	
Complete only if a Moda HSA-eligible health plan will be offered. Moda offers integration with BenefitHelp Solutions, our preferred HSA Administrator and subsidiary company. This integration allows BenefitHelp Solutions to automatically set up health savings accounts for each employee enrolled on a Moda HSA-eligible health plan and offers employees the ability to pay providers directly from their HSA. The integrated HSA administration with BenefitHelp Solutions is provided at no cost to fully insured groups. Employers will utilize the BenefitHelp Solutions employer portal for posting HSA contributions and a signed ACH form will be required to authorize BenefitHelp Solutions to pull HSA contribution amounts from the employer's designated bank account.	
1. Will the group elect BenefitHelp Solutions to administer its health savings accounts? If yes, complete the below information: 1a. Will you be transferring current Health Savings Account balances? ☐ Yes ☐ No 1b. Will you be sending a bulk transfer for all employees? ☐ Yes ☐ No HSA employer contribution amount: _____ Frequency: ☐ Annually ☐ Per Pay Period ☐ Per Month 1c. If divisions are required for reporting or funding list the division names: _____	☐ Yes ☐ No

Company Contacts
Only the individuals listed below will be authorized to communicate with the BenefitHelp Solutions Employer Services team.

Primary employer contact (this contact will have access to the BenefitHelp Solutions employer portal)

Name		Title	
Email address		Report notifications: ☐ Yes ☐ No	
Phone number	Ext.	Secondary Phone	Ext.

Secondary employer contact (this contact will have access to the BenefitHelp Solutions employer portal)

Name		Title	
Email address		Report notifications: ☐ Yes ☐ No	
Phone number	Ext.	Secondary Phone	Ext.

Consultant/Broker contact

Name		Title	
Email address		Report notifications: ☐ Yes ☐ No	
Phone number	Ext.	Secondary Phone	Ext.

Payment Information

Premium payment information
Group name

All monthly premium payments are to be submitted by the group using the eBill process within the Employer Dashboard.

Once your application has been processed and we have your group set up in our system, you will receive access to the Employer Dashboard. Once you activate your account you can manage the monthly bill within our eBill tool, including paying your first month's premium payment (Binder Payment) and setting up how future payments are made. You will also be able to view your group's monthly invoices through eBill.

Access to eBill will be fully functional on your group's effective date.

For more information about the eBill tool, Employer Dashboard, or information on alternative ways of making your first premium payment, please contact your sales team contact or email modagroupsales@modahealth.com.

Agent Information	
Agent name	Agency name
Agent NPN	Agency tax ID

By signing below, I agree that the signature will be the electronic representation of my signature and initials for all purposes when I (or my agent) use them on documents, including legally binding contracts.

Authorized signature for group X	Title
Authorized signer's printed name	Date
Authorized agent signature X	Date
Authorized agent's printed name	
Moda Health/Delta Dental representative signature X	Date

Agent / Group Signature Page

Agent information	
Agent name	Agency
NPN:	Tax ID# (For tax purposes, please indicate if tax ID or S/S #): ☐ Tax ID ☐ S/S #
I hereby make application to Moda Health/Delta Dental, on behalf of the Group, for the Group Policies indicated in this group application. I understand that there is no coverage in effect until Moda Health/Delta Dental accepts this Application and premium deposit and establishes an effective date. If this Application is not accepted, the premium deposit will be refunded. I hereby certify all eligible employees are enrolling in the selected Group Policies and all enrolling employees meet the eligibility requirements specified above. In addition, I hereby appoint the above agent as our Agent of Record to represent us in matters of group insurance benefits provided by Moda Health/Delta Dental. This appointment is in effect on the same day as this Policy and will remain in force until rescinded in writing. Applicable for medical policies only: I hereby acknowledge responsibility on behalf of the Group to provide the Summary of Benefits & Coverage (SBC), Uniform Glossary, and the Initial Notice of HIPAA Special Enrollment Rights and Exclusion Periods to all employees on or before the date they enroll in the selected Group Policies.	

Authorization	
By signing below, I agree that the signature will be the electronic representation of my signature and initials for all purposes when I (or my agent) uses them on documents, including legally binding contracts.	
Authorized signature for GROUP X	Authorized signer's title
Authorized signer's printed Name X	Date
Authorized AGENT signature X	
Authorized agent's printed name X	Date
Marketing representative signature X	Date

Electronic Services Agreement

This Electronic Services Agreement (“Agreement”) states the terms and conditions that govern the use of online services by _____ (“Employer”) through Employer’s online account (the “Account”).

1. Employer Dashboard

Employer Dashboard includes the following (individually and collectively, the “Services”):

A. Online Services. Online Services include any or all of the following services dependent upon eligibility criteria: review of employee and dependent enrollment and claims data, electronic entry, modification, termination, designation of primary care physicians, ID card requests, and other group enrollment related functions that may become available from time to time.

Employers using electronic eligibility file processing to manage enrollment and eligibility will be able to access information on the dashboard, but will not be able to add, change or terminate eligibility through the Employer Dashboard. Other functions such as ID card requests, designation of primary care providers and other functions may be available from time to time.

B. eBill. eBill includes the electronic distribution of billing invoices and payment of premiums.

i. Participation. By signing this Agreement, Employer consents to the electronic distribution of billing invoices.

ii. Payment. Payment must be posted by the due date noted on the billing invoice. Please allow up to three days for processing of online payments. Immediate and past-due payments will not be accepted through eBill; Employer should contact their Membership Accounting specialist or Sales and Service representative for immediate or past-due payments.

Employer has the ability to schedule payments for specific dates. Scheduled payments can be changed or cancelled at any time prior to being processed. Moda Health and Delta Dental will not accept scheduled payments on eBill as proof of payment until that payment has been marked “PAID” on the payment history screen.

iii. Account Information. eBill uses email as the primary source of communication. Employer will be notified when statements are available online or if a payment cannot be processed. Employer may view or print invoices through the Account. Employer may change the group’s bill delivery preference or discontinue email notifications at any time by changing their preferences. Employer also has the ability to select to be notified when there is payment confirmation. Employer shall ensure that Employer email information is updated.

C. Other online features, included but not limited to; reporting when applicable, ability to generate or view enrollment census, etc.

D. Online access is based on the role assignments below:

Company Admin: This is the highest level of access available to an employer. Specifically, a Company Admin is able to access all features available online (enrollment, billing and claims data and/or reporting when applicable). Each group will have at least one Company Admin. The Company Admin has the ability to assign roles as outlined below within their organization and manage access to those roles as follows;

Group Admin: Allows access to view employee and dependent eligibility, make changes to enrollment including address changes, termination of coverage, and primary care provider assignments. The above services are not currently available to employers utilizing an electronic eligibility file. The Company Admin can determine if access to claims data or reporting data (when available) is permitted for this role.

Financial Admin: Allows access to view bills, make payments and receive notification of bills electronically. Able to view enrollment data, however there is no access to process enrollment changes or request ID cards. A Company Admin can determine if access to claims data or reporting data (when available) is permitted for this role.

Company Admin will remove any access for any employee who was granted access no later than the last day of employment with the employer.

2. Company Admin Contact Information

The Contact Person is the person within the Employer organization who is designated by the Employer to authorize user access to the Account. If Employer changes the Company Admin Contact Person, Employer shall notify Moda Health and/or Delta Dental in writing no later than five business days after such change.

Company admin contact person		
Phone number	Ext	Company admin email address

3. Agreement

Use or access of approved Services by Employer or Employer's authorized representatives constitutes agreement to the terms and conditions of this Agreement. Moda Health Plan, Inc. ("Moda Health") and Delta Dental Plan of Oregon and Delta Dental of Alaska ("Delta Dental") may amend or change this Agreement from time to time, in its sole discretion, by providing Employer written notice by electronic or regular mail, or by posting the updated terms on Moda Health and Delta Dental's website. Continued use of the Services following such change or amendment will be considered Employer's agreement to the change or amendment.

Employer may discontinue use of the Services at any time if these terms and conditions are unacceptable.

4. Confidentiality

Employer shall maintain the security and confidentiality of the information maintained through the Account, including individually identifiable health information of a member as defined in 45 CFR §160.103 (collectively the "Information"), as required by all applicable state and federal laws. Employer agrees not to use or further disclose the Information for any purpose except as necessary to carry out this Agreement and to administer Employer's health plan. Employer will use appropriate physical, technical and administrative safeguards to prevent use or disclosure of the Information other than as provided for by this Agreement. Employer will maintain confidentiality of user identifications and passwords and prevent any unauthorized individual(s) from accessing the Account and/or using Information in a manner contrary to this Agreement.

5. Access, Passwords, and Security

Employer agrees to follow the security and privacy protocols established by Moda Health and Delta Dental and described in the user guide, website terms of use, or other related documentation that may be provided by Moda Health and Delta Dental (collectively, the "Security and Privacy Protocols"), to ensure that all transactions are authorized and to protect all Information from improper access.

6. Reporting Violations

Employer agrees to immediately notify Moda Health and Delta Dental if Employer becomes aware of any of the following:

- Any loss or theft of access codes or passwords
- Any unauthorized use of any access codes or passwords
- Any unauthorized use of the Account
- Any loss, theft or unauthorized use of Information
- Any loss or theft of hardware which contains Information

Employer further agrees to make any and all reasonable efforts to correct or mitigate the effects of any such occurrences and to prevent reoccurrence.

7. Enrollment Materials

Employer agrees to retain all written and electronic enrollment materials, including but not limited to, enrollment forms, applications, personal data sheets, and any forms required to update or change employee information (collectively, "Enrollment Materials"), for a period of 10 years from the date they are received by Employer. Employer shall provide Moda Health and Delta Dental with reasonable access to such Enrollment Materials upon request.

8. Indemnification

Employer agrees to indemnify and defend Moda Health and Delta Dental from and against any and all claims, losses, damages, liability, costs and expenses (including but not limited to defense costs and reasonable attorneys' fees) arising from or related to Employer's violation of this Agreement, misuse of the Information, or violation of any third-party's rights, including violation of any proprietary right and invasion of any privacy rights. This obligation will survive the termination of this Agreement.

9. Termination

Moda Health and Delta Dental reserve the right to terminate Employer access to the Account, or any portion of the Services in its sole discretion, at any time, without notice and without limitation, for any reason whatsoever, including but not limited to unauthorized use of Employer access codes or passwords, misuse or unauthorized use of the Information, failure to adhere to policies set forth in the Security and Privacy Protocols, or breach of this Agreement.

10. Assignment

Employer may not assign its rights, interests or obligations or any part thereof under the Agreement without prior written permission of Moda Health and Delta Dental.

11. Severability

If any provision of this Agreement shall be invalid or unenforceable in any respect for any reason, the validity and enforceability of any such provision in any other respect and of the remaining provisions of this Agreement shall not be in any way impaired.

12. Terms of Use

Employer shall abide by any additional Terms of Use posted on the Moda Health and Delta Dental website.

Employer represents and warrants that the person signing this Agreement has the authority to do so, and is entering into this Agreement on behalf of Employer and all existing and future employees.

The individual signing this Agreement on behalf the Employer must be the owner of the business in a sole proprietorship; a partner in a partnership; the designated principal in a limited partnership, corporation or other licensed entity; an officer; or supervisor or manager at the Employer entity.

By signing this Agreement, Employer acknowledges that Employer has read, understands and accepts the terms and conditions as stated in this Agreement.

Employer	
Signature X	Title
Date	Tax identification #

Late Acknowledgment



Moda Health and Delta Dental of Oregon and Alaska normally require new group applications be submitted and received by the 10th of the month prior to the effective date. At your direction, we have accepted the application for this group after the 10th.

Because we are accepting this information after the 10th, we are asking you to acknowledge that all aspects of your group's set-up may not be completed by the 1st. Your group's information may not be completely set up in the system, the member's identification cards may not be ready and in the member's hands prior to the effective date.

Moda Health and Delta Dental are committed to completing this process in a timely fashion and will commit to providing your group set-up as timely as possible. Again, thank you for your business!

Best Regards,

A handwritten signature in black ink, appearing to read "Jason Gootee", with a long horizontal flourish extending to the right.

Jason Gootee

VP, Sales & Strategic Market Development

X

Group Administrator/Authorized Representative

X

Producer/Agent