

Moda Health/Delta Dental 1-50 Oregon Group Plan Confirmation Form



Please complete the below application and submit to Moda Health/Delta Dental 20 days prior to the effective date of your policy to avoid disruption of coverage. If you have any questions, please contact your Service Rep or Account Manager.

Legal Name	
Group Number	Effective Date of Renewal

What plan options would you like to be renewed with?

Medical Plan Option 1
Medical Plan Option 2
Medical Plan Option 3
Vision Plan Rider

A maximum of 3 plans may be selected from our plan portfolio with a minimum of 1 member enrolled in each. For Part D creditable plans, please review the creditable coverage status of prescription drug plans for Oregon small employer plans at www.modahealth.com/employers/compliance.shtml

Only groups with 15 or more enrolling are eligible for Orthodontia Plans.

Delta Dental Plan Option
Delta Dental Orthodontia Rider
Direct Option Plan
DeltaVision® Plan

Is the group a small employer based on the Group Size Determination Form?	☐ Yes ☐ No
Is the group subject to COBRA? Count the employees employed on a typical business day in the previous calendar year. Do not count self-employed individuals, independent contractors, and members of the board of directors. If the group had 20 or more employees during at least 50% of the previous calendar year, the group is subject to COBRA.	☐ Yes ☐ No
Is the group subject to Medicare Secondary Payer (MSP) provision? Count the current total number of full-time employees, part-time employees, seasonal employees and partners. Do not count retirees, COBRA members, individuals on other continuation options or self-employed individuals. If the employee count is 20 or more, the group is subject to MSP.	☐ Yes ☐ No

Health plans provided by Moda Health Plan, Inc.

Dental plans in Oregon provided by Oregon Dental Service, dba Delta Dental Plan of Oregon.
Delta Dental is a trademark of Delta Dental Plans Association.

Would you like to update your probationary period? If yes, what probationary period do you select?	☐ Yes ☐ No
Are you making any changes to your contribution, eligibility, or plan? If so, please outline the changes below:	☐ Yes ☐ No

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.

For questions about the information on this form, I have received advice and counsel from my agent or legal counsel.

Authorized Signature for Group X	Date
Authorized Signer's Printed Name	Title