moda HEALTH

DELTA DENTAL

Apply online by visiting shopmodaplans.com.
Questions? We're here to help. Call us at 855-718-1767.

2024 | Individual dental plan application

for Oregon individuals and families

Your application can be reviewed more quickly if you apply online.

For most enrollments, we must receive your complete application no later than the 15th of the month before the date you want your coverage to start.

What you need to complete this enrollment form:

- A copy of any documentation needed to show legal guardianship, if applicable
- Your insurance agent's information (if an agent helped you)
- Your first month's premium payment (needed before your policy effective date)

You are eligible to enroll if:

- You have a permanent home address in Oregon
- You live in Oregon at least 6 months out of the year
- If you had Delta Dental individual dental coverage that ended during the past 12 months, you have a special enrollment qualifying event or have had continuous group coverage since leaving Delta Dental

☐ I confirm I meet these requirements.

Section 1: Why am I applying

☐ New policy/subscriber
☐ Changing my current coverage
Current subscriber name _____ Current subscriber ID# _____
☐ Add dependent to existing plan
☐ Plan change only

If you are not enrolling during Open Enrollment, you must have a special enrollment event to make changes or enroll in a new policy.

Date of special enrollment qualifying event: _____ / _____ / _____

We must receive your application no more than 60 days after the date of your special enrollment event.

Mark your qualifying event in the table below.

Qualifying Events
☐ Gained or became a dependent due to ☐ Marriage or registered domestic partnership (RDP) ☐ 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 RDP
☐ Loss of eligibility for group coverage
☐ COBRA ended due to expiration of coverage or end of employer contributions or government subsidy
☐ Loss of Oregon Health Plan (OHP) coverage
☐ Other _____

Section 2: Choose a plan

IMPORTANT: There is no out-of-network coverage for EPO plans.
If you choose an EPO plan, you must use in-network providers for services to be covered.

I want my coverage to start on: _____ / _____ / _____

I choose this dental plan:

- ☐ Delta Dental PPO[1]
- ☐ Delta Dental EPO[1]
- ☐ Delta Dental PPO MAC[1]
- ☐ Delta Dental Premier 1000[2]
- ☐ Delta Dental PPO Bright Smiles[1]

[1] Includes pediatric dental coverage that meets the requirements of the Affordable Care Act
[2] Non-certified plan. Does not meet the requirement for pediatric dental coverage under the Affordable Care Act

If you are changing from one Delta Dental individual plan to another because of a special enrollment qualifying event, any amount applied to your annual maximum plan payment limit will be transferred to your new plan.

Enrolling

List all family members you want to cover (sections 3-5).

Only your legal spouse, domestic partner and children under age 26 are eligible.

We are committed to understanding and valuing diversity among our members. We ask for gender identity and race/ethnicity information so we can refer to and communicate with you appropriately and respectfully. This information is optional. Use these codes to fill out the information for each member:

*Gender identity: **M**-male, **F**-female, **T**-transgender, **C**-cisgender, **GN**-gender nonconforming, **NB**-nonbinary, **TG**-third gender, **Q**-questioning, **O**-other, **P**-prefer not to answer

Race/ethnicity: **AI-American Indian/Alaska Native, **A**-Asian, **B**-Black/African American, **C**-Caucasian, **H**-Hispanic/Latino, **PI**-Native Hawaiian/other Pacific Islander, **O**-other _____

Attach additional pages if needed to include more than 3 children. I have attached _____ pages.

Section 3: Subscriber information

This section must be completed with subscriber information.

Is this application for a child- or children-only policy?

☐ No ☐ Yes If yes, list the youngest child as the subscriber.

Children age 26 or older must be on their own policy.

Name *(Last, First, M.I.)*			
Date of birth *(mm/dd/yyyy)*		Social Security no.	
Home address			
City		State	ZIP
Phone		Email	
Mailing address *(if different)*			
City		State	ZIP
Gender ☐ M ☐ F	Gender identity*	Race/ethnicity**	Primary language

Section 4: Dependent Information — spouse or registered domestic partner (RDP)

Name *(Last, First, M.I.)*			
Date of birth *(mm/dd/yyyy)*		Social Security no.	
Gender ☐ M ☐ F	Gender identity*	Race/ethnicity**	Primary language

Section 5: Dependent Information — eligible children

Name *(Last, First, M.I.)*			
Date of birth *(mm/dd/yyyy)*		Social Security no.	
Gender ☐ M ☐ F	Gender identity*	Race/ethnicity**	Primary language

Name *(Last, First, M.I.)*			
Date of birth *(mm/dd/yyyy)*		Social Security no.	
Gender ☐ M ☐ F	Gender identity*	Race/ethnicity**	Primary language

Name *(Last, First, M.I.)*			
Date of birth *(mm/dd/yyyy)*		Social Security no.	
Gender ☐ M ☐ F	Gender identity*	Race/ethnicity**	Primary language

Section 6: Other insurance

Will you have other medical and/or dental insurance? ☐ Yes ☐ No other coverage

Section 7: Credit toward benefit exclusion period (for new dental coverage)

For applicants age 19 and over:

Have you had dental insurance for the last 12 months with no more than a 90-day break in coverage from the end of the old policy to the expected effective date of this new policy?

☐ No ☐ Yes (If this coverage was through Delta Dental Plan of Oregon, we'll automatically waive the exclusion period on your dental coverage. If this coverage was through a different carrier, we can credit your prior coverage toward the benefit exclusion period. Attach a letter from your prior carrier or employer documenting the start and end dates of your prior dental coverage).

Section 8: Billing and payment method

If you choose eBill or EFT, your premium invoice is paperless and located in the eBill section of your Member Dashboard. Otherwise, you will receive paper invoices in the mail. You may change your billing preference in the eBill section of your Member Dashboard.

Choose your payment option:

☐ Automatic eBill payment through your Member Dashboard.

☐ Electronic fund transfer (EFT), see authorization agreement below.

☐ Personal check, money order or cashier's check.

For monthly automatic premium deductions from your bank (EFT) you must sign below and:

- > Attach a photocopy of a voided personal check from the account, or
- > Provide the bank routing and account numbers below

Bank name	Account type ☐ Checking ☐ Savings
Routing number	Account number

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
Account holder name (print)	

EFT initiates around the 5th of the month and usually takes one or two days to post to your account. Your first payment may be later if your enrollment is processed after the 5th of the month.

Billing address (if different than mailing address):		
City	State	Zip

Section 9: Basic terms of enrollment

I understand and agree that:

- This application is not an offer of coverage. Coverage does not begin until this application is received and reviewed by Delta Dental and an effective date of coverage is assigned.
- This application becomes part of my policy.
- I have the right to examine and return the policy within 10 days of receipt.
- Being accepted for coverage has these requirements:

  A) Subscriber must be an Oregon "resident" to apply for and keep coverage under a Delta Dental plan. "Resident" means a person who lives in the plan's service area and intends to live in the service area permanently or indefinitely. Delta Dental may require proof of residency, including but not limited to, my street address (not a post office box).

  B) I cannot be covered by more than one Delta Dental individual dental plan at any time.

- If I chose a Delta Dental plan that does not include pediatric dental benefits, I attest that I and my dependents on the application have obtained or will obtain a pediatric dental plan certified by the Health Insurance Marketplace.
- My benefits may be less than the amount billed by my provider when I do not get treatment from a contracted provider.
- No benefits are available under a Delta Dental plan for services or supplies, including those related to an inpatient stay, that were received before the effective date of coverage.
- Changes to state or federal laws or rules may change the benefits or rates of the plan I chose. Changes will be effective January 1.
- Regardless of my enrollment date, my plan premium will renew January 1.
- I have read the Delta Dental privacy statement that is available on deltadentalor.com.

Section 10: Certification of completion and correctness

Be sure to sign and date the application below. Your spouse, registered domestic partner and any children over age 18 are also 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 understand that if this application contains any intentional misrepresentations of material fact, Delta Dental may deny coverage, modify or cancel the contract and/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. 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 applicant, I understand I have the right to inspect the information in my file.

I (We) have read and understand this application, terms, and certification and privacy statements.

Applicant (subscriber) or parent/guardian (for child-only policy): _____

Printed name of ☐ Parent ☐ Guardian[1] ☐ Applicant _____

Signature X	**Date**
If enrolling: Signature of Spouse/domestic partner X	**Date**
Signature of Child age 18 or older X	**Date**
Signature of Child age 18 or older X	**Date**

[1]If not a parent, please attach legal documentation if you are the legal guardian or holder of Power of Attorney.

By providing my contact information, I am consenting to receive communications from Moda Health Plan, Inc., Delta Dental Plan of Oregon, and their affiliates and business partners regarding my health plan benefits, payments and treatment.

Please keep in mind that communications via email over the internet may not be secure. Although it is unlikely, there is a possibility that information included in an email could be obtained by other parties besides the person to whom it is addressed. We recommend that you do not include personal identifying information such as your birth date or personal medical information in any emails you send to us. You do not have to provide your email address or phone number as a condition to purchasing any goods or services.

Section 11: Agent of Record (to be completed by agent only)

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

To become the agent of record, you must be actively appointed with Delta Dental of Oregon.

Agent name	Agency name	NPN
Phone	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	Date

Note to agent: Payment does not have to be included with the application, but the first payment is required to activate coverage.

Ready to submit?

- Have you filled out the application completely, and signed it?
- Have you attached required documentation (guardianship, etc.)?
- Have you included your first month's premium payment? Payment does not have to be included with the application, but coverage will not start until we have received your first payment.

Send your signed, completed application and attachments to us:

- email: Scan and send to individualapp@DeltaDentalOR.com
- Fax: 503-219-3696
- Mail: Delta Dental, Membership Accounting,
  601 SW Second Ave.,
  Portland, OR 97204-3156

Go paperless!

New to Delta Dental Plan of Oregon? After your application is approved, you will receive a welcome letter with your member ID number. With this ID number, simply set up your Member Dashboard account by visiting deltadentalor.com. Log in to your Member Dashboard to:

- View your Member Handbook
- See how your claims were paid by opting to receive electronic explanations of benefits (EOBs)
- Go paperless - you'll receive an email when your first bill is ready

Questions? Contact Moda Health/Delta Dental at 855-718-1767.

modahealth.com | deltadentalor.com

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

2688-NDS-MH+DD-Commercial (01/24)

ORIndvDentAppv2

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 1-877-605-3229 (الهاتف النصي: 711)

توجہ دیں: اگر آپ اردو (URDU) بولتے ہیں تو لسانی اعانت آپ کے لیے بلا معاوضہ دستیاب ہے۔ پر کال کریں 1-877-605-3229 (TTY: 711)

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)

توجه: در صورتی که به فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما موجود است. با 1-877-605-3229 (TTY: 711) تماس بگیرید.

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 Sprachassistenzdienste 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（TYY、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。

અગત્યનુ઼ : જો તમે (ભાષાંતર કરેલ ભાષા અહીં દર્શાવો) બોલો છો તો તે ભાષામાં તમારે માટે વિના મૂલ્યે સહાય ઉપલબ્ધ છે. 1-877-605-3229 (TTY: 711) પર કૉલ કરો

ໂປດຊາບ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການຊ່ວຍເຫຼືອດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສັຍຄ່າ. 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 คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี 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 Ilocano, 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)