Idaho Large Employer Group Application (51+) Cover Page

Thank you for choosing Moda Health.

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

☐ 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)

All new group enrollment materials must be received by Moda Health ***no later than the 10th of the month*** for a first of the following month's effective date.

Electronic delivery disclosure

Most of the written communication for the Group policy is provided via electronic delivery (for example, billing, plan summary or certificate of coverage) with your consent. If you choose to have these documents delivered electronically, you may call 800-578-1402 and request a paper copy. You may withdraw the consent of electronic delivery by calling 800-578-1402 or change the option at the Employer Dashboard from our website. Moda Health will send these documents in paper form to you after your selection is updated in our system.

Equipment and other applications for electronic delivery

To conduct a transaction online, these are the hardware, software and operating system required, including:

1. a working internet connection
2. a current web browser that includes 128-bit encryption and with cookies enabled (e.g., Internet Explorer version 11.0 and above, Firefox version 52.0 and above, Chrome version 55.0 and above, or Safari 9.1 and above)
3. a valid email account with an internet service provider and email software
4. an operating system and telecommunications connections to the internet capable of receiving, accessing, displaying, and either printing or storing documents received from us is an electronic form via a plain text-formatted email or HTMLformatted email or by access to our website using one of the browsers specified above
5. a computer with sufficient storage space to save past communications and documents
6. an installed printer to print documents

You are responsible for installation, maintenance and operation of a computer, browser and software or obtaining access to a computer with the required capabilities. Moda Health is not responsible for errors or failures from any malfunction of a computer, browser or software used to access documentation delivered via electronic transmission. Moda Health is also not responsible for computer viruses or related problems associated with use of an online system.

Electronic delivery consent

I, in representation of the Group, consent to submitting this medical policy application online and further consent to payment of premiums in an electronic format if this is the option selected. I understand the Group may change my payment method by contacting Moda Health.

I consent to receiving some documents (for example, billing, plan summary, policy or certificate or coverage) through electronic delivery.

I have read the disclosure on electronic delivery. I agree with the requirements. I also certify the Group has access to documents transmitted via electronic media.

I understand the Group may withdraw the consent of the electronic delivery by calling 800-578-1402 or change the option at the Employer Dashboard from the Moda Health website. Moda Health will send these documents in paper form to the Group after the selection is updated in their system.

I agree that the Group will inform Moda Health as soon as reasonably possible when there is a change in the Group contact's email address.

☐ The Group consents to electronic submission of this application.

☐ The Group consents to electronic delivery of documents and I understand I may withdraw the consent of electronic delivery of documents

X _____ _____

Authorized Signature for GROUP **Title**

X _____ _____

Authorized Signer's printed name **Date**

Idaho Large Employer Group Application (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:	Advance renewal notice (days) ☐ 90 days ☐ 120 days ☐ 150 days ☐ 180 days ☐ 210 days ☐ 240 days		
Is the group subject to ERISA (Employee Retirement Income Security Act of 1976)? 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

What percentage of the medical premium is to be contributed by the employer? If choosing multiple plans, the minimum contribution is 50% of the plan with the lowest premium.

For employees (minimum 50%): _____ For dependents: _____

Existing coverage

Please provide the name for the current insurance carrier:

Medical: _____

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 ☐ Other: _____

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 ☐ No

If yes, do you cover:

☐ Same gender/sex ☐ Opposite gender/sex ☐ Regardless of gender/sex

Class setup

Our standard setup groups all employees into a single class. If a medical group has out of state employees, we will create an additional class to make it easier to identify the correct plan and network combination.

Classes allow 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 will 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 Idaho 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 17.5): _____

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, no waiting 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

☐ 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: _____

_____

COBRA

Moda Health's subsidiary, BenefitHelp Solutions (BHS), provides COBRA administration for Moda Health Medical Groups between 51 – 99 employees at no additional cost.

Fees will apply for employers with 100+ eligible employees and/or when BHS provides administration for product lines outside of Moda Health.

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

BHS-S&Steam@benefithelpsolutions.com

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

☐ Yes. Please provide the following:

TPA Name
Address
Phone

☐ No. Please answer the following:

Will the employer elect COBRA administration through BHS? ☐ Yes ☐ No

Who will be paying the COBRA premiums? ☐ Employer ☐ TPA – Do not print bill ☐ TPA – Print bill

Payment Information

Premium payment method

☐ ACH pull (complete EFT information) ☐ ACH push (payment will be set up through eBill)

Effective date	Date of transfer ☐ 25th (prior month for future month's premium) ☐ 1st

Instructions for EFT payments

1. Provide your banking information
2. If you have ACH security in place, please add company ID 3930989307 to your ACH filter list
3. For a checking account, please attach a VOIDED check
4. For a savings account, attach a deposit slip

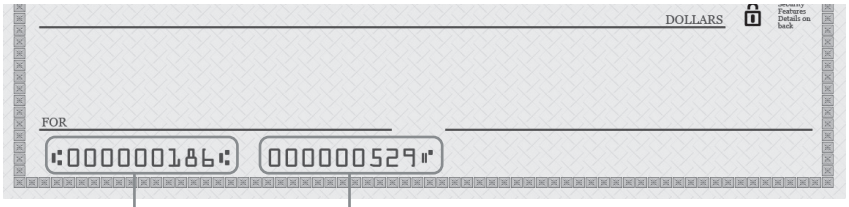
Effective date	Date of transfer ☐ 25th (prior month for future month's premium) ☐ 1st

Transaction type

☐ Binder and reoccuring payments ☐ Reoccuring payments only ☐ Binder payment only

I (we) hereby authorize Moda Health hereinafter called COMPANY, to initiate debit entries to my (our) Checking account indicated below and the depository named below, hereinafter called DEPOSITORY, to debit the same to such account.

Depository name	Branch	
City	State	ZIP
Bank routing no.	Account no.	



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, 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 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. This appointment is in effect on the same day as this Policy and will remain in force until rescinded in writing.

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

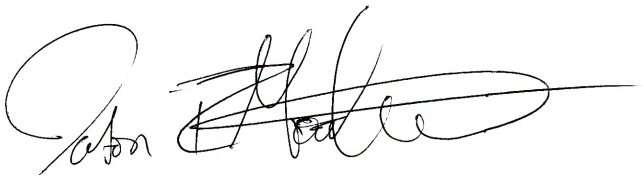
Late Acknowledgment

Moda Health 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 is 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,



Jason Gootee

VP, Sales & Strategic Market Development

X _____

Group Administrator/Authorized Representative

X _____

Producer/Agent

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

moda HEALTH

Health plans provided by Moda Health Plan, Inc.

2688-NDS-MH+DD-Commercial (06/23)

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。

અગત્યનુ઼ં: 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)