

2017 | Individual dental plan application

for Alaska individuals and families

Please complete all sections of this application and submit it to us. If the application is incomplete or we need more information, your effective date may be delayed. Be sure information is clearly written. If we can't read something, we will return your application to you. We must receive your complete submission prior to the requested effective date. For special enrollment, we must receive this application within 60 days of the special enrollment event date.

Section 1 ▶ Application type

The reason I am applying or making a change is:

Open enrollment

- New policy/subscriber
- Add dependent to existing plan
- Plan change only*

Existing Delta Dental subscriber name

Existing subscriber ID

*Plan change is only available during open enrollment or special enrollment.

Special enrollment Date of event: ___ / ___ / ____

- 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
- Other _____

Please provide proof of your life event that made you eligible for a special enrollment with your completed application to eliminate any delay in your enrollment.

You will need a special enrollment event for changes or new policies made outside of the open enrollment period. **If you are enrolling due to a special enrollment event and requesting a later effective date, please note the requested effective date here:** ___ / ___ / ____

Section 2 > Eligibility and residency

To apply and remain eligible for one of our Alaska individual dental plans, you must be an Alaska resident and live in our service area for six months out of the year. **The service area for PPO plans is limited to the following zip codes:**

Anchorage Municipality			Matanuska-Susitna Borough (Mat-Su Valley)			
99501-99524	99567	99599	99623	99652	99674	99688
99529-99530	99577	99695	99629	99654	99683	99693
99540	99587		99645	99667	99687	99694

If you terminated from Delta Dental individual dental coverage during the past two years, you won't be eligible unless you have had continuous group dental coverage since leaving Delta Dental.

I confirm I meet the eligibility and residency requirements.

Section 3 > Plan selection

I select the following dental plan and deductible for the requested effective date of ___ / ___ / ____ :

Plans available in Anchorage and the Mat-Su Valley

- Delta Dental PPO 1000 – \$0 deductible
- Delta Dental PPO 1500 – \$0 deductible

Plans available throughout Alaska

- Delta Dental Premier – \$0 deductible
- Delta Dental Premier Healthy Smiles – \$0 deductible
- Delta Dental Premier Preventive Alaska Mandated Plan – \$25 per person/\$75 family deductible

Section 4 > Subscriber information

This section must be completed with subscriber information.

Is this a child- or children-only plan? No Yes. If yes, please list the youngest child as the subscriber. Children age 26 or older must be on their own policy.

Last name		First name		M.I.	
Date of birth (mm/dd/yyyy)		Social Security number		Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Race					
<input type="checkbox"/> American Indian or Alaska Native		<input type="checkbox"/> Asian		<input type="checkbox"/> Black or African American	
<input type="checkbox"/> Caucasian		<input type="checkbox"/> Hispanic or Latino		<input type="checkbox"/> Native Hawaiian or other Pacific Islander	
<input type="checkbox"/> Other (please specify) _____					
Language preference					
<input type="checkbox"/> English		<input type="checkbox"/> Spanish		<input type="checkbox"/> Other (please specify) _____	
Residence address		City		State	ZIP
Mailing address (if different)		City		State	ZIP
Email address		Primary phone		Secondary phone	

Section 5 ▶ Dependent Information – spouse or domestic partner (DP)

Please complete this section for spouse or DP to be covered on this dental plan.

Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> RDP	Last name	First name	M.I.
Date of birth (mm/dd/yyyy)		Social Security number	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Other (please specify) _____			
Language preference <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (please specify) _____			

Section 6 ▶ Dependent Information – children

Please list all children to be covered on this dental plan (children must be under age 26). Attach additional copies of this page, if necessary, to list other family members to be included on this application.

Last name	First name		
Date of birth (mm/dd/yyyy)	Social Security number	Gender <input type="checkbox"/> M <input type="checkbox"/> F	

Last name	First name		
Date of birth (mm/dd/yyyy)	Social Security number	Gender <input type="checkbox"/> M <input type="checkbox"/> F	

Last name	First name		
Date of birth (mm/dd/yyyy)	Social Security number	Gender <input type="checkbox"/> M <input type="checkbox"/> F	

Last name	First name		
Date of birth (mm/dd/yyyy)	Social Security number	Gender <input type="checkbox"/> M <input type="checkbox"/> F	

Last name	First name		
Date of birth (mm/dd/yyyy)	Social Security number	Gender <input type="checkbox"/> M <input type="checkbox"/> F	

Please explain relationship to the applicant for any member listed above whose last name is different from the applicant or is not a natural or adopted child of the applicant.

If any children listed above have a different race or primary language than the applicant, please list their name, race and primary language here.

Section 7 › Other insurance

Will you have other dental insurance?

- Yes No

Section 8 › Credit toward benefit exclusion period (for new dental coverage)

For applicants and dependents age 19 and over:

Do you have 12 months of prior dental insurance with no more than a 90-day break in coverage?

- No Yes. If yes, please provide documentation demonstrating your prior dental coverage.

This documentation of prior coverage is required in order for credit to be applied toward the benefit exclusion period. In addition, please provide the following information:

Name of individual(s) enrolled in prior dental plan		
Prior insurance company	Prior insurance company phone	Prior subscriber ID
Coverage effective date (<i>mm/dd/yyyy</i>)	Coverage end date (<i>mm/dd/yyyy</i>)	

Section 9 › Payment method

We offer three payment options for you to choose from.

1. Electronic fund transfer (EFT), see authorization agreement below.
2. Automatic eBill payment through MyModa.
3. Personal check, money order or cashier's check.

EFT authorization agreement

EFT initiates around the fifth of the month and typically takes one or two days to post to your account. Your initial payment may initiate on a later date in the event that the enrollment is processed after the 5th of the month. Your premium invoice will be paperless and located in the eBill section of myModa.

1. Complete and sign below as the account holder for monthly automatic premium deductions from your bank.
2. Attach a photocopy of a voided personal check from the account, or provide the bank routing and account numbers below.

Applicant		Account holder	
Name of bank	Routing number	Account number	

I authorize Delta Dental to charge my checking 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
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Section 10 > Billing options

If you are set up for EFT your premium invoice will be paperless. If you are not set up for EFT you will be set up for paper invoices. You may change your billing preference to paperless by going to the eBill section of myModa.

If the bill needs to go to an address other than your mailing address, please note the billing address below.

Billing address	City	State	ZIP
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Section 11 > Agent of record (to be completed by producer only)

I (the agent) certify I have explained the eligibility provisions to the applicant. I have not made any statements about benefits, conditions or limitations of the contract 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.

In order for you to become the agent of record, you must be actively appointed with Delta Dental. Please sign and date below.

Agent name	Agency name	Phone	Agent NPN
Address	City	State	ZIP

I certify that the information supplied to me by the applicant has been truly and accurately recorded.

Agent signature (required) X	Signature date
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Note to agent: Payment does not have to be included with the application, but the first payment is due by the effective date to activate coverage.

Section 12 > Basic terms of enrollment

- > I understand and agree that this application is not an offer of coverage, and coverage does not begin until this application is received and reviewed by Delta Dental and an effective date of coverage is assigned.
- > I understand and agree that this application becomes a part of my plan.
- > I understand that no benefits are available under this plan for services or supplies that were received prior to the effective date of coverage.
- > I understand that acceptance for coverage requires that individuals listed on this application must be residents of the state of Alaska to apply for and maintain coverage under this plan.
- > "Resident" means a person who lives in the state of Alaska and intends to live in the state permanently or indefinitely. Delta Dental may require proof of residency from time to time. Such proof shall include, but not be limited to, the street address of the individual's residence and not a post office box.
- > I understand that I may receive benefits that are less than the amount billed by my provider when treatment is not received from a contracted provider.
- > I have the right to examine and return the policy within 10 days of receipt.
- > Potential changes due to state or federal mandates, effective in January, may alter the benefits or rates of my current plan.
- > Regardless of my enrollment date, my plan rate will renew January 1.

Section 13 > Go paperless!

You can view your explanation of benefits (EOBs) online by logging in to myModa. After your application is approved, you will receive a welcome letter with your Moda member ID number. With this ID number, simply set up a myModa account by visiting modahealth.com and opt to receive electronic EOBs.

Section 14 > Certification of completion and correctness

Be sure to sign and date the application below. Your spouse, DP and any dependents 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 have provided these answers as part of the application procedure required by Delta Dental to enroll in its insurance coverage. I understand that if this application contains any intentional misrepresentations of material fact that Delta Dental may deny coverage, modify or cancel the contract, rescind the contract 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. I understand and agree that no coverage will be in force until approved by Delta Dental. 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 acknowledge that I have read and agree to the terms of this application.

Print name of responsible party ¹ if child- or children-only policy X	Relationship ²
Signature of applicant (<i>if applicant is under age 18, signature of parent/guardian</i>) X	Signature date
Signature of applicant's legal spouse or DP, if applying for coverage X	Signature date
Signature of dependent(s), age 18 and older, if applying for coverage X	Signature date
Signature of dependent(s), age 18 and older, if applying for coverage X	Signature date

1 *Responsible party: If you are an adult not covered by this plan and you bear financial responsibility or act as the primary caregiver for the subscriber and others covered by this plan, then you are the responsible party*

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

Ready to submit? Mail, fax or email this form to Delta Dental:

Mail: Delta Dental, Billing and Eligibility, 601 S.W. Second Ave., Portland, OR 97204-3156

Fax: 503-219-3696 **Email:** Scan and send to individualapp@modahealth.com.

New to Delta Dental of Alaska? Visit modahealth.com to log in to myModa and view your Member Handbook and bill. Once you sign up for myModa and go paperless (see Section 9), you'll receive an email when your first bill is ready.

Questions? Contact us at 855-718-1767.

modahealth.com

Dental plans in Alaska provided by
Oregon Dental Service, dba Delta Dental of Alaska.

Moda Health nondiscrimination notice

Moda, Inc. complies with applicable federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability or sex.

Moda provides free, timely aids and services to people with disabilities to help them communicate with us effectively. These accommodations include sign language interpreters and written information in other formats.

If your primary language is not English, Moda also provides free, timely interpretation services and/or materials written in other languages.

If you need any of the services listed above, contact:

Customer Service,
888-217-2363 (TDD/TTY 711)

If you believe that Moda has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a written grievance by mailing or faxing it to:

Moda, Inc.
Attention: Appeal Unit
601 SW Second Ave.
Portland, OR 97204
Fax: 503-412-4003

If you need assistance filing a grievance, 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 to:

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).

Office for Civil Rights complaint forms are available at hhs.gov/ocr/office/file/index.html.

Moda's efforts to assure nondiscrimination are coordinated by:

Tom Bikales, VP Legal Affairs
601 SW Second Ave.
Portland, OR 97204
855-232-9111
compliance@modahealth.com

Health plans in Oregon and Alaska 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 of Oregon & Alaska



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).

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）

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)

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)

ВНИМАНИЕ! Если Вы говорите по-русски, воспользуйтесь бесплатной языковой поддержкой. Позвоните по тел. 1-877-605-3229 (текстовый телефон: 711).

تنبيه: إذا كنت تتحدث العربية، فهناك خدمات مساعدة لغوية متاحة لك مجاناً. اتصل برقم (الهاتف النصي: 711) 1-877-605-3229

ATANSYON: Si ou pale Kreyòl Ayisyen, nou ofri sèvis gratis pou ede w nan lang ou pale a. Rele nan 1-877-605-3229 (moun ki itilize sistèm TTY rele : 711)

ATTENTION : si vous êtes locuteurs francophones, le service d'assistance linguistique gratuit est disponible. Appelez au 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)

ATENÇÃO: Caso fale português, estão disponíveis serviços gratuitos de ajuda linguística. Telefone para 1-877-605-3229 (TERMINAL: 711)

ATTENZIONE: Se parla italiano, sono disponibili per lei servizi gratuiti di assistenza linguistica. Chiamare il numero 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（TTY、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。

Achtung: Falls Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistenzen zur Verfügung. Rufen sie 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.

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)

โปรดทราบ: หากคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี โทร 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.



Delta Dental of Oregon & Alaska

