Hello.

Thank you for choosing Moda Health and Delta Dental.

Please forward the completed copy to:

ModaGroupSalesAK@modahealth.com

OR

Print and mail a completed copy to:
Moda Health and Delta Dental
Attn: Sales and Account Services
510 L St., Suite 270
Anchorage, AK 99501

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)*
- ☐ Enrollment forms/Waiver forms for all eligible employees
  - Please include hire dates on all enrollment forms
  - Enrollment forms must match census information
- ☐ Declinations for all employees waiving or opting out *(applicable to groups with all levels of participation)*
- ☐ First Month's Premium *(make check payable to Moda Health)*
- ☐ EOS Agreement/EFT (Electronic Funds Transfer) Authorization Form *(if applicable)*
- ☐ Late Acknowledgement Agreement *(if enrolling past the 20th of the month)*

Member Handbooks

We encourage our members to view their handbooks online at www.modahealth.com.

Electronic Application

Please note, this application is intended to be completed electronically, saved, then emailed to the Moda Group Sales inbox. If this application is not completed electronically, drop downs and embedded calculations will not be functional. Please feel free to contact the Sales Team with any questions that you may have.

All new group enrollment materials must be received by Moda Health and Delta Dental ***no later than the 20th of the month*** *for a first of the following month's effective date.*

Alaska Master Group Application
Groups Sized 1-50

Application Type	
Effective Date:	
Renewal Date:	

Group Information							
Legal Name							
*Group names are limited to 50 characters, including spaces. If your group is over this limit, please indicate how you would like the legal name to read in our system. The following characters ?	/ \ * > < : are not accepted.*							
Physical Address		City		State		ZIP	
Principal Business Address		City		State		ZIP	
Is the group's billing information the same as their legal name and physical address?							
Billing Name							
Billing Address		City		State		ZIP	
Is the group administrator the same as the billing contact?							
Group Administrator							
E-Mail Address		Phone #		Fax #			
Billing Contact							
E-Mail Address		Phone #		Fax #			
Employer Tax ID #							
NAICS Code							
SpeedeRates Quote #							
1. What percentage of your medical premium is contributed by the employer? If choosing multiple plans, the minimum contribution is 50% of the richest plan.							
Employee Minimum = 50%		Dependents					
2. What percentage of your dental premium is contributed by the employer?							
Standard Plan Employee Minimum = 50% Voluntary Plan Employee Minimum = 0%		Dependents					
3. If enrolling in a dental plan, can employees and their dependents enroll in the dental plan without enrolling in the group's medical plan regardless if Moda Health is or is not the medical carrier? (Yes = Standalone; No = Integrated)							

Eligibility		
4. How many hours per week must employees work to be eligible for benefits? (20 minimum)		
5. What is the eligibility period employees must complete before being eligible for benefits?		
The first of the month following:		
OR Coverage begins following		days of employment with the group.
6. Is the group subject to ERISA (Employee Retirement Income Security Act of 1974?		
7. Is Domestic Partner coverage available?		
8. What business entity type is the group registered as? (LLC, sole proprietor, s-corp., etc.)		
9. Is this an existing Moda group with an active line of coverage?		

ALASKA STANDARDIZED GROUP PROFILE FORM

For group medical plans purchased outside of the SHOP marketplace, this form must be completed for all new and renewing groups to determine whether a group qualifies as a small employer.

Moda Health must treat an employer as a small employer if the employer has at least one but not more than 50 employees on average during the preceding calendar year and has at least one employee enrolled on the first day of the plan year.

Are you a Controlled Group?

If Yes, please list Controlled and Affiliated Groups:

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 size determination 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 a large employer. Therefore, each affiliated employer is considered a large group for the purposes of group size determination.

SECTION A

Is this a SHOP plan or a non-SHOP plan?	
Is this an employee only plan?	
1. On average, how many employees did the employer employ during the *preceding* calendar year? If less than 1 enrolled, 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.	
2 If an employer was not in existence through the preceding calendar year, what is the average number of employees the employer reasonably expects to employ on business days in the current calendar year? If less than 1 enrolled, 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.	
3. How many employees will be employed on the date that coverage is to take effect? The employer must have at least 1 employee enrolled on the date coverage will take effect in order to be issued small group coverage.	
4. Out of the number of employees indicated in question #1 or #2 , indicate the number of employees not eligible for coverage due to group's *eligibility* rules:	
5. Total number of group eligible employees *(#3 - #4)*: To be an eligible employee an independent contractor must have federal taxes deducted from income related to the Group's business	

	Medical	Dental
6. Out of the number of employees indicated in question #5, indicate the number of employees waiving due to other group or *individual* coverage:		
7. Total employee count (for participation requirement) (*#5 - #6):*		
8. Out of the number of employees indicated in question #7, indicate the number of employees opting out of coverage: Count employees choosing not to take coverage here.		
9. Total number of employees enrolling (#7 - #8):		
10.Total number COBRA (include primary insured's only):		
11.Total number of employees and COBRA enrollees *(#9 + #10)*:		

12. What type of employees are you offering coverage to: a. All employees working 20 hours or more per week b. All employees working the minimum hours required by your specific company in order to qualify for benefits (i.e. 40 hours per week)	

13. To determine if your group is subject to COBRA, indicate how many employees you 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 plan qualifies for COBRA continuation).	
14. To determine if your group is subject to Medicare Secondary Payer provision, do you have 20 or more employees for each working day in each 20 or more calendar weeks in the current calendar year or the preceding calendar year? Count all employees on the employment payroll. Do not count retirees, COBRA qualified beneficiaries, individuals on other continuation options or self-employed individuals.	

Comments:

EMPLOYEE PARTICIPATION	Medical	Dental
15. What percentage of *employees* participate in the plan(s)? *(#9 divided by #7)* For non-SHOP groups of 1-4 employees, a minimum of 100% of eligible employees must participate. For non-SHOP groups of 5-50, a minimum of 70% of eligible employees must participate. For SHOP groups, a minimum of 70% of eligible employees must participate. **For Voluntary Dental plans, a minimum of 25% of eligible employees must participate with a minimum of 10 enrolling.**		

DEPENDENT PARTICIPATION

If you checked "yes" to EMPLOYEE ONLY PLAN on page 1, please mark "N/A" for dependent participation in question #16 below. Please note that under an employee only contract, Moda will not allow any future dependents to be covered on this plan.

If you checked "no" to EMPLOYEE ONLY PLAN on page 1, but currently have no eligible dependents to enroll, please indicate 0% for dependent participation in question #16 below. Please note that under an employee + dependent contract, Moda will allow any future dependents to be covered on this plan.

If you checked "no" to EMPLOYEE ONLY PLAN on page 1, and currently have eligible dependents to enroll, please calculate your current dependent participation and indicate this percentage in question #16 below. Please note that under an employee + dependent contract, Moda will allow any future dependents to be covered on this plan.

	Medical	Dental
16. What percentage of *dependents* participate in the plan(s)?		

SECTION B

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:

Name *(printed please)*		**Signature:**		**Date:**	

Types of Coverage	
17. The group will utilize the following Network:	
For non-SHOP groups selecting multiple medical plans only: Please note, a maximum of three plans may be selected from our plan portfolio with a minimum of one enrolled in each plan.	
18. Please indicate your chosen SpeedeRates Medical Plan design 1 name:	
19. Please indicate your chosen SpeedeRates Medical Plan design 2 name:	
20. Please indicate your chosen SpeedeRates Medical Plan design 3 name:	
All plans are Part D creditable except Endeavor Providence Bronze 4000, Endeavor Select Bronze 4000, Endeavor Providence Bronze 5000, Endeavor Select Bronze 5000, Endeavor Providence Bronze 5500, Endeavor Select Bronze 5500, Endeavor Providence Bronze 7350, Endeavor Select Bronze 7350, Endeavor Providence Silver HDHP 2000, Endeavor Select Silver HDHP 2000, Endeavor Providence Silver HDHP 2500, Endeavor Select Silver HDHP 2500, Endeavor Providence Bronze HDHP 3300, Endeavor Select Bronze HDHP 3300.	
21. Is Moda Health/Delta Dental to cover your out of state employees?	
21a. If yes, list state(s) and number of employees in each: - = not eligible to enroll for medical coverage.	
22. Please indicate your chosen SpeedeRates Vision Plan Design name: Only non-SHOP groups are eligible for Vision Plans	
23a. For non-Shop groups: Please indicate your chosen SpeedeRates Dental Plan Design name:	
23b. For Shop groups: Please indicate your chosen SpeedeRates Dental Plan Design name:	
24. Please indicate your chosen Orthodontia Plan Design name: *Only non-SHOP groups with 26 or more enrolling are eligible for Orthodontia Plans*	
25. Do you currently have another medical group policy? If yes, please indicate the carrier.	
26. Do you currently have another dental group policy? If yes, please indicate the carrier.	
27. If this plan is replacing an existing plan, will members receive deductible credit from the previous plan?	
27a. If Yes, please indicate the type of report that will be available from your previous medical plan.	
27b. If Yes, please indicate the type of report that will be available from your previous dental plan.	

Rates					
	EE only	**EE + Spouse**	**EE + Family**	**EE + Child**	**Total**
Medical Employee Counts -					
Med1					
Vision Rider					
Subtotal Medical					
Medical Employee Counts -					
Med2					
Vision Rider					
Subtotal Medical					
Medical Employee Counts -					
Med3					
Vision					
Subtotal Medical					
Dental Employee Counts					
Dental					
Orthodontia					
Subtotal Dental					
Total					

COBRA: (when applicable)			
To determine if your group is subject to COBRA, use the group profile form. If the number to question #13 is 20 or greater your group is subject to COBRA. If electing to use Benefit Help Solutions to administer your COBRA mark Yes for question 31. Please note, fees will apply.			
28. Do you use a COBRA Third Party Administrator (TPA)?			
29. If yes, enter the TPA Name and contact information:			
Name:			
Address:		Phone:	
30. If you answered no to question 29, will you elect COBRA administration through BenefitHelp Solutions (BHS): *If your group is 20 or greater and is choosing BenefitHelp Solutions as your TPA for standalone COBRA, please call 1-800-556-3137 to speak with a Representative regarding a quote.*			
31. Who will be remitting payment to Moda/Delta Dental for COBRA premiums?			
Payment			
32. Will the group make payments via eBill, EFT, or by check?			
If remitting payments via eBill, please complete and return the Employer Online Services Agreement. If remitting payments via EFT, please complete and return the Authorization Agreement for Electronic Funds Transfer Debits as well as a copy of a voided check.			
Agent Information			
33. Agent Name:			
34. Agency Name:			
35. Agency Tax ID:			
36. Agent NPN:			

I hereby make application to Moda Health/Delta Dental, on behalf of the Group, for the Group Policies indicated above. I understand 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.

For medical groups only: In addition, I hereby acknowledge responsibility on behalf of the Group to provide 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.

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:		Title:	
Authorized Signer's Printed Name:		Date:	
Authorized Agent Signature:		Date:	
Authorized Agent's Printed Name:		Date:	
Moda Representative Signature:		Date:	

EMPLOYER ONLINE SERVICES AGREEMENT

This Employer Online Services Agreement ("Agreement") states the terms and conditions that govern the use of employer online services by_______________________________ ("Employer") through Employer's online account (the "Account").

1. EMPLOYER ONLINE SERVICES.

Employer online services include 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, 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. The above services are not currently available to groups utilizing an electronic eligibility file.

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

2. 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") 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'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.

3. 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 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.

4. ACCESS, PASSWORDS, AND SECURITY.

Employer agrees to follow the security and privacy protocols established by Moda Health and described in the user guide, website terms of use, or other related documentation that may be provided by Moda Health (collectively, the

"Security and Privacy Protocols"), to ensure that all transactions are authorized and to protect all Information from improper access.

5 Reporting Violations.

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

a. Any loss or theft of access codes or passwords.
b. Any unauthorized use of any access codes or passwords.
c. Any unauthorized use of the Account.
d. Any loss, theft or unauthorized use of Information.
e. 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.

6. 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 seven years from the date they are received by Employer. Employer shall provide Moda Health with reasonable access to such Enrollment Materials upon request.

7. eBill.

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

B. Payment. Payment must be posted by the due date noted on the billing invoice. Please allow up to 3 days for processing of online payments. Immediate and past due payments will not be accepted through eBill; Employer should contact their Billing and Eligibility 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 will not accept scheduled payments on eBill as proof of payment until that payment has been marked "PAID" on the payment history screen.

C. 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.

8. Indemnification.

Employer agrees to indemnify and defend Moda Health 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 reserves 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.

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 website.

13. EMPLOYER 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 Contact Person, Employer shall notify Moda Health in writing no later than five business days after such change.

Contact Person: ____

Contact Telephone Number: ____

Contact E-mail Address: ____

The remainder of this page is intentionally left blank.

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

____
Title

____
Date

____
Tax Identification #

____
Moda Health Group Number

Return the signed agreement to: Online Services Administrator Moda Health Plan, Inc.
PO Box 40384
Portland, OR 97240-0384

enroll@modahealth.com

VOLUNTARY EFT PREMIUM GROUPS

AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER (EFT) DEBITS

PLEASE CHECK ONE: ☐ Enroll ☐ Withdraw ☐ Change/edit current account

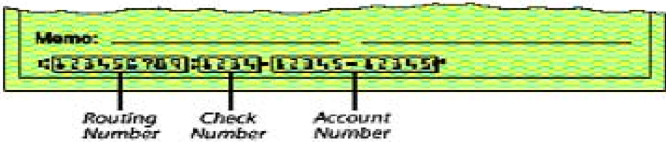
PLEASE INDICATE EFFECTIVE DATE: ________/________
Month/year

DATE OF TRANSFER: ____ 25th (prior month for future month's premium)

____ 1st

Instructions for completing the authorization agreement for EFT debits:

1. Complete and sign the authorization form
2. For a checking account, please attach a VOIDED check
3. For a savings account, attach a deposit slip
4. Return the authorization form with the voided check or deposit slip to Moda Health Plan, Inc.



COMPANY NAME______________________________ **COMPANY TAX ID NUMBER**____________________

I (we) hereby authorize **Moda Health Plan,** 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__________________

ROUTING / ABA NO.__________________________ ACCOUNT NO.______________________________

This authority is to remain in full force and effect until COMPANY and DEPOSITORY has received written notification from me (or either of us) of its termination in such time in such manner to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

NAME______________________________ NAME ______________________________
please print please print

DATE______________________________ DATE______________________________

SIGNED ______________________________ SIGNED ______________________________

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. 15019019 (8/16)

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 hổ 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 مجانًا. اتصل برقم 1-877-605-3229 (الهاتف النصي: 711)

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 Sprachassistenzdienste 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

Delta Dental of Oregon & Alaska

moda HEALTH