Alaska Master Group Application
Groups Sized 1-50

Submit

Print

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 #	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 lookback measurement period used for variable-hour employees?		
7. Is the group subject to ERISA (Employee Retirement Income Security Act of 1974?		
8. Is Domestic Partner coverage available?		
9. What business entity type is the group registered as? (LLC, sole proprietor, s-corp., etc.)		
10. 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	0
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):*	0
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):	0
10.Total number COBRA (include primary insured's only):	
11.Total number of employees and COBRA enrollees *(#9 + #10)*:	0
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

For non-SHOP groups of 1-4 , 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 <u>Voluntary Dental plans,</u> a minimum of 25% of eligible employees must participate with a minimum of 10 enrolling.**	

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

15. 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.

16. Please indicate your chosen SpeedeRates Medical Plan design 1 name:	
17. Please indicate your chosen SpeedeRates Medical Plan design 2 name:	
18. 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, Endeavor Providence Bronze HDHP 6750, Endeavor Providence Bronze HDHP 5000, Endeavor Select Bronze HDHP 5000, Endeavor Select Bronze HDHP 6750, Pioneer Bronze 6500, Pioneer Bronze HDHP 5000.

19. Is Moda Health/Delta Dental to cover your out of state employees?	
20. If yes, list state(s) and number of employees in each: 9YLJf2èŜŜă øK2 ꞽŜăꞽŘŜ ʎƴűKŜ ăűl·űŜ 2Ŧ l l·øl·ꞽ l·ꞽŜ not eligible to enroll for medical coverage.	
21. Please indicate your chosen SpeedeRates Dental Plan Design name:	
22. Please indicate your chosen Orthodontia Plan Design name: *Only groups with 15 or more enrolling are eligible for Orthodontia Plans*	
23. Do you currently have another medical group policy? If yes, please indicate the carrier.	
24. Do you currently have another dental group policy? If yes, please indicate the carrier.	
25. If this plan is replacing an existing plan, will members receive deductible credit from the previous plan?	
25a. If Yes, please indicate the type of report that will be available from your previous medical plan.	
25b. 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 -					0
Med1					$ 0.00
Subtotal Medical					$ 0.00
Medical Employee Counts -					0
Med2					$ 0.00
Subtotal Medical	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
Medical Employee Counts -					0
Med3					$ 0.00
Subtotal Medical	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
Dental Employee Counts					0
Dental					$ 0.00
Orthodontia					$ 0.00
Subtotal Dental	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
Total	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00

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.			
26. Do you use a COBRA Third Party Administrator (TPA)?			
27. If yes, enter the TPA Name and contact information:			
Name:			
Address:		Phone:	
28**. 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.*			
29**. Who will be remitting payment to Moda/Delta Dental for COBRA premiums?**			
Payment			
30. 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			
31. Agent Name:			
32. Agency Name:			
33. Agency Tax ID:			
34. 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:	

Moda does not discriminate

Moda, Inc. follows federal civil rights laws. We do not discriminate based on race, 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 Customer Service at:

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

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.

Dave Nesseler-Cass coordinates our nondiscrimination work:

Dave Nesseler-Cass,
Chief Compliance Officer
601 SW Second Ave.
Portland, OR 97204
855-232-9111
compliance@modahealth.com

moda HEALTH

DELTA DENTAL

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（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。

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.

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DELTA DENTAL

Delta Dental of Oregon & Alaska