Declination of group dental coverage form

DELTA DENTAL

moda HEALTH

Section 1 › Employer information

Employer name

Section 2 › Patient information

I hereby acknowledge that I have been offered group dental coverage under my employer's plan for myself and/or my dependents. However, I am declining coverage for: (check one)

☐ **Myself** (employee only coverage)

☐ **My eligible family members only** (spouse/partner and/or dependent children)

☐ **Myself and my eligible family members** (employee and dependent coverage)

I decline dental coverage for myself and/or my family members due to the following reason: (check one)

☐ **Group coverage through spouse, partner or parent's employer**

☐ **Group coverage through a second employer**

☐ **Coverage through Medicaid or Veteran's Affairs**

☐ **Cost / premium contribution**

☐ **Other** (specify reason) _____

Section 3 › Authorization

Late Enrollee

I understand that if I do not enroll myself and/or my eligible dependents within 31 days of first becoming eligible, I may do so later as a "late enrollee." I understand that as a late enrollee, I am only eligible to enroll during my group's annual open enrollment period. Special Enrollment rights are explained below.

Special Enrollment

I further understand that if I am declining enrollment for myself and/or my dependent(s) (including my spouse) because of other dental coverage, I may in the future be able to enroll myself or my dependent(s) in this plan provided that I request enrollment within 31 days after my other coverage ends. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. In addition, if I or a dependent lose coverage under Medicaid or CHIP OR become eligible for premium assistance for Medicaid or CHIP, I may be able to enroll myself and the dependent, provided that I request enrollment within 60 days after the termination of coverage or the determination of eligibility for premium assistance.

Coverage will begin at the group's first premium payment date following application.

Employee name *(print)*	
Employee signature X	Date

Ready to submit? Mail or fax this form to Moda Health:

Mail: Moda Health Sales and Service, Attn: 10th Floor, Moda Health, 601 S.W. Second Ave., Portland, OR 97204

Fax: 503-243-3949

Questions? Contact the Moda Health Sales and Service Department at 800-578-1402. TTY users, please dial 711.

modahealth.com

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