Individual health plan application

California individuals and families

Please complete all sections of this application. If the application is incomplete or additional information is required, your effective date may be delayed. Illegible and incomplete applications will be returned. We must receive your complete submission prior to the requested effective date.

No-cost language services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call Moda Health at 855-718-1767.

Servicios de idiomas sin costo. Usted puede solicitar un intérprete. Puede solicitar que se le lean los documentos y que algunos de ellos se le envién en su idioma. Para obtener ayuda, llame al 855-718-1767.

免費語言服務。您可以取得口譯員服務。我們可以把文件朗讀給您聽，部分文件可以翻譯成您的語言並寄送給您。如需協助，請撥電話號碼 855-718-1767 與我們聯絡。

Section 1 › Eligibility

To be eligible to apply for one of our California individual health plans, you must be a California resident, reside in our market service area at least six months out of the year and not be enrolled in Medicare. Our market service area includes the regions where we market and sell the individual PPO plans.

Section 2 › Plan selection

I select the following health plan:

Be Radiant - Platinum Plan
☐ $0 deductible

Be Valiant - Gold Plan
☐ $0 deductible

Be Assured - Silver Plan
☐ Medical: $2,000 deductible
Rx: $250 deductible

Be Motivated - Silver Plan
☐ $3,000 deductible

Be Optimistic - Bronze Plan
☐ $5,000 deductible

Be Flexible (HSA) - Bronze Plan
☐ $4,500 deductible

Be Dynamic - Bronze Plan
☐ $4,250 deductible

Section 3 › Subscriber information

Is this a child/children-only plan? Children 26 or older must be on their own policy except a disabled child can be included as a dependent regardless of age (documentation of disability is required within 60 days of the coverage effective date).

☐ No ☐ Yes. If yes, please list the youngest child as the subscriber.

Last name	First name	M.I.		Gender ☐M ☐F
Date of birth (mm/dd/yyyy)	Social Security no.	Language preference ☐ English ☐ Spanish ☐ Other (please specify) _____		
Residence address		City	State	ZIP
Mailing address (if different)		City	State	ZIP
Email address	Primary phone	Secondary phone		

Section 4 › Dependent information

Please list all family members to be covered on this health plan. Family members include the following relationships: spouse, registered domestic partner, child or step child, adopted child, legal guardianship, and assumption of a parent-child relationship. Attach additional copies of this page, if necessary, to list other family members to be included on this application.

Relationship ☐ Spouse ☐ Registered domestic partner	Spouse/registered domestic partner last name	First name		M.I.
Date of birth (mm/dd/yyyy)	Social Security no.	Gender ☐ M ☐ F	Language preference ☐ English ☐ Spanish ☐ Other (please specify) ______	

Last name of family member	First name	Social Security no.	Date of birth (mm/dd/yyyy)	Gender	Language preference
Child				☐ M ☐ F	☐ English ☐ Spanish ☐ Other (please specify) ______
Child				☐ M ☐ F	☐ English ☐ Spanish ☐ Other (please specify) ______
Child				☐ M ☐ F	☐ English ☐ Spanish ☐ Other (please specify) ______
Child				☐ M ☐ F	☐ English ☐ Spanish ☐ Other (please specify) ______
Child				☐ M ☐ F	☐ English ☐ Spanish ☐ Other (please specify) ______
Child				☐ M ☐ F	☐ English ☐ Spanish ☐ Other (please specify) ______
Explain relationship to the applicant for any family member listed above whose last name is different from the applicant.					

Section 5 > Application type

Effective dates are assigned by Moda Health on the first of the month following receipt of the completed application or on the date as required by California regulations. You will need a special enrollment reason for changes or new policies made outside the open enrollment period. If enrolling due to a special enrollment reason and requesting a future effective date, please note the requested effective date here (no later than 60 days after your event date): _____ / _____ / _____

The reason I am applying or making a change is:

Open enrollment

☐ New policy/subscriber ☐ Add dependent on existing plan ☐ Plan change only

Special enrollment

Date of event: _____ / _____ / _____

☐ Loss of minimum essential coverage, including, but not limited to, loss of eligibility for coverage as a result of: legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, termination of employer contributions, and exhaustion of COBRA continuation coverage; loss of coverage because the covered employee becomes eligible for Medicare; and bankruptcy of the employer from whose employment the covered employee retired. Loss of minimum essential coverage also includes loss of that coverage for any reason other than due to failure to pay premiums or situations allowing for a rescission under CIC § 10384.17 (fraud or intentional misrepresentation of material fact).

☐ Gaining or becoming a dependent (due to marriage, domestic partnership, birth, adoption, placement for adoption, or assumption of a parent-child relationship)

☐ State or Federal Court mandate to be covered as a dependent

☐ Release from incarceration

☐ Health coverage issuer substantially violated a material provision of the health coverage contract

☐ Gaining access to new health benefit plans as a result of a permanent move

☐ Receiving services from a contracting provider under another health insurance plan for (a) an acute condition, (b) a serious chronic condition, (c) a pregnancy, (d) a terminal illness, (e) care of a newborn child between birth and age 36 months, or (f) performance of a surgery or other procedure that has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered insured, and that provider is no longer participating in the health benefit plan

☐ Being misinformed that one had minimum essential coverage

☐ Returning from active duty of the reserve forces of the United States military or the California National Guard

For purposes of this section:

Acute condition means a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.

Serious chronic condition means a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.

Terminal illness means an incurable or irreversible condition that has a high probability of causing death within one year or less.

Existing Moda Health subscriber name	Existing subscriber ID

Section 6 › Payment

We offer three payment options for you to choose from. Please select the option that is best for you:

☐ Pay with eBill, our electronic billing service. Access and pay your premium invoice online in myModa, your personalized member website. **Your premium invoices will be paperless**, and you can set up recurring payments or initiate payment each month. Setting up a myModa account is easy. Once you receive your Moda Health ID card, visit modahealth.com and follow the instructions to create a myModa account.

☐ Pay with electronic funds transfer (EFT). **Please fill out the EFT authorization agreement below.** 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 the 25th of the month. Your premium invoice will be paperless and located in the eBill section of myModa.

☐ Paper bill. If you select this option, we'll send you a paper bill in the mail every month. If the bill needs to go to a different address than other mail, please note the billing address below.

Billing address	City	State	ZIP

EFT authorization agreement

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

Applicant	Account holder
Name of bank	
Routing number	Account number

I (or we, if this is a joint account) authorize Moda Health to charge my (our) 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

You may be billed for the premium payment necessary to begin electronic deductions. If you want to cancel your bank deductions,we must receive written notice 15 days before the next deduction date.

Section 7 › Producer of record (to be completed by producer only)

I (the producer) certify that 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 Moda Health. I have informed the applicant that the effective date of coverage is assigned only by Moda Health.

For you to become the Producer of Record, you must be actively appointed with Moda Health. Please sign and date below.

Producer name	Agency name	Phone	Tax ID number

Address	City	State	ZIP

I (the producer) further attest to the following:

1. To the best of my knowledge, the information on the application is complete and accurate.
2. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information, and the applicant understood the explanation.
3. In addition to any applicable penalties or remedies available under current law, I may be subject to a civil penalty of up to $10,000 if I willfully state as true any material fact I know to be false.

Producer signature (required) X	Signature date

Note to producer: Payment does not have to be included with the application, but the first payment is required to activate coverage.

Section 8 > 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, reviewed and accepted by Moda Health 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, including those related to an inpatient confinement and that were received prior to the effective date of coverage.

> I understand that acceptance for coverage is dependent on:
A. Individuals listed on this application must be residents of the state of California and reside in our market service area to apply for and maintain coverage under this plan.
B. No one listed on this application is 65 years of age or older and enrolled in Medicare on the date coverage would begin.

"Resident" means a person who lives in our market service area in the state of California and intends to live in our market service area permanently or indefinitely. Moda Health may require proof of residency. Such proof shall include, but not be limited to, the street address on the individual's residence and not a post office box.

> I understand and agree that only Moda Health can:
A. Make or modify the terms of the application or contract
B. Waive any of the Moda Health rights or requirements

> 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 Jan. 1.

Section 9 > Certification of completion and correctness

Be sure to sign and date the application within this section.

I affirm that the answers given in this application are complete and correct. I have provided these answers as part of the application procedure required by Moda Health for enrollment. I understand Moda Health shall not rescind a health insurance policy, or limit any provisions of a health insurance policy, once I am covered under the policy unless Moda Health can demonstrate that I have performed an act or practice constituting fraud or made an intentional misrepresentation of material fact as prohibited by the terms of the policy. After a health insurance policy is in effect for 24 months, Moda Health shall not rescind the policy for any reason, cancel the policy, limit any of the provisions of the policy or raise premiums on the policy due to any omissions, misrepresentations, or inaccuracies in the application form, whether willful or not. Moda Health will send a notice of rescission 30 days prior to cancellation of coverage. I understand and agree that no coverage shall be in force until approved by Moda Health. If approved, coverage will be in force as of the effective date determined by Moda Health. Moda Health may contact me to clarify answers on this application. As the applicant, I understand that 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 if child or children-only policy X	Relationship*
Signature of applicant, parent or legal guardian, if applicant is under age 18 X	Signature date

**If not a parent, please attach legal documentation if you are the legal guardian or holder of Power of Attorney. For the assumption of a parent-child relationship, please attach an affidavit of the parent-child relationship, including the effective date of the relationship and a description of the assumption of relationship (such as assumption of parental status or parental duties).*

IMPORTANT NOTICE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Ready to submit? Mail, fax or email this form to Moda Health.
Mail: Moda Health, Billing and Eligibility, 601 SW Second Ave., Portland, OR 97204-3156
Fax: 503- 219-3696 **Email:** Scan and send to individualapp@modahealth.com.

New to Moda Health? Visit modahealth.com to view your Member Handbook and bill. You'll receive an email when your first bill is ready.

Questions? Contact Moda Health at 855-718-1767.

modahealth.com

To view the Summary of Benefits and Coverage (SBC) for these plans, please visit choosemoda.com and go to "Explore plans." A Glossary of Health Coverage and Medical Terms is available to help you understand the most common healthcare terms at http://www.dol.gov/ebsa/healthreform. For free print copies of the SBC or the Glossary of Health Coverage and Medical Terms, contact Moda Health at 855-718-1767.