Individual health plan application

Washington 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.

Section 1 › Eligibility

To be eligible to apply for one of our Washington Individual health plans, you must be a Washington resident, reside in our service area for six months out of the year, and not be eligible for Medicare.

Section 2 › Plan selection

I select the following health plan:

- ☐ Be Serene $650 deductible
- ☐ Be Reliable $2,750 deductible
- ☐ Be Active HSA $4,750 deductible
- ☐ Be Agile $1,250 deductible
- ☐ Be Certain $5,250 deductible

Section 3 › Application type

Effective dates are assigned by Moda Health on the 1st of the month following receipt of the completed application or on the date as required by Washington regulations. You will need a special enrollment reason for changes made outside the open enrollment period. Special enrollment includes adding dependents to an existing plan and enrolling in the plan due to loss of other coverage.

The reason I am applying or making a change is:

Special enrollment

Date of event: _____ / _____ / _____

- ☐ Marriage
- ☐ Registered domestic partner
- ☐ Birth, adoption or placement for adoption
- ☐ Loss of coverage due to turning 26
- ☐ Loss of coverage due to end of marriage or registered domestic partnership (RDP)
- ☐ Involuntary loss of group coverage
- ☐ COBRA ended due to exhausting benefit
- ☐ Other _____

Open enrollment

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

Existing subscriber	ID no. of policy of existing subscriber

Section 4 › Subscriber information

Is this a child/children-only plan? Children 26 or older must be on their own policy.

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

Last name	First name	M.I.	Social Security no.	Gender ☐ M ☐ F

Race ☐ Alaska Native ☐ American Indian ☐ White ☐ Other (please specify)	Date of birth (mm/dd/yyyy)	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

To view the summary of benefits and coverage (SBC) for these plans, please visit choosemoda.com and go to "explore plans."
A uniform glossary is available to help you understand the most common healthcare terms at www.cciio.cms.gov.
For free print copies of the SBC or uniform glossary, contact Moda Health at 855-718-1767.

Section 5 > Dependent information

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

Relationship ☐ Spouse ☐ RDP	Spouse/RDP last name	First name	M.I.
Date of birth (mm/dd/yyyy)	Social Security no.	Gender ☐ M ☐ F	
Race ☐ Alaska Native ☐ American Indian ☐ White ☐ Other (please specify) ______		Language preference ☐ English ☐ Spanish ☐ Other (please specify) ______	

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

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 your voided personal check from the account to be drafted.

Applicant	Account holder
Name of bank	

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	Signature date
X	

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 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.

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

Producer signature (required)	Signature date
X	

Note to producer: Payment does not have to be included with the application, but the first payment is due by the effective date 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, that were received prior to the effective date of coverage.
- I understand that acceptance for coverage is dependent on:
  A. persons listed on this application must be residents of the state of Washington in order to apply for and maintain coverage under this plan; and
  B. no one listed on this application is 65 years of age or older and eligible for Medicare on the date coverage would begin.

  "Resident" means a person who lives in the state of Washington, and intends to live in the state permanently or indefinitely. Moda Health may require proof of residency from time to time. 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 may:
  A. make or modify the terms of the application or contract; or
  B. waive any of the Moda Health rights or requirements.
- I understand that I may receive benefits which 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. A spouse/RDP or any dependent(s) over age 18 is required to sign the application.

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 that if this application contains any intentional misrepresentations of material fact Moda Health may deny coverage, modify or cancel the contract, rescind the contract, or take other legal action. I understand it is a crime to knowingly provide false, incomplete, or misleading information to a health carrier for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of health coverage benefits. 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 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
Signature of applicant's legal spouse/RDP, 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

**If not 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 Moda Health.
Mail: Moda Health, 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 Moda? 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