DELTA DENTAL®

Delta Dental of Oregon & Alaska

View our plans at shopmodaplans.com.
Questions? We're here to help. Call us at 855-718-1767.

2019 | Individual dental plan application

for Alaska individuals and families

Please fill out all sections of this application and submit it to us. If the application is incomplete or we need more information, your effective date may be delayed. Be sure information is clearly written. If we can't read something, we will return your application to you. We must receive your complete application no later than the 15th of the month before the requested effective date. For special enrollment, we must receive this application and supporting documentation within 60 days of the special enrollment event date. Your application process could be delayed or denied if supporting documentation is not provided.

Section 1 › Application type

The reason I am applying or making a change is:

Open enrollment

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

Existing Delta Dental subscriber name
Existing subscriber ID

Special enrollment

Date of event *(mm/dd/yyyy)*

- ☐ Marriage or domestic partnership (DP)
- ☐ Birth, adoption or placement for adoption
- ☐ Placement of foster child
- ☐ Loss of coverage because I turned 26
- ☐ Loss of coverage due to end of marriage or DP
- ☐ Loss of eligibility for group coverage
- ☐ COBRA ended due to expiration of coverage
- ☐ Other

Your completed application must include proof of the life event that made you eligible for a special enrollment. A list of acceptable documentation to support your life event can be found at modahealth.com/shop/special-enrollment.

You will need a special enrollment event for changes or new policies made outside of the open enrollment period.

If you are enrolling due to a special enrollment event and want a later effective date, please note the requested effective date here *(mm/dd/yyyy)*

Section 2 › Eligibility and residency

To apply and remain eligible for one of our Alaska individual dental plans, you must currently reside in the service area for the plan selected, and continue to reside in the service area for six months out of the year.
The service area for PPO plans is limited to the following zip codes:

Anchorage Municipality		Fairbanks North Star Borough			Matanuska-Susitna Borough (Mat-Su Valley)		
99501-99524	99577	99701	99708	99714	99623	99654	99687
99529-99530	99587	99702	99709	99716	99629	99667	99688
99540	99599	99703	99710	99725	99645	99674	99693
99567	99695	99705	99711	99775	99652	99683	99694
		99707	99712				

If you had Delta Dental individual dental coverage that ended during the past two years, you won't be eligible unless you have a special enrollment qualifying event or have had continuous group dental coverage since leaving Delta Dental.

☐ **I confirm I meet these requirements.**

Section 3 › Plan selection

I select the following dental plan and deductible for the requested effective date of ____ / ____ / _____ :

Plans available only in Anchorage, Fairbanks North Star Borough, and Mat-Su Valley

☐ Delta Dental PPO 1000 – $0 deductible

☐ Delta Dental PPO 1500 – $0 deductible

Plans available throughout Alaska

☐ Delta Dental Premier – $0 deductible

☐ Delta Dental Premier Healthy Smiles – $0 deductible

☐ Delta Dental Premier Preventive Alaska Mandated Plan – $25 per person/$75 family deductible

If you are changing from one Delta Dental of Alaska individual plan to another outside of open enrollment, any amount applied to the annual maximum plan payment limit will be transferred to your new plan.

Section 4 › Subscriber information

This section must be completed with subscriber information.

Is this a child- or children-only plan?

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

Children age 26 or older must be on their own policy.

Last name	First name	M.I.	Suffix
Date of birth *(mm/dd/yyyy)*	Social Security number	Gender ☐ M ☐ F	

Race

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Caucasian ☐ Hispanic or Latino ☐ Native Hawaiian or other Pacific Islander
☐ Other (please specify) _____

Preferred spoken and written language

☐ English ☐ Spanish ☐ Other (please specify) _____

Residence address	City	State	ZIP
Mailing address (if different)	City	State	ZIP

Email address	Primary phone	Secondary phone

Section 5 › Dependent Information – spouse or domestic partner (DP)

Please complete this section for spouse or DP to be covered on this dental plan.

Relationship ☐ Spouse ☐ DP	Last name	First name	M.I.	Suffix
Date of birth *(mm/dd/yyyy)*		Social Security number	Gender ☐ M ☐ F	

Race
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Caucasian ☐ Hispanic or Latino ☐ Native Hawaiian or other Pacific Islander
☐ Other (please specify) ____________________

Preferred spoken and written language
☐ English ☐ Spanish ☐ Other (please specify) ____________________

Section 6 › Dependent Information – children

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

Last name	First name	Suffix
Date of birth *(mm/dd/yyyy)*	Social Security number	Gender ☐ M ☐ F

Last name	First name	Suffix
Date of birth *(mm/dd/yyyy)*	Social Security number	Gender ☐ M ☐ F

Last name	First name	Suffix
Date of birth *(mm/dd/yyyy)*	Social Security number	Gender ☐ M ☐ F

Last name	First name	Suffix
Date of birth *(mm/dd/yyyy)*	Social Security number	Gender ☐ M ☐ F

Last name	First name	Suffix
Date of birth *(mm/dd/yyyy)*	Social Security number	Gender ☐ M ☐ F

If any children listed above have a different race or primary language than the subscriber, please list their name, race and primary language here.

Section 7 › Other insurance

Will you have other dental insurance?

☐ Yes ☐ No

Section 8 › Credit toward benefit exclusion period (for new dental coverage)

For subscribers and dependents age 19 and over:

Do you have 12 continuous months of prior dental coverage with no more than a 90-day break in coverage from the end of the old policy to the expected effective date of the new policy?

☐ No ☐ Yes. If yes, please provide a letter from your prior carrier or employer documenting the start and end dates of your prior dental coverage. This documentation of prior coverage is required for credit to be applied toward the benefit exclusion period. In addition, please provide the following information:

Name of individual(s) enrolled in prior dental plan		
Prior insurance company	Coverage start date *(mm/dd/yyyy)*	Coverage end date *(mm/dd/yyyy)*

Section 9 › Payment method

We offer three payment options for you to choose from.

1. Automatic eBill payment through MyModa.
2. Electronic fund transfer (EFT), see authorization agreement below.
3. Personal check, money order or cashier's check.

EFT authorization agreement

EFT initiates around the fifth of the month and usually takes one or two days to post to your account. Your initial payment may initiate on a later date if your enrollment is processed after the 5th of the month. Your premium invoice will be paperless and located in the eBill section of myModa.

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

Subscriber		Account holder	
Name of bank	Routing number	Account number	Account type ☐ Checking ☐ Savings

I authorize Delta Dental to charge my 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	

Section 10 > Billing options

If you are set up for EFT your premium invoice will be paperless. If you are not set up for EFT you will receive paper invoices in the mail. You may change your billing preference to paperless by going to the eBill section of myModa.

If the bill needs to go to an address other than your mailing address, please note the billing address below.

Billing address	City	State	ZIP

Section 11 > Agent of record (to be completed by producer only)

I (the agent) certify I have explained the eligibility provisions to the subscriber. I have not made any statements about benefits, conditions or limitations of the contract except through written material furnished by Delta Dental. I have informed the subscriber that the effective date of coverage is assigned only by Delta Dental.

In order for you to become the agent of record, you must be actively appointed with Delta Dental. Please sign and date below.

Agent name	Agency name	Phone	Agent NPN

Address	City	State	ZIP

I certify that the information supplied to me by the subscriber has been truly and accurately recorded.

Agent signature (required)	Signature date
X	

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

Section 12 > 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 and reviewed by Delta Dental and an effective date of coverage is assigned.
- I understand if my previous policy ended because I did not pay premiums when due, this new coverage may not begin until I have paid my past-due premium amounts from the last 12 months in addition to the first month's premium for this new policy.
- 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 that were received prior to the effective date of coverage.
- I understand that acceptance for coverage requires that individuals listed on this application must be residents of the state of Alaska to apply for and maintain coverage under this plan.
- **"Resident"** means a person who lives in the service area and intends to live in the service area permanently or indefinitely. Delta Dental may require proof of residency from time to time. Such proof shall include, but not be limited to, the street address of the individual's residence and not a post office box.
- 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 January 1.
- I have read the Moda privacy statement that is available on modahealth.com.

Section 13 › Go paperless!

You can view your explanation of benefits (EOBs) online by logging in to myModa. After your application is approved, you will receive a welcome letter with your Moda member ID number. With this ID number, simply set up a myModa account by visiting modahealth.com and opt to receive electronic EOBs.

Section 14 › Certification of completion and correctness

Be sure to sign and date the application below. Your spouse, DP and any dependents over age 18 must also sign the application.

I affirm that the answers given on this application are complete and correct to the best of my knowledge. I have provided these answers as part of the application procedure required by Delta Dental to enroll in its insurance coverage. I understand that if this application contains any intentional misrepresentations of material fact that Delta Dental may deny coverage, modify or cancel the contract, rescind the contract or take other legal action. I will promptly inform Delta Dental in writing if anything happens before my coverage takes effect that makes this application incomplete or incorrect. I understand and agree that no coverage will be in force until approved by Delta Dental. If approved, coverage will be in force as of the effective date determined by Delta Dental. Delta Dental may contact me to clarify answers on this application. As the subscriber, I understand I have the right to inspect the information in my file.

I acknowledge that I have read and understand this application, terms and certification, and privacy statement.

Print name of responsible party[1] if child- or children-only policy X	Relationship[2]
Signature of subscriber ***(if subscriber is under age 18, signature of parent/guardian)*** X	**Signature date**
Signature of subscriber's legal spouse or DP, 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**

1 *Responsible party: If you are an adult not covered by this plan and you bear financial responsibility or act as the primary caregiver for the subscriber and others covered by this plan, then you are the responsible party*

2 *If not a 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 Delta Dental:

Mail: Delta Dental, Membership Accounting, 601 S.W. Second Ave., Portland, OR 97204-3156

Fax: 503-219-3696 **Email:** Scan and send to individualapp@modahealth.com.

New to Delta Dental of Alaska? Visit modahealth.com to log in to myModa and view your Member Handbook and bill. Once you sign up for myModa and go paperless (see Section 13), you'll receive an email when your first bill is ready.

Questions? Contact us at 855-718-1767.

modahealth.com

Dental plans in Alaska provided by
Oregon Dental Service, dba Delta Dental of Alaska.

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:

Medicare Customer Service,
877-299-9062 (TDD/TTY 711)

Medicaid Customer Service,
888-788-9821 (TDD/TTY 711)

Customer Service for all other plans
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

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

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.

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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 hỗ 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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