2020 Application for Vision and Hearing Benefits Rider to Oregon Medicare Supplement Plan

Please mail your completed application to:

Moda Health Plan, Inc., Attn: Membership Accounting, 601 S.W. Second Ave., Portland, OR 97204-3156
Email: Scan and send to individualapp@modahealth.com.
phone 844-235-8012 • fax 503-219-3696 • modahealth.com/medicare

Complete this application if you are currently enrolled in a Moda Health Medicare Supplement plan, and you wish to supplement your policy with vision and hearing benefits. These benefits are sold as a package for an additional premium and not available separately. Your application must be submitted during the annual renewal period and prior to January 1. The effective date is January 1. Please print legibly in black or blue ink.

Enrollment information

Last name	First name	Middle initial
Moda Health subscriber ID no.		
Residence street address		
City	State	ZIP
Home telephone no.	County	

Mailing address (if different)

Name (c/o)	Relationship to applicant		
Address	City	State	ZIP
Email address			

Check the box below to add the vision/hearing rider to your Moda Health Medicare supplement plan.

☐ I'd like to purchase a vision and hearing benefits rider to supplement my Moda Health Medicare supplement plan for an additional monthly premium of $5.

After you enroll, your coverage will automatically renew each January with the plan's annual renewal date, as long as you remain a member on a Moda Health Medicare Supplement plan. If you cancel this optional vision/hearing rider, you will not be able to re-enroll until the following calendar year.

Plan Premium

If you are currently receiving bills from us, or having your premium deducted from your bank account, your vision and hearing benefits premium will be deducted using the same method and will be included with your Medicare Supplement policy monthly invoice.

For agent use only			
I (the agent) have explained the eligibility provisions to the applicant. I have not made any statements about benefits, conditions or limitations of the policy except through written material furnished by Moda Health. I CERTIFY THAT THE INFORMATION SUPPLIED TO ME BY THE APPLICANT HAS BEEN TRULY AND ACCURATELY RECORDED HERE.			
Agent name (print or type)			
Agency name		Telephone no.	
Street address	City	State	ZIP
Agent's signature (required)			Date

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

Authorization

Be sure to sign and date the application below. Signature applies to "Certification of completeness and correctness," "Authorization for release of information" and "Applicant's statement."

By completing this application form, I agree to adding vision and hearing coverage to my Moda Health Medicare Supplement plan policy at renewal for the monthly premium amount on page 1, in addition to my monthly base Moda Health Medicare Supplement premium. I understand that the additional coverage is subject to the terms and conditions stated in my Moda Health Medicare Supplement plan policy and the vision and hearing benefits rider.

Certification of completion and correctness

I affirm that the information given in this application is complete and correct. I am providing the information as part of the application procedure required by Moda Health to enroll in its insurance coverage. I understand that if this application contains any material misstatements or omissions, Moda Health may, within the first two years of coverage, deny coverage, modify or cancel the policy, and/or take any other legal action available to it by law. I will promptly inform Moda Health in writing if anything happens before my coverage takes effect that makes this application incomplete or incorrect. Moda Health may phone me to clarify any information on this application. As the applicant, I understand I have the right to inspect the information in my file.

Authorization for release of information

To any physician; healthcare provider; hospital; insurance or reinsurance company; the Medical Information Bureau, Inc. (MIB) or other insurance information exchange:

I authorize you to give medical information (including alcohol, chemical dependency, mental treatment or HIV treatment) you have about me to Moda Health or its representatives. This authorization takes effect on the date shown below. This authorization shall be valid for 24 months from the date following my signature below unless the authorization is revoked. I have the right to revoke this authorization in writing at any time. Any uses or disclosures already made with my permission cannot be taken back. A photocopy of this authorization is as valid as the original.

Applicant's statement

I understand that if this application contains material misstatements or omissions, Moda Health may do any or all of the following:

- Cancel the vision and hearing rider as though it were never effective
- Deny benefits under the "pre-existing" clause of the policy, if applicable
- Take any other legal action available to it by law

I understand that my agent is not authorized to make any statements about the benefits, conditions or limitations of the policy except through written materials furnished by Moda Health. If my agent completed any information on my behalf, I have reread all information and verified that it is true and complete. I understand that only Moda Health can determine whether to issue a policy to me, and that my agent has no authority to do so.

I understand, upon acceptance, that this application becomes part of the policy.

Signature of applicant	Date

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Nondiscrimination notice

We follow 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 Partners, 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.

Health plans in Oregon and Alaska provided by Moda Health Plan, Inc. Dental plans in Oregon provided by Oregon Dental Service, dba Delta Dental Plan of Oregon. Dental plans in Alaska provided by Delta Dental of Alaska. 42677508 (8/18)

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).

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)

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）

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)

تنبيه: إذا كنت تتحدث العربية، فهناك خدمات
مساعدة لغوية متاحة لك مجانًا. اتصل برقم
1-877-605-3229 (الهاتف النصي: 711)

توجہ دیں: اگر آپ اردو (URDU) بولتے ہیں تو لسانی
اعانت آپ کے لیے بلا معاوضہ دستیاب ہے۔
1-877-605-3229 (TTY: 711) پر کال کریں

ВНИМАНИЕ! Если Вы говорите по-русски, воспользуйтесь бесплатной языковой поддержкой. Позвоните по тел. 1-877-605-3229 (текстовый телефон: 711).

ATTENTION : si vous êtes locuteurs francophones, le service d’assistance linguistique gratuit est disponible. Appelez au 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.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपको भाषाई सहायता बिना कोई पैसा दिए उपलब्ध है। 1-877-605-3229 पर कॉल करें (TTY: 711)

Achtung: Falls Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistenzdienste zur Verfügung. Rufen sie 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。

અગત્યનું: જો તમે (ભાષાંતર કરેલ ભાષા અહીં દર્શાવો) બોલો છો તો તે ભાષામાં તમારે માટે વિના મૂલ્યે સહાય ઉપલબ્ધ છે. 1-877-605-3229 (TTY: 711) પર કૉલ કરો

ໂປດຊາບ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການຊ່ວຍເຫຼືອດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສັຍຄ່າ. ໂທ 1-877-605-3229 (TTY: 711)

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)

ប្រុងប្រយ័ត្ន៖ 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.

โปรดทราบ: หากคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือด้านภาษา ได้ฟรี โทร 1-877-605-3229 (TTY: 711)

FA’AUTAGIA: Afai e te tautala i le gagana Samoa, o loo avanoa fesoasoani tau gagana mo oe e le totogia. Vala’au i le 1-877-605-3229 (TTY: 711)

IPANGAG: Nu agsasaoka iti Ilocano, sidadaan ti tulong iti lengguahe para kenka nga awan bayadna. Umawag iti 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)

modahealth.com

Delta Dental of Oregon & Alaska