



Enrollment application & change of information form

Medical WellConnect and dental (51-99)

Moda Health use only

Group number _____

Subscriber number _____

To expedite your application, please print legibly in black or blue ink and return as instructed. Please complete all sections of this application. If the application is incomplete or additional information is required, your effective date may be delayed.

Section 1 > Application type

You'll need a special enrollment reason for some 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:

Open enrollment

Effective date: _____ / _____ / _____

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

Changes

- Name change
New name: _____
Old name: _____
- New address
(please write new address in Section 3)

Special enrollment

Date of event: _____ / _____ / _____

- Marriage
- Registered domestic partner (RDP)
- Birth, adoption or placement for adoption
- Loss of coverage because I turned 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 _____

Section 2 > Coverage

Medical coverage

WellConnect:

- Community Care Network (CCN)
- Companion plan_

Dental coverage

- ODS Dental
- DirectOption (Willamette Dental)

Group name	Group number
Subgroup	Class

Section 3 > Employee information

*First name	M.I.	*Last name	*Social Security number		
*Mailing address		*City	*State	*ZIP	
Home phone	*Date of birth (mm/dd/yyyy) ____ / ____ / ____	*Gender <input type="checkbox"/> M <input type="checkbox"/> F	*Date of employment (mm/dd/yyyy) ____ / ____ / ____		
Primary language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____		Email address			
Employee System of Care (SOC) selection: <input type="checkbox"/> Legacy Health SOC (LH) <input type="checkbox"/> Adventist SOC (Adv) <input type="checkbox"/> OHSU SOC <input type="checkbox"/> Salem Health SOC (SH) <input type="checkbox"/> PeaceHealth SOC (PH) <input type="checkbox"/> St. Charles SOC (StC)					

Section 4 > Dependents

Relationship code: SP = spouse, DP = domestic partner, RDP = registered domestic partner (DP and RDP only if applicable to your plan)

System of Care (SOC) - code: LH = Legacy Health SOC, Adv = Adventist SOC, OHSU = OHSU SOC, SH = Salem Health SOC, PH = PeaceHealth SOC, StC = St. Charles SOC

Add	Term	Med	SOC	Den	*Dependent first name	*Last	*Social Security number	*Date of birth (mm/dd/yyyy)	*Gender	*Relationship	Primary language (if different from employee)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> LH <input type="checkbox"/> SH <input type="checkbox"/> Adv <input type="checkbox"/> PH <input type="checkbox"/> OHSU <input type="checkbox"/> StC	<input type="checkbox"/>					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> SP <input type="checkbox"/> DP <input type="checkbox"/> RDP	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> LH <input type="checkbox"/> SH <input type="checkbox"/> Adv <input type="checkbox"/> PH <input type="checkbox"/> OHSU <input type="checkbox"/> StC	<input type="checkbox"/>					<input type="checkbox"/> M <input type="checkbox"/> F	Child ¹	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> LH <input type="checkbox"/> SH <input type="checkbox"/> Adv <input type="checkbox"/> PH <input type="checkbox"/> OHSU <input type="checkbox"/> StC	<input type="checkbox"/>					<input type="checkbox"/> M <input type="checkbox"/> F	Child ¹	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> LH <input type="checkbox"/> SH <input type="checkbox"/> Adv <input type="checkbox"/> PH <input type="checkbox"/> OHSU <input type="checkbox"/> StC	<input type="checkbox"/>					<input type="checkbox"/> M <input type="checkbox"/> F	Child ¹	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> LH <input type="checkbox"/> SH <input type="checkbox"/> Adv <input type="checkbox"/> PH <input type="checkbox"/> OHSU <input type="checkbox"/> StC	<input type="checkbox"/>					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Child ¹ <input type="checkbox"/> Ward	

* Enrollment will be delayed if fields with an asterisk are not filled out.

¹ Please list only eligible dependent children. See Section 6 for dependent children qualifications.

Section 5 > Other insurance (coordination of benefits)

Will employee or any dependents have other insurance? Yes No

Section 6 > Dependent(s) not living with employee

Are any of the dependent(s) not living with the employee? If yes, please provide the state and ZIP code. This is for informational purposes only and does not impact eligibility.

Dependent name	State	ZIP
Dependent name	State	ZIP
Dependent name	State	ZIP
Dependent name	State	ZIP

Children are eligible to enroll for coverage through age 25. Please see your Member Handbook for additional eligibility information. The following are eligible dependent children:

- > Your or your spouse’s natural or adopted child
- > Children placed with you for adoption
- > Newborns born to a covered dependent, for whom you are financially responsible (legal guardianship is required for coverage after the first 31 days)
- > Your domestic partner’s natural child or adopted child (if domestic partners by affidavit can enroll in your employer plan)
- > Your registered domestic partner’s natural child or adopted child
- > Children related by blood or marriage for whom you are the legal guardian (you will need to attach a signed court order showing legal guardianship)

Section 7 > System of Care information release authorization

By signing your enrollment form below and selecting a preferred System of Care, you hereby authorize the sharing of information between Moda Health, your System of Care and providers in your System of Care. This information may include demographic and contact information, as well as medical information, including but not limited to, diagnosis and treatment for services within or outside of your System of Care. Any information shared on your behalf will remain confidential between Moda Health, your System of Care and the providers in your System of Care. If you make any changes to your preferred System of Care, the authorizations contained in this enrollment form will continue to apply to the newly selected preferred System of Care.

Section 8 > Authorization (please read and sign below)

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law.² Health information requested or disclosed may be related to treatment or services performed by:

- > A physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- > A clinic, hospital, long term care or other medical facility;
- > Any other institution providing care, treatment, consultation, pharmaceuticals or supplies or;
- > An insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports dental records, or hospital records (including nursing records and progress notes). This acknowledgement does not apply to obtaining information regarding HIV/AIDS, Psychotherapy Notes, Alcohol/Drug and Genetic Testing. A separate authorization will be used for information related to these health conditions. 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.

I certify that the information provided on this form is true and correct to the best of my knowledge. I acknowledge that my enrollment form will be delayed if all fields with an asterisk are not filled out entirely.

*Employee signature X	*Signature date
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* Enrollment will be delayed if fields with an asterisk are not filled out.

² For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Notice of Privacy Practices. A copy is available by calling the Privacy Office at 503-243-4492.

Questions? Contact your benefits administrator or visit modahealth.com
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