Enrollment application & change of information form

Summit Plan

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

Outside of the open enrollment period, you would need a special enrollment reason to enroll or make changes (for example, add dependents or switch plans). If you are enrolling or making changes due to a special enrollment event, please specify the event below and provide documentation of your life event. The reason I am applying or making a change is:

Open enrollment

Date of event: _____ / _____ / _____

- ☐ New policy/subscriber
- ☐ Add dependent on existing plan
- ☐ Plan change only
- ☐ *Waiver of coverage (see Section 7)*

Changes *(these can be made outside of open enrollment)*

- ☐ Name change
  New name: _____
  Old name: _____
- ☐ New address
  (please write new address in Section 3)
- ☐ Medical home provider
  (please see Section 8)

Special enrollment

Date of event: _____ / _____ / _____

- ☐ Marriage
- ☐ Registration of 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/continuation ended due to exhausting benefit
- ☐ Other _____

Section 2 › Coverage

☐ **Summit**

Group name	Subgroup	Group no.	Class

Section 3 › Employee information

First name*	M.I.	Last name*	Social Security no.*	
Mailing address*		City*	State*	ZIP*
Home phone	Date of birth *(mm/dd/yyyy)**	Gender* ☐ M ☐ F	Date of employment *(mm/dd/yyyy)**	
Primary language ☐ English ☐ Spanish ☐ Other _____		Email address		

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

Section 4 › Dependent children eligibility information

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)
- 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)
- Your domestic partner's natural child or adopted child (if domestic partners by affidavit can enroll in your employer's plan)
- Your registered domestic partner's natural child or adopted child

Section 5 › Dependents

Relationship code: **SP** = spouse, **DP** = domestic partner, **RDP** = registered domestic partner *(DP and RDP only if applicable to your plan)*
Please use additional form if needed.

Add	Term	Dependent first name*	Dependent last name*	Social Security no.*	Date of birth* *(mm/dd/yyyy)*	Gender*	Relationship*	Primary language *(if different from employee)*
☐	☐					☐ M ☐ F	☐ SP ☐ DP ☐ RDP	
☐	☐					☐ M ☐ F	Child[1]	
☐	☐					☐ M ☐ F	Child[1]	
☐	☐					☐ M ☐ F	☐ Child[1] ☐ Ward	

Section 6 › Other insurance (coordination of benefits)

Will employee or any dependents have other insurance? ☐ Yes ☐ No

If your Group's size is less than 20 employees, Medicare will be assumed to be the primary payer and we will coordinate benefits as the secondary payer even if you have not elected coverage under Medicare. When your Group's size is 20 employees or more, Medicare will be considered the secondary payer.

Section 7 › Waiver of coverage information

Please include the names of all eligible members who will NOT be enrolling. *Please use additional form if needed.*

Person waiving	Reason for waiver	Health plan name	Policy no.	Employer group name
	☐ Individual ☐ Employer group ☐ Medicare ☐ Other _____			
	☐ Individual ☐ Employer group ☐ Medicare ☐ Other _____			

Notice: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may, in the future, be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after marriage, birth, adoption or placement for adoption.

** If prior coverage was under Medicaid or a children's health insurance program (CHIP) you must request enrollment within 60 days after the coverage ends.*

** Enrollment will be delayed if fields with an asterisk are not filled out*
1 Please list only eligible dependent children. See Section 5 for dependent children qualifications.

Section 8 › Medical home selection

For changes, list only person requesting change. *Please use additional form if needed.*

Subscriber

Subscriber name		Date of birth (mm/dd/yyyy)	
Medical home provider name			
Medical home provider address	City	State	ZIP

Dependent(s)

Dependent name		Date of birth (mm/dd/yyyy)	
Medical home provider name			
Medical home provider address	City	State	ZIP

Dependent name		Date of birth (mm/dd/yyyy)	
Medical home provider name			
Medical home provider address	City	State	ZIP

Dependent name		Date of birth (mm/dd/yyyy)	
Medical home provider name			
Medical home provider address	City	State	ZIP

Section 9 › Authorization (please read and sign below)

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (people 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*	Signature date*
X	

** 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.

Moda Health nondiscrimination notice

Moda, Inc. complies with applicable federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability or sex.

Moda provides free, timely aids and services to people with disabilities to help them communicate with us effectively. These accommodations include sign language interpreters and written information in other formats.

If your primary language is not English, Moda also provides free, timely interpretation services and/or materials written in other languages.

If you need any of the services listed above, contact:

Customer Service,
888-217-2363 (TDD/TTY 711)

If you believe that Moda has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a written grievance by mailing or faxing it to:

Moda, Inc.
Attention: Appeal Unit
601 SW Second Ave.
Portland, OR 97204
Fax: 503-412-4003

If you need assistance filing a grievance, 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 to:

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).

Office for Civil Rights complaint forms are available at hhs.gov/ocr/office/file/index.html.

Moda's efforts to assure nondiscrimination are coordinated by:

Tom Bikales, VP Legal Affairs
601 SW Second Ave.
Portland, OR 97204
855-232-9111
compliance@modahealth.com

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（TTY、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.