# Enrollment application & change of information form

Synergy Plan and Dual Dental – PCP

Moda 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				Sectio	n 2 > C	Coverage	
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:				☐ Synergy – PCP				
					□ Dental coverage			
Open enrollment  Date of event: /  New policy/subscriber  Add dependent on existing		Date of even	Special enrollment  Date of event: / /  Marriage  Registration of domestic partner (RDP)			☐ Delta Dental ☐ Direct Option (Willamette Dental network)		
☐ Plan change only	Jiuri							
	<ul><li>☐ Plan change only</li><li>☐ Birth, adoption or placement for adopt</li><li>☐ Waiver of coverage (see Section 7)</li><li>☐ Loss of coverage because I turned 26</li></ul>							
Changes  Name change New name: Old name: New address (please write new address in PCP (please see Section 8)  Group name		due to exhausting benefit			no. Class		ass	
Section 3 > Employee in	formation	Last name*		Social S	Security no.	*		
						1	T	
Mailing address*			City*			State*	ZIP*	
Home phone	Date of birt	h (mm/dd/yyyy)*	Gender*	Date of	e of employment <i>(mm/dd/yyyy)</i> *			
Primary language			Email address	1				
□ English □ Spanish □ Othe	er		_					





## 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.

A	Add Te	erm	Med Der	Dependent first name*	Dependent last name*	Social Security no.*	Date of birth* (mm/dd/yyyy)	Gender*	Relationship*	Primary language (if different from employee)
			0 0					□ M	□ SP □ DP □ RDP	
			0 0					□ M □ F	Child <sup>1</sup>	
			0 0					□ M □ F	Child <sup>1</sup>	
			0 0					□ M □ F	□ Child¹ □ 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 30 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 30 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 withing 60 days after coverage ends.

<sup>\*</sup> Enrollment will be delayed if fields with an asterisk are not filled out

<sup>1</sup> Please list only eligible dependent children. See Section 4 for dependent children qualifications.

#### Section 8 ➤ PCP selection

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

Su	bscr	ıh	er

Subscriber name	•			Date of birth (mm/dd/yyyy)			
PCP name		1					
PCP address	City		State	ZIP			
Dependent(s)							
Dependent name		Date of birth (mn	n/dd/yyyy)				
PCP name							
PCP address	City		State	ZIP			
Dependent name	Date		Date of birth (mm/dd/yyyy)				
PCP name		 					
PCP address	City		State	ZIP			
Dependent name	ie			Date of birth (mm/dd/yyyy)			
PCP name		,					
PCP 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.<sup>2</sup> 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	

<sup>\*</sup> Enrollment will be delayed if fields with an asterisk are not filled out.

<sup>2</sup> 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 855-425-4192.

# 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 Customer Service at:

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

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.

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 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 712-605-3229 (الهاتف النصي: 711)

(URDU) توجبه دین: اگر آب اردو بولتے ہیں تو لسانی اعسانت آپ کے لیے 1-877 بلا معساونے دستیاب ہے۔ کے کال کریں (TTY: 711) 205-605

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 -605-877-1 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, ການຊ່ວ ຍເຫຼືອດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສັ້ ຍຄ່າ. ໂທ 1-877-605-3229 (TTY: 711)

УВАГА! Якщо ви говорите українською, для вас доступні безкоштовні консультації рідною мовою. Зателефонуйте 1-877-605-3229 (ТТҮ: 711)

ATENŢIE: Dacă vorbiţi limba română, vă punem la dispoziţie serviciul de asistenţă lingvistică în mod gratuit. Sunaţi 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)

ត្រូវចងចាំ៖ បើអ្នកនិយាយភាសាខ្មែរ បោយត្រូវការសេវាកម្មជំនួ យផ្នែកភាសាដោយឥតគិតថ្ លៃ 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.

โปรตหราบ: หากคุณพูดภาษาไหย คุณ สามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี โหร 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)