Enrollment application & change of information form

Medical

moda HEALTH

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

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 subscriber
- ☐ Add dependent
- ☐ 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)

Special enrollment

Date of event: _____

- ☐ Marriage
- ☐ Domestic partnership
- ☐ Birth, adoption or seek to adopt in a suit
- ☐ Loss of coverage because I turned 26
- ☐ Loss of coverage due to end of marriage or domestic partnership if domestic partner can enroll in your plan
- ☐ Involuntary loss of group coverage
- ☐ COBRA/continuation ended due to exhausting benefit
- ☐ Other _____

Group name	Subgroup	Group no.	Class

Section 2 › Coverage

☐ **Medical coverage**

_____

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

Primary language	Email address
☐ English ☐ Spanish ☐ Other _____	

The following fields are optional. We are committed to understanding and valuing diversity among our members. We are seeking this information so our staff can refer to and communicate with you in the most appropriate and respectful way.

Gender/sex: ☐ Female ☐ Male ☐ Prefer not to answer

Gender identity: ☐ Female ☐ Male ☐ Transgender ☐ Cisgender ☐ Gender non-conforming ☐ Non-binary / Third gender ☐ Questioning ☐ Prefer not to answer ☐ Another ☐ Undefined / Unspecified

** 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 Certificate of Coverage for additional eligibility information. The following are eligible dependent children:

- Your or your spouse's natural or adopted child
- Children you seek to adopt in a suit
- Your or your spouse's newborn
- 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)
- Children under a qualified medical child support order
- Grandchildren if they are dependents on your federal tax return at the time of application for coverage
- Your domestic partner and your domestic partner's natural child or adopted child if your plan covers registered domestic partners or domestic partners by declaration of domestic partnership

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	Med	Vis	Relationship*	Dependent first name*	Dependent last name*	Social Security no.*	Date of birth* *(mm/dd/yyyy)*	Primary language *(if different from employee)*
☐	☐	☐	☐	☐ SP ☐ DP ☐ RDP					
Gender/sex: ☐ Female ☐ Male ☐ Prefer not to answer				**Gender identity:** ☐ Female ☐ Male ☐ Transgender ☐ Cisgender ☐ Gender non-conforming ☐ Non-binary / Third gender ☐ Questioning ☐ Prefer not to answer ☐ Another ☐ Undefined / Unspecified					

Add	Term	Med	Vis	Relationship*	Dependent first name*	Dependent last name*	Social Security no.*	Date of birth* *(mm/dd/yyyy)*	Primary language *(if different from employee)*
☐	☐	☐	☐	Child[1]					
Gender/sex: ☐ Female ☐ Male ☐ Prefer not to answer				**Gender identity:** ☐ Female ☐ Male ☐ Transgender ☐ Cisgender ☐ Gender non-conforming ☐ Non-binary / Third gender ☐ Questioning ☐ Prefer not to answer ☐ Another ☐ Undefined / Unspecified					

Add	Term	Med	Vis	Relationship*	Dependent first name*	Dependent last name*	Social Security no.*	Date of birth* *(mm/dd/yyyy)*	Primary language *(if different from employee)*
☐	☐	☐	☐	Child[1]					
Gender/sex: ☐ Female ☐ Male ☐ Prefer not to answer				**Gender identity:** ☐ Female ☐ Male ☐ Transgender ☐ Cisgender ☐ Gender non-conforming ☐ Non-binary / Third gender ☐ Questioning ☐ Prefer not to answer ☐ Another ☐ Undefined / Unspecified					

Add	Term	Med	Vis	Relationship*	Dependent first name*	Dependent last name*	Social Security no.*	Date of birth* *(mm/dd/yyyy)*	Primary language *(if different from employee)*
☐	☐	☐	☐	☐ Child[1] ☐ Ward					
Gender/sex: ☐ Female ☐ Male ☐ Prefer not to answer				**Gender identity:** ☐ Female ☐ Male ☐ Transgender ☐ Cisgender ☐ Gender non-conforming ☐ Non-binary / Third gender ☐ Questioning ☐ Prefer not to answer ☐ Another ☐ Undefined / Unspecified					

Section 6 › Other insurance (coordination of benefits)

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

** Enrollment will be delayed if fields with an asterisk are not filled out.*
[1] Please list only eligible dependent children. See Section 4 for dependent children qualifications.

Section 7 › PCP selection

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

Subscriber

Subscriber name		Date of birth (mm/dd/yyyy)	
PCP name			
PCP address	City	State	ZIP

Dependent(s)

Dependent name		Date of birth (mm/dd/yyyy)	
PCP name			
PCP address	City	State	ZIP

Dependent name		Date of birth (mm/dd/yyyy)	
PCP name			
PCP address	City	State	ZIP

Dependent name		Date of birth (mm/dd/yyyy)	
PCP name			
PCP address	City	State	ZIP

Section 8 › 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 seeking a suit 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 seeking a suit 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.*

The employee and their dependents were not induced or pressured by the employer, agent, or health insurer into declining coverage. The employee and/or dependents were informed of the availability of large group health coverage and elected to decline coverage.

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. 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.*

Section 10 › Electronic Delivery Consent

Electronic delivery disclosure

Moda Health may provide communications regarding your health plan benefits, payments and treatment by electronic delivery. If you choose to have these documents delivered electronically, you may call 844-931-1779 and request a paper copy. You may withdraw the consent of electronic delivery by calling 844-931-1779 or change the option at Member Dashboard from our website. Moda Health will send these documents in paper form to you after your selection is updated in our system.

Please keep in mind that communications via email over the internet may not be secure. Although it is unlikely, there is a possibility that information included in an email could be obtained by other parties besides the person to whom it is addressed. We recommend that you do not include personal identifying information such as your birth date, or personal medical information in any emails you send to us. There is no requirement to provide your email address or phone number as a condition to purchasing any goods or services.

Equipment and other applications for electronic delivery

To conduct a transaction online, these are the hardware, software and operating system required, including:

1. a working Internet connection
2. a current web browser that includes 128-bit encryption and with cookies enabled (e.g., Internet Explorer version 11.0 and above, Firefox version 52.0 and above, Chrome version 55.0 and above, or Safari 9.1 and above)
3. a valid email account with an internet service provider and email software
4. an operating system and telecommunications connections to the internet capable of receiving, accessing, displaying, and either printing or storing documents received from us in an electronic form via a plain text-formatted email or HTML formatted email or by access to our website using one of the browsers specified above
5. a computer with sufficient storage space to save past communications and documents
6. an installed printer to print documents.

You are responsible for installation, maintenance and operation of a computer, browser and software or obtaining access to a computer with the required capabilities. Moda Health is not responsible for errors or failures from any malfunction of a computer, browser or software used to access documentation delivered via electronic transmission. Moda Health is also not responsible for computer viruses or related problems associated with use of an online system.

Electronic delivery consent

I consent to receiving communications regarding health plan benefits, payments and treatment by electronic delivery. I understand I may change the delivery method by contacting Moda Health.

I consent to receiving some documents (for example, explanation of benefits and certificate of coverage) through electronic delivery.

I have read the disclosure on electronic delivery. I agree with the requirements. I also certify I have access to documents transmitted via electronic media.

I understand I may withdraw the consent of electronic delivery by calling 844-931-1779 or change the option at Member Dashboard from the Moda Health website. Moda Health will send the communications in paper form to me after my selection is updated in their system.

I agree that I will inform Moda Health as soon as reasonably possible when there is a change in my email address or mobile phone number.

☐ I consent to electronic submission of this enrollment application

☐ I consent to receive communications from Moda Health by electronic delivery and I understand I may withdraw the consent of electronic delivery of documents.

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

moda HEALTH

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 hỗ 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۔ پر کال کریں 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).

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)

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.

โปรดทราบ: หากคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี 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)

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