Oregon Large Employer Group Application (51+) Cover Page

Thank you for choosing Moda Health and Delta Dental.

Please forward the completed copy to:
ModaGroupSales@modahealth.com

New Group Enrollment Checklist for Employers and Agents

Please note, if any of the below items are not completed in full, enrollment will be delayed

Is this an existing Moda Health or Delta Dental group with an active line of coverage? ☐ Yes ☐ No

☐ Group Application (completed and signed by the group and agent)

Does the group have COBRA eligible lines of coverage other than Moda Health (medical coverage)? ☐ Yes ☐ No

☐ Quote sheet for selected plans

☐ Enrollment forms have been reviewed for the following:
- ☐ Enrollment forms/Waiver forms provided for all eligible employees
- ☐ Please include hire dates on all enrollment forms/green enrollment spreadsheet
- ☐ Enrollment forms match census information
- ☐ Moda Select plans are only available to employees living in the Portland metro area (Clackamas, Multnomah and Washington counties). Enrollment forms have been reviewed to verify zip codes (if choosing a Moda Select plan).

☐ First Month's Premium (paid electronically)

☐ Electronic Services Agreement

☐ Late Acknowledgement Agreement (if enrolling past the 10th of the month)

All new group enrollment materials must be received by Moda Health and Delta Dental ***no later than the 10th of the month*** for a first of the following month's effective date.

Oregon Large Employer Group Application (51+)

Effective date: _____

Group information

Legal name			Tax ID #
DBA name (appears on bills):			NAICS:
Physical address (no P.O. box)	City	State	ZIP
Group administrator			
Group administrator phone #			
Group administrator email address			
Renewal date:	Advance renewal notice (days) ☐ 90 days ☐ 120 days ☐ 150 days ☐ 180 days ☐ 210 days ☐ 240 days		
Is the group subject to ERISA (Employee Retirement Income Security Act of 1976)? Note: In general, ERISA does not cover group health plans established or maintained by governmental entities, churches for their employees, or plans which are maintained solely to comply with applicable workers compensation, unemployment or disability laws.	☐ Yes ☐ No		

Form of organization (check all that apply):

☐ Association Filed date: _____ Approval # _____

☐ Trust Filed date: _____ Approval # _____

☐ Bargaining agreement (union)

Effective date: _____

Expiration date: _____

☐ Corporation ☐ LLC ☐ Non-profit ☐ Partnership ☐ S Corporation ☐ Sole proprietor ☐ Government entity

What percentage of the medical premium is to be contributed by the employer? If choosing multiple plans, the minimum contribution is 50% of the plan with the lowest premium.

For employees (minimum 50%): _____ For dependents: _____

What percentage of the dental premium is to be contributed by the employer?

For employees (minimum 50%): _____ For dependents: _____

Existing coverage

Please provide the name for the current insurance carrier(s), both medical and dental:

Medical: _____ Dental: _____

If this plan is replacing an existing plan, will members receive credit from the previous plan? ☐ Yes ☐ No

If Yes, check the type(s) of report(s) below that will be available for applying credit:

☐ Medical deductible ☐ Dental deductible ☐ Other: _____

Group Structure Worksheet

Subgroup setup			
Our standard subgroup setup designates if subscribers are "Active" or have elected "COBRA". Subgroups can be used to categorize your membership by a different billing location or entity. Custom subgroups will create billing statements, separate your members on your invoice and impact reporting (if applicable) for each subgroup defined. If you require additional explanation or assistance with subgroup setup, please speak with your sales representative.			
Subgroup name	**Subgroup billing contact name (if different than group administrator)**	**Subgroup billing address (if different than physical address)**	
Active	Name:	Address:	
	Phone number:	City:	
	Email:	State:	Zip:
COBRA	Name:	Address:	
	Phone number:	City:	
	Email:	State:	Zip:
	Name:	Address:	
	Phone number:	City:	
	Email:	State:	Zip:
	Name:	Address:	
	Phone number:	City:	
	Email:	State:	Zip:
Registered domestic partners are eligible dependents. Is domestic partnership coverage also available by declaration? If yes, do you cover: ☐ Same gender/sex ☐ Opposite gender/sex ☐ Regardless of gender/sex		☐ Yes ☐ No	

Class setup

Our standard setup groups all employees into a single class. If a medical group has out of state employees, we will create an additional class to make it easier to identify the correct plan and network combination.

Classes allow you to define the benefits available to a subset of membership. If all of your employees must work the same hours, meet the same probationary period and will have the same benefits available to them, our standard setup should work.

If you require additional explanation or assistance with class setup, please speak with your sales representative.

Service area for medical groups

Will employees who reside outside of Oregon and Southwest Washington (Clark and Cowlitz counties) be covered by a Moda Health medical plan?

☐ Yes ☐ No

If yes, list state(s): _____

Note: Employees who reside in the state of Hawaii are not eligible to enroll for medical coverage.

How many hours per week must an employee work to be eligible for benefits? (minimum 17.5): _____

Will the minimum hours apply to all eligible employees? ☐ Yes ☐ No

If no, please describe: _____

_____

What is the waiting period an employee must complete before becoming eligible for benefits?

☐ **Date of hire, no waiting period**

OR

1st of the month following:

☐ Date of hire

☐ Date of hire, plus one month orientation period

☐ Date of hire or date of hire when 1st of the month

☐ Date of hire or date of hire when 1st of the month, plus one month orientation period

☐ 30 days

☐ 30 days, plus one month orientation period

☐ 60 days

☐ 60 days, plus one month orientation period

☐ 90 days (dental only)

☐ 90 days, plus one month orientation period (dental only)

☐ Other, please describe _____

Will the eligibility period apply to all eligible employees? ☐ Yes ☐ No

If no, please describe: _____

_____

For employer's initial enrollment only, will the waiting period be waived for all current eligible employees?	☐ Yes ☐ No
If a part-time employee becomes eligible for coverage, does part-time employment count towards the waiting period for full-time employees?	☐ Yes ☐ No

Will all plans be available to all employees? ☐ Yes ☐ No

If no, please describe: _____

_____

Will the Medical and Dental plan be integrated (bundled)? ☐ Yes ☐ No

If yes, indicate which lines are integrated:

☐ **Medical, Dental, Vision** ☐ **Medical, Dental**

COBRA

Moda Health's subsidiary, BenefitHelp Solutions (BHS), provides COBRA administration for Moda Health Medical Groups 51+ employees at no additional cost.

Fees will apply when BHS provides administration for product lines outside of Moda Health and Delta Dental.

If a group has COBRA eligible plans outside of Moda, please contact BHS for COBRA administration fees:

BHS-S&Steam@benefithelpsolutions.com

Does the group use a third-party administrator (TPA) for COBRA or Retiree Administration?

☐ Yes. Please provide the following:

TPA Name
Address
Phone

☐ No. Please answer the following: Will the employer elect COBRA administration through BHS? ☐ Yes ☐ No

If yes, please answer the following questions:

Should BHS charge an additional 48% administrative fee for COBRA participants that meet the disability requirement and are eligible for an additional 11 months of COBRA? ☐ Yes ☐ No

List all company contacts who should have Online COBRA employer portal access:

_____

_____

☐ Check here if Online COBRA broker portal access should be granted. Broker's tax ID number _____

Who will be paying the COBRA premiums? ☐ Employer ☐ TPA – Do not print bill ☐ TPA – Print bill

Payment Information

Premium payment method

☐ ACH pull (complete EFT information) ☐ ACH push (payment will be set up through eBill)

Effective date (If a transfer date is not selected, we will default to the 1st of the month.)	Date of transfer ☐ 25th (prior month for future month's premium) ☐ 1st

Instructions for EFT payments

1. Provide your banking information
2. If you have ACH security in place, please add company ID 3930989307 to your ACH filter list
3. For a checking account, please attach a VOIDED check
4. For a savings account, attach a deposit slip

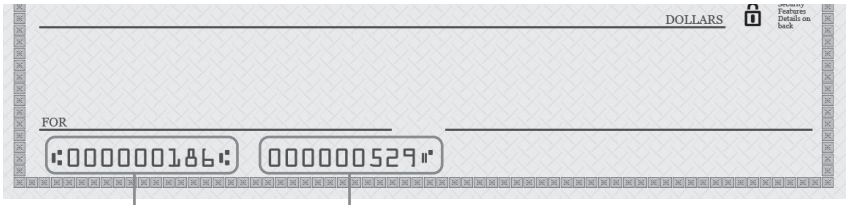
Effective date	Date of transfer ☐ 25th (prior month for future month's premium) ☐ 1st

Transaction type

☐ Binder and reoccuring payments ☐ Reoccuring payments only ☐ Binder payment only

I (we) hereby authorize Moda Health hereinafter called COMPANY, to initiate debit entries to my (our) Checking account indicated below and the depository named below, hereinafter called DEPOSITORY, to debit the same to such account.

Depository name	Branch	
City	State	ZIP
Bank routing no.	Account no.	



Agent / Group Signature Page

Agent information	
Agent name	Agency
NPN:	Tax ID# (For tax purposes, please indicate if tax ID or S/S #): ☐ Tax ID ☐ S/S #

I hereby make application to Moda Health/Delta Dental, on behalf of the Group, for the Group Policies indicated in this group application.

I understand that there is no coverage in effect until Moda Health/Delta Dental accepts this Application and premium deposit and establishes an effective date. If this Application is not accepted, the premium deposit will be refunded.

I hereby certify all eligible employees are enrolling in the selected Group Policies and all enrolling employees meet the eligibility requirements specified above. In addition, I hereby appoint the above agent as our Agent of Record to represent us in matters of group insurance benefits provided by Moda Health/Delta Dental. This appointment is in effect on the same day as this Policy and will remain in force until rescinded in writing.

Applicable for medical policies only: I hereby acknowledge responsibility on behalf of the Group to provide the Summary of Benefits & Coverage (SBC), Uniform Glossary, and the Initial Notice of HIPAA Special Enrollment Rights and Exclusion Periods to all employees on or before the date they enroll in the selected Group Policies.

Authorization

By signing below, I agree that the signature will be the electronic representation of my signature and initials for all purposes when I (or my agent) uses them on documents, including legally binding contracts.

Authorized signature for GROUP X	Authorized signer's title
Authorized signer's printed Name X	Date

Authorized AGENT signature X	
Authorized agent's printed name X	Date

Marketing representative signature X	Date

Late Acknowledgment

Moda Health and Delta Dental of Oregon and Alaska normally require new group applications be submitted and received by the 10th of the month prior to the effective date. At your direction, we have accepted the application for this group after the 10th.

Because we are accepting this information after the 10th, we are asking you to acknowledge that all aspects of your group's set-up may not be completed by the 1st. Your group's information may not be completely set up in the system, the member's identification cards may not be ready and in the member's hands prior to the effective date.

Moda Health and Delta Dental is committed to completing this process in a timely fashion and will commit to providing your group set-up as timely as possible. Again, thank you for your business!

Best Regards,

Jason Gootee

VP, Sales & Strategic Market Development

X _____ X _____

Group Administrator/Authorized Representative **Producer/Agent**

Nondiscrimination notice

We follow federal civil rights laws. We do not discriminate based on race, religion, 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:

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

Scott White coordinates our nondiscrimination work:

Scott White,
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.

modahealth.com

2688-NDS-MH+DD-Commercial (01/24)

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。

અગત્યનુ઼ં: 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)