

## Moda Health 1-50 Group Plan Confirmation Form

*Please complete the below application and submit to Moda Health 20 days prior to the effective date of your policy to avoid disruption of coverage. If you have any questions, please call 503-243-3948.*

<b>Legal Name</b>			
<b>Group Number</b>		<b>Effective Date of Renewal</b>	

**What plan options would you like to be renewed with?**

Medical Plan Option 1	
Medical Plan Option 2	
Medical Plan Option 3	

I have reviewed the creditable coverage status of prescription drug plans for Alaska small employer plans at [www.modahealth.com/employers/compliance.shtml](http://www.modahealth.com/employers/compliance.shtml) and consulted with the Group before selection of medical plans.

Delta Dental Plan Option	
Orthodontia Plan Option	

Rates					
	EE only	EE + Spouse	EE + Family	EE + Child	Total
Medical Employee Counts					
Medical Plan 1					
<b>Subtotal Medical</b>					
Medical Employee Counts					
Medical Plan 2					
<b>Subtotal Medical</b>					
Medical Employee Counts					
Medical Plan 3					
<b>Subtotal Medical</b>					
Dental Employee Counts					
Dental					
Orthodontia					
<b>Subtotal Dental</b>					
<b>Total Billed</b>					

<b>Would you like to update your probationary period? If yes, what probationary period do you select?</b>		
First of the month following:		
<b>OR</b> Coverage begins following		days of employment with the group.
<b>Are you making any changes to your contribution, eligibility, or plan?</b>		Yes    No
If so, please outline the changes below:		

## Alaska Standardized Group Profile Form

This form must be completed for all new and renewing groups to determine whether a group qualifies as a small employer.

Moda Health must treat an employer as a small employer if the employer has at least one but not more than 50 employees on average during the preceding calendar year and has at least one employee enrolled on the first day of the plan year.

<b>Are you a Controlled Group?</b>	Yes	No
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If Yes, please list Controlled and Affiliated Groups:

If you are a controlled or affiliated group of employers as described under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986, Moda Health must treat all employees within the affiliated group as a single group for purposes of determining group size. You must fill out one group size determination form for the entire controlled group. If a controlled group is determined as a large employer, each affiliated employer is part of the large employer even if separately the employer would not meet the definition of a large employer. Therefore, each affiliated employer is considered a large group for the purposes of group size determination.

### SECTION A

<b>Is this an employee only plan?</b>	Yes	No
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**1. On average, how many employees did the employer employ during the preceding calendar year?**

If less than 1 enrolled, no Alaska small group exists.  
 If 1 to 50, the group is a small group.  
 If more than 50, the group is a large group and not eligible as an Alaska small group.

**2 If an employer was not in existence through the preceding calendar year, what is the average number of employees the employer reasonably expects to employ on business days in the current calendar year?**

If less than 1 enrolled, no Alaska small group exists.  
 If 1 to 50, the group is a small group.  
 If more than 50, the group is a large group and not eligible as an Alaska small group.

**3. How many employees will be employed on the date that coverage is to take effect?**

The employer must have at least 1 employee enrolled on the date coverage will take effect in order to be issued small group coverage.

**4. Out of the number of employees indicated in question #1 or #2 , indicate the number of employees not eligible for coverage due to group's eligibility rules:**

**5. Total number of group eligible employees (#3 - #4):**

To be an eligible employee an independent contractor must have federal taxes deducted from income related to the Group's business

**6. Out of the number of employees indicated in question #5, indicate the number of employees waiving due to other group or individual coverage:**

**7. Total employee count (for participation requirement) (#5 - #6):**

**8. Out of the number of employees indicated in question #7, indicate the number of employees opting out of coverage:**

Count employees choosing not to take coverage here.

**9. Total number of employees enrolling (#7 - #8):**

<b>10.Total number COBRA (include primary insured's only):</b>		
<b>11.Total number of employees and COBRA enrollees (#9 + #10):</b>		
<b>12. What type of employees are you offering coverage to:</b> a. All employees working 20 hours or more per week b. All employees working the minimum hours required by your specific company in order to qualify for benefits (i.e. 40 hours per week)		
<b>13. To determine if your group is subject to COBRA, indicate how many employees you employed on a typical business day in the previous calendar year:</b> Do not count self-employed individuals, independent contractors, and members of the board of directors. (If the group had 20 or more employees during at least 50% of the previous calendar year, the plan qualifies for COBRA continuation).		1 - 19 Employees  20 - 50 Employees
<b>14. To determine if your group is subject to Medicare Secondary Payer provision, do you have 20 or more employees for each working day in each 20 or more calendar weeks in the current calendar year or the preceding calendar year?</b> Count all employees on the employment payroll. Do not count retirees, COBRA qualified beneficiaries, individuals on other continuation options or self-employed individuals.		Yes    No
<b>EMPLOYEE PARTICIPATION</b>		
For groups of 1-4, minimum of 100% of eligible employees must participate. For groups of 5-50, a minimum of 70% of eligible employees must participate. For dental only groups of 2-4, a minimum of 100% of eligible employees must participate. For Voluntary Dental plans, a minimum of 25% of eligible employees must participate with a minimum of 10 enrolling.		1 - 4 Employees  5 - 50 Employees
<b>SECTION B</b>		
<b>To the best of my knowledge, I certify that all the information contained herein is correct. I understand that the final rates will be based on actual enrollment and may be different than the rates originally quoted and that additional information may be required to verify eligibility of the group.</b>		
<b>I am the:</b>		
<b>Name (printed please)</b>	<b>Signature:</b>	<b>Date:</b>

# 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.

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**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](https://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](https://hhs.gov/ocr/office/file/index.html).

**Dave Nessler-Cass coordinates our nondiscrimination work:**

Dave Nessler-Cass,  
Chief Compliance Officer  
601 SW Second Ave.  
Portland, OR 97204  
855-232-9111  
[compliance@modahealth.com](mailto:compliance@modahealth.com)

