### **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.

Legal Name					
Group Number	Effective Date of Renewal				
				•	
What plan options would you like to be	e renewed wit	th?			
Medical Plan Option 1					
Medical Plan Option 2					
Medical Plan Option 3					
I have reviewed the creditable covera www.modahealth.com/employers/co plans.	ge status of pr mpliance.shtn	rescription drug all and consulted	plans for Alask I with the Grou	a small employ p before select	er plans at ion of medical
Delta Dental Plan Option					
Orthodontia Plan Option					
Rates					
	EE only	EE + Spouse	EE + Family	EE + Child	Total
Medical Employee Counts					
Medical Plan 1					
Subtotal Medical					
Medical Employee Counts					
Medical Plan 2					
Subtotal Medical					
Medical Employee Counts					
Medical Plan 3					
Subtotal Medical					
Dental Employee Counts					
Dental					
Orthodontia					
Subtotal Dental					
Total Billed					
	II.	-			
Would you like to update your probation	ary period? If	ves. what proba	ationary period	do vou select?	
First of the month following:		,, p	, p	,	
OR Coverage begins following		days of employn	nent with the g	roup.	
Are you making any changes to your cont				Yes No	
If so, please outline the changes below:	, 0				
in 30, picase outline the changes below.					
is 30, 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.

## Are you a Controlled Group? Yes No

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 Yes Is this an employee only plan? No 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):





10.Total number CO	OBRA (include primary ins	sured's only)	):					
11.Total number of	employees and COBRA er	nrollees (#9	+ #10):					
12. What type of e	mployees are you offering	g coverage t	o:					
a. All employees worki	ng 20 hours or more per wee	k						
b. All employees working the minimum hours required by your specific company in order to qualify for								
benefits (i.e. 40 hours	per week)							
	our group is subject to COBR				1 -	19 Employees		
	pical business day in the pre		•		20	50 Employees		
Do not count self-employed individuals, independent contractors, and members of the board of directors. (If				•	20 -	30 Employees		
the group had 20 or more employees during at least 50% of the previous calendar year, the plan qualifies for COBRA continuation).				stor				
·								
_	our group is subject to Medi				Yes	No		
		•	20 or more calendar weeks in th	ne				
•	r or the preceding calendar y		s CORPA qualified honoficiaries					
Count all employees on the employment payroll. Do not count retirees, COBRA qualified beneficiaries, individuals on other continuation options or self-employed individuals.								
EMPLOYEE PARTICI	PATION							
For groups of 1-4, mini	mum of 100% of eligible employ	ees must part	icipate.		1 - 4	4 Employees		
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.				5 - 5	50 Employees			
For Voluntary Dental plans, a minimum of 25% of eligible employees must participate with a minimum of 10 enrolling.								
	iiiig.							
SECTION B								
To the best of my k	nowledge, I certify that al	I the inform	ation contained herein is cor	rect. I u	ınders	stand		
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.								
I am the:								
Name (printed		Signature:		Date:				
please)		•		<b></b>				
·	<u>l</u>				11			





## 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

# 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

## 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.





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 222-605-877 (الهاتف النصي: 711)

بولتے ہیں تو ان (URDU) توجہ دیں: اگر آپ اردو اعانت آپ کے لیے بلا معاوضہ دستیاہ ہے۔ 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 222-605-877) 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 (ભાષાં તર કરેલ ભાષા અહીં દશાર્વો) બોલો છો તો તે ભાષામાં તમારે માટે વિના મૂલ્યે સહાય ઉપલબ્ધ છે. 1-877-605-3229 (TTY: 711) પર કૉલ કરો

ໂປດຊາບ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການຊ່ວ ຍເຫຼືອດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສັຍ ຄ່າ. 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)

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)

ត្រវចងចាំ៖ បើអ្នកនិយាយភាសាខ្មែរ ហើយត្រវ ការសេវាកម្មជំនួយផ្នែកភាសាដោយឥតគិតថ្លៃ៍ គឺមានផ្ដល់ជូនលោកអ្នក។ 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.

โปรดหราบ: หากคุณพูดภาษาไหย คุณ สามารถใช้บริการช่วยเหลือด้านภาษา ได้ฟรี 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)



