

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
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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

Is this an employee only plan?	Yes	No
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<p>1. On average, how many employees did the employer employ during the preceding calendar year?</p> <p>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.</p>	
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<p>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?</p> <p>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.</p>	
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<p>3. How many employees will be employed on the date that coverage is to take effect?</p> <p>The employer must have at least 1 employee enrolled on the date coverage will take effect in order to be issued small group coverage.</p>	
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<p>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:</p>	
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<p>5. Total number of group eligible employees (#3 - #4):</p> <p>To be an eligible employee an independent contractor must have federal taxes deducted from income related to the Group's business</p>	
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<p>6. Out of the number of employees indicated in question #5, indicate the number of employees waiving due to other group or individual coverage:</p>	
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<p>7. Total employee count (for participation requirement) (#5 - #6):</p>	
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<p>8. Out of the number of employees indicated in question #7, indicate the number of employees opting out of coverage:</p> <p>Count employees choosing not to take coverage here.</p>	
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<p>9. Total number of employees enrolling (#7 - #8):</p>	
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10.Total number COBRA (include primary insured's only):		
11.Total number of employees and COBRA enrollees (#9 + #10):		
12. What type of employees are you offering coverage to: 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)		
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: 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
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? 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
EMPLOYEE PARTICIPATION		
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
SECTION 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.		
I am the:		
Name (<i>printed please</i>)		Signature: _____ Date: _____

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 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

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 مجاناً. اتصل برقم (الهاتف النصي): 1-877-605-3229 (711)

بوتے ہیں تو سانی (URDU) توجہ دیں: اگر آپ اردو 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)

توجہ: در صورتی کہ بہ فارسی صحبت می کنید، خدمات ترجمہ بہ صورت رایگان برای شما موجود است. با تماس بگیرد. (TTY: 711) 1-877-605-3229

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 Sprachassistentendienste 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 (TTY、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。

အကူအညီ: ဤတမ်း (အမျိုးအနွယ် အမျိုးအနွယ်) အလိုအတိုင်း ဖြစ်တိုင်း အမျိုးအနွယ် တမ်းအား မှား မှား မှား မှား ဖြစ်ပါသည်။ 1-877-605-3229 (TTY: 711) ပါ အလိုအတိုင်း

ໂປດຊາຍ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການຊ່ວຍເຫຼືອດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. 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 llocano, 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)