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 renewed with?

Medical Plan Option 1	
Medical Plan Option 2	
Medical Plan Option 3	
Vision Plan Rider	

A maximum of 3 plans may be selected from our plan portfolio with a minimum of 1 member enrolled in each

For Part D creditable plans, please review the creditable coverage status of prescription drug plans for Oregon small employer plans at www.modahealth.com/employers/compliance.shtml

Synergy plans have enrollment limitations based on where the employee resides. If you have employees that reside outside of Oregon and are enrolling in the health plan, we require you to select an additional non- Synergy plan to ensure the best possible experience for those members who reside outside of the Synergy network service area.

Only those groups with 26 or more enrolling are eligible for Orthodontia Plans

Delta Dental Plan Option	
Delta Dental Orthodontia Rider	
DirectOption Plan	

Rates					
	EE only	**EE + Spouse**	**EE + Family**	**EE + Child**	**Total**
Medical Employee Counts					0
					$ 0.00
Vision					$ 0.00
Subtotal Medical	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
Medical Employee Counts					0
					$ 0.00
Vision					$ 0.00
Subtotal Medical	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
Medical Employee Counts					0
					$ 0.00
Vision					$ 0.00
Subtotal Medical	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
Dental Employee Counts					0
					$ 0.00
					$ 0.00
Subtotal Dental	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
DirectOption Employee Counts					0
					$ 0.00
Subtotal DO Dental	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
Total Billed	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00

moda HEALTH

DELTA DENTAL
Delta Dental of Oregon & Alaska

Would you like to update your probationary period? If yes, what probationary period do you select?	
Date of hire?	Yes ☐ No ☐
The first of the month following:	
Are you making any changes to your contribution, eligibility, or plan?	Yes ☐ No ☐
If so, please outline the changes below:	

moda HEALTH

DELTA DENTAL

Delta Dental of Oregon & Alaska

Group Size Determination 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 profile 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 large employer. Therefore each affiliated employer is considered a large group for the purpose of group size determination.

Employee Counting Instructions:

a) Total the number of employees working 130 hours for each month of the preceding calendar year.
b) Total the number of hours worked by employees working less than 130 hours for each month of the preceding calendar year, but do not include more than 120 hours per employee in a month and divide by 120. This is your Full Time Equivalent (FTE) count of the preceding calendar year.
c) Add the numbers from a and b together and divide by 12. This is your group size.

When counting employees to determine group size, do not count a sole proprietor, a partner in a partnership, a 2-percent S corporation shareholder, the spouse of a person who is a sole proprietor, a temporary, seasonal, leased, or contracted employee, a retired employee, or a former employee on continuation coverage.

SECTION A

Is this an employee only plan?	Yes ◯ No ◯
1. On average, how many full time employees did the employer have during the preceding calendar year? Total the number of employees working 130 hours or more for each month of the preceding calendar year and divide by 12.	
2. On average how many Full Time Equivalent (FTE) employees did the employer have during the preceding calendar year? Total the number of hours worked by employees working less than 130 hours for each month of the preceding calendar year, but do not include more than 120 hours per employee in a month and divide by 120. Then divide the total number by 12.	
3. Total employee count (for determining group size) (#1+#2) If less than 1 enrolled, no Oregon 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 Oregon small group.	
4. How many employees does the employer expect to have on the date coverage will take effect? The employer must have at least one employee enrolled on the date coverage will take effect in order to be issued small group coverage.	
5. How many employees will be eligible for coverage based on the group's eligibility rules?	
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):	

moda HEALTH

DELTA DENTAL
Delta Dental of Oregon & Alaska

10. Total number COBRA/State Continuation enrollees (include primary insured's only):	
11. Total number of employees and COBRA or state continuation enrollees *(#9 + #10)*:	
12. 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). Otherwise, the group qualifies for state continuation.	◯ 1 - 19 Employees ◯ 20 - 50 Employees
13. What type of employees are you offering coverage to: a. All employees working 17.5 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)	
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	
15. For groups of 1-4 employees, a minimum of 100% of eligible employees must participate. For groups of 5-50 employees, a minimum of 70% of eligible employees must participate. For Voluntary Dental Plans, a minimum of 25% of eligible employees must participate with a minimum of 10 enrolling. For Voluntary Direct Option, minimum of 25% of eligible employees must participate with a minimum of 2 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 *(printed please):*		**Signature:**		**Date:**	

moda HEALTH

DELTA DENTAL

Delta Dental of Oregon & Alaska

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

Dental plans in Oregon provided by Oregon Dental Service, dba Delta Dental Plan of Oregon. Dental plans in Alaska provided by Delta Dental of Alaska. Health plans provided by Moda Health Plan, Inc. Individual medical plans in Alaska provided by Moda Assurance Company. 39969758 (9/19)

moda HEALTH

DELTA DENTAL
Delta Dental of Oregon & Alaska

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。

અગત્યનુ઼ : 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)

modahealth.com

moda HEALTH

DELTA DENTAL

Delta Dental of Oregon & Alaska

39969758 (9/19)