Individual health plan application

Oregon Individuals and families

Please complete all sections of this application. If the application is incomplete or additional information is required, your effective date may be delayed. Illegible and incomplete applications will be returned. We must receive your complete submission prior to the requested effective date.

Section 1 > Eligibility

To be eligible to apply for one of our Oregon Individual health plans, you must be an Oregon resident and continue to live in our service area for six months out of the year; and not be eligible for Medicare.

Section 2 > Application type

Effective dates are assigned by Moda Health on the 1st of the month following receipt of the completed application or on the date required by Oregon regulations. For consideration of a particular date in the future (not more than 90 days from the date you sign this form), **please include date:** _____

Please select the reason your are submitting this application:

- ☐ **New member**
- ☐ **Child/Children only (ages 0-25)**
- ☐ **Coverage upgrade**
- ☐ **Addition of a dependent to an existing policy**

  To add spouse/domestic partner outside of open enrollment, please include a copy of the marriage certificate/registration. To add an adopted child, please include the adoption/placement paperwork.

  If you check this box, please provide the following information:

Existing policyholder	
ID no. of policy	
Spouse/date of marriage	Registered Domestic Partner (RDP)/date of registration
Newborn/date of birth	Child/date of birth
Adopted child/date of placement or custody	
Other	

To view the summary of benefits and coverage (SBC) for these medical plans, please visit www.modahealth.com.

A uniform glossary to help you understand the most common terms in healthcare is available at www.cciio.cms.gov. You may also obtain a free paper copy of the SBC or uniform glossary by contacting Moda Health at 877-277-7073.

Section 3 > Plan selection

I select the following health plan:

Be Protected
☐ $750 deductible

Be Focused*
☐ $500 deductible

Standard Gold Plan
☐ $1,300 deductible

Be Prepared
☐ $1,000 deductible

Be Smart
☐ $3,000 deductible

Be Aligned*
☐ $2,500 deductible

Standard Silver Plan
☐ $2,500 deductible

Be Connected*
☐ $4,250 deductible

Be Savvy
☐ $5,250 deductible

Standard Bronze Plan
☐ $5,000 deductible

I select the following dental plans:

- ☐ Delta Dental PPO plan
- ☐ Delta Dental EPO plan

**These plans require residency in Multnomah, Clackamas, Washington, Marion, Yamhill or Polk counties.*

Ready to submit? Mail, fax or email this form to Moda Health:

Mail: Moda Health, Billing and Eligibility, 601 S.W. Second Ave., Portland, OR 97204-3156

Fax: 503-219-3696 **Email:** Scan and send to individualapp@modahealth.com.

DELTA DENTAL

Questions? Contact Moda Health at 877-277-7073.

Section 4 > Applicant information

Last name	First name	M.I.	Social Security no.
Marital status ☐ Single ☐ Married ☐ Registered Domestic Partner (RDP)	Date of birth (mm/dd/yyyy)	Age	Gender ☐ M ☐ F
Race ☐ Alaska Native ☐ American Indian ☐ White ☐ Other (please specify)		Primary language ☐ English ☐ Spanish ☐ Other (please specify)	

Residence address	City	State	ZIP
Mailing address	City	State	ZIP

Email address	Home phone	Business phone

Please list all family members to be covered (children under 26 years old) on this health plan.
Attach additional copies of this page, if necessary, to list other family members to be included on this application.

Spouse/RDP last name	First name	M.I.	Social Security no.
Email address	Date of birth (mm/dd/yyyy)	Age	Gender ☐ M ☐ F
Race ☐ Alaska Native ☐ American Indian ☐ White ☐ Other (please specify)		Primary language ☐ English ☐ Spanish ☐ Other (please specify)	

Last name of family member	First name	Date of birth (mm/dd/yyyy)	Gender	Race	Primary language
Child			☐ M ☐ F	☐ Alaska Native ☐ American Indian ☐ White ☐ Other (please specify)	☐ English ☐ Spanish ☐ Other (please specify)
Child			☐ M ☐ F	☐ Alaska Native ☐ American Indian ☐ White ☐ Other (please specify)	☐ English ☐ Spanish ☐ Other (please specify)
Child			☐ M ☐ F	☐ Alaska Native ☐ American Indian ☐ White ☐ Other (please specify)	☐ English ☐ Spanish ☐ Other (please specify)
Child			☐ M ☐ F	☐ Alaska Native ☐ American Indian ☐ White ☐ Other (please specify)	☐ English ☐ Spanish ☐ Other (please specify)
Child			☐ M ☐ F	☐ Alaska Native ☐ American Indian ☐ White ☐ Other (please specify)	☐ English ☐ Spanish ☐ Other (please specify)
Child			☐ M ☐ F	☐ Alaska Native ☐ American Indian ☐ White ☐ Other (please specify)	☐ English ☐ Spanish ☐ Other (please specify)
Child			☐ M ☐ F	☐ Alaska Native ☐ American Indian ☐ White ☐ Other (please specify)	☐ English ☐ Spanish ☐ Other (please specify)

Explain relationship to the applicant for any member listed above whose last name is different from the applicant

Section 5 › Health information

Health related information provided by the applicant will be used only for health care management purposes. The applicant's coverage cannot and will not be denied, terminated, delayed, limited, or rescinded based on the applicant's responses or lack of responses to the following questions.

To identify applicants who may benefit from our health management programs, please answer the following questions:

1. Do you or any dependents have a disability and/or a chronic health condition (e.g., asthma, lung disease, depression, diabetes, heart disease, or spine/joint)? ☐ Yes ☐ No
2. Have you or any dependents been advised in the last 12 months that hospitalization, surgery or treatment is needed or pending? ☐ Yes ☐ No

Please list the name of all individuals to be enrolled for coverage to which you've answered yes to question 1 or 2, and provide a reason:

Name	Reason

Section 6 › Producer of record (to be completed by producer only)

I (the producer) certify I have explained the eligibility provisions to the applicant. I have not made any statements about benefits, conditions or limitations of the contract except through written material furnished by Moda Health and provided the Oregon Disclosure Information required. I have informed the applicant that the effective date of coverage is assigned only by Moda Health.

In order for you to become the Producer of Record, you must be actively appointed with Moda Health. Please sign and date below.

Producer name	Agency name	Phone		
Doug Ellsworth	Health Benefits Solution, Inc	503-922-2903		
Address	**City**	**State**	**ZIP**	
5200 SW Meadows Rd, Suite 150	Lake Oswego	OR	97035	

I certify that the information supplied to me by the applicant has been truly and accurately recorded.

Producer signature (required)	Signature date
X	

Note to producer: Payment does not have to be included with the application, but the first payment is due by the effective date to activate coverage.

Section 7 › Certification of completion and correctness

Be sure to sign and date the application within this section. A spouse/RDP or any dependent(s) over age 18 is required to sign the application.

I affirm that the answers given in this application are complete and correct. I have provided these answers as part of the application procedure required by Moda Health for enrollment. I understand that if this application , except for section 5, contains any intentional misrepresentations of material fact Moda Health may deny coverage, modify or cancel the contract, rescind the contract, or take other legal action. I will promptly inform Moda Health in writing if anything happens before my coverage takes effect that makes this application incomplete or incorrect. I understand and agree that no coverage shall be in force until approved by Moda Health. If approved, coverage will be in force as of the effective date determined by Moda Health. Moda Health may contact me to clarify answers on this application. As the applicant, I understand I have the right to inspect the information in my file.

I acknowledge that I have read and agree to the terms of this application.

If I am purchasing a plan that does not include embedded pediatric dental benefits, I attest that I and other dependents on the application have obtained a pediatric dental plan certified by Cover Oregon.

Signature of applicant, parent or legal guardian, if applicant is under age 18 X	Signature date
Signature of applicant's legal spouse/RDP, if applying for coverage X	Signature date
Signature of dependent(s), age 18 and older, if applying for coverage X	Signature date
Signature of dependent(s), age 18 and older, if applying for coverage X	Signature date
Print name of parent or legal guardian for minors on this application X	Relationship*

**If not parent, please attach legal documentation if you are the legal guardian or Holder of Power of Attorney.*

Section 8 › Payment

We offer three payment options for you to choose from. Please select the option that is best for you:

☐ 1. Pay with eBill, our electronic billing service. Access and pay your premium invoice online in myModa, your personalized member website*. With eBill, you can:

   a. Choose to receive an email notification when a bill is ready

   b. Choose to receive an email notification before a bill is due

   c. Set up payment methods

   d. Set up a recurring payment

   *Setting up a myModa account is easy. Once you receive your Moda Health ID card, visit modahealth.com and follow the instructions to create a myModa account.

☐ 2. Pay with electronic funds transfer (EFT). **Please fill out the EFT authorization agreement below.** Funds transfer automatically around the fifth calendar day of each month.

☐ 3. Paper bill. If you select this option, we'll send you a paper bill in the mail every month.

EFT authorization agreement

1. Complete and sign below as account holder for monthly automatic bank deduction of premium.
2. Attach a photocopy of your voided personal check from the account to be drafted.
3. Submit the completed application and appropriate documents with your application.

Applicant	Account holder
Name of bank	

I (or we, if this is a joint account) authorize Moda Health to charge my (our) checking account for monthly premiums for the above named individual. I also authorize my bank named here to honor these monthly charges. This authority will remain in effect until I give my bank a reasonable chance to act upon it. I can stop payment by notifying my bank before my account has been charged.

Account holder signature X	Signature date

You may be billed for the premium payment necessary to begin electronic deductions. If you wish to cancel your bank deductions, we must receive written notice 15 days before the next deduction date.