Individual dental plan application

Oregon individuals and families

Section 1 › Eligibility

To be eligible to apply for one of our Oregon individual dental plans, you must be an Oregon resident and continue to live in our service area for six months out of the year. If you terminate this coverage, you will be required to wait two years before you may re-apply, except for a special enrollment qualifying event.

Section 2 › Plan selection

I select the following dental plan for requested effective date of _____ / _____ / _____ :

☐ Delta Dental Preferred Provider Option (PPO) plan

☐ Delta Dental Exclusive Provider Option (EPO) plan

Please note: Both dental plan options meet the pediatric dental benefit requirements of the Affordable Care Act.

Section 3 › Applicant information

Last name	First name	M.I.	Social Security no.		
Mailing address		City		State	ZIP
Date of birth (mm/dd/yyyy)	Gender ☐ M ☐ F	Age	Primary language ☐ English ☐ Spanish ☐ Other (please specify)		
Email address			Home phone		

Section 4 › Dependent information

Please list dependent children from youngest to oldest up to the dependent age maximum of 26 years old (age maximum may differ for child(ren)-only plans). Parents are not required enrollees for child(ren)-only plans, but one parent should be listed above as applicant.

☐ Check here if applicant is applying for coverage only for dependent(s) listed below and not themselves.

Name (first, middle initial, last)	Date of birth (mm/dd/yyyy)	Gender	Social Security no.
Spouse/registered domestic partner	_____ / _____ / _____	☐ M ☐ F	
Dependent	_____ / _____ / _____	☐ M ☐ F	
Dependent	_____ / _____ / _____	☐ M ☐ F	
Dependent	_____ / _____ / _____	☐ M ☐ F	
Dependent	_____ / _____ / _____	☐ M ☐ F	

For applicants and dependents age 19 and over:

Do you have 12 months of prior dental insurance with no more than a 90-day break in coverage? ☐ Yes ☐ No
If yes, please provide the following:

a. Name of individual enrolled in prior plan: _____

b. Carrier name: _____ c. Carrier telephone number : _____

d. Effective:_____ /_____ / _____ e. Termed: _____ /_____ / _____

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

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

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

Questions? Contact us at 877-277-7073.

modahealth.com

over ›

Section 5 › 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 the account holder for a monthly automatic bank deduction of your 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	Signature date
X	

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.

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

I (the agent) 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. I have informed the applicant that the effective date of coverage is assigned only by Moda Health.

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

Agent name	Agency name 20-8047918	Phone
Douglas 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.

Agent signature (required)	Signature date
X	

Note to agent: Payment does not have to be included with the application, but coverage will not be effectuated until the premium is received.

Section 7 › Applicant authorization

I understand that complete submission is required before the desired effective date in order to process this application. If my application does not otherwise meet the eligibility requirements as stipulated, Moda Health will notify me in writing and my payment will be returned if provided. Coverage will not be effective until the premium is received.

Applicant signature (required)	Signature date
X	

(Provide signature of minor's representative for any applicant(s) under the age of 18)