DELTA DENTAL®

Apply online by visiting choosemoda.com.
Questions? We're here to help. Call us at 855-718-1767.

2016 | Individual dental plan application

for Oregon individuals and families

Please complete all sections of this application and send it to us. If the application is incomplete or we need more information, your effective date may be delayed. Be sure information is clearly written. If we can't read something, we will return your application to you.

Section 1 › Application type

☐ New policy/subscriber ☐ Add dependent to existing plan ☐ Plan change only*

Existing Delta Dental subscriber name	Existing subscriber ID

**Plan change is only available during open enrollment or special enrollment.*

Section 2 › Eligibility and residency

To be eligible to apply for one of our Oregon individual dental plans, you must be an Oregon resident and live in our service area for six months out of the year. Members aren't eligible if they terminated from Delta Dental individual dental coverage in the past two years unless they had continuous group dental coverage since leaving.

☐ **I confirm I meet the eligibility and residency requirements.**

Section 3 › Plan selection

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

☐ Delta Dental PPO – $0
☐ Delta Dental Exclusive – $0
☐ Delta Dental PPO Bright Smiles – $0
☐ Delta Dental Premier – $50
☐ No dental coverage

Section 4 › Subscriber information

Is this a child- or children-only plan? Children age 26 or older must be on their own policy.
☐ No ☐ Yes. If yes, please list the youngest child as the subscriber.

Last name	First name	M.I.

Date of birth *(mm/dd/yyyy)*	Social Security number	Gender ☐ M ☐ F

Race

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Caucasian ☐ Hispanic or Latino ☐ Native Hawaiian or other Pacific Islander
☐ Other (please specify) _____

Language preference

☐ English ☐ Spanish ☐ Other (please specify) _____

Residence address	City	State	ZIP

Mailing address (if different)	City	State	ZIP

Email address (required to go paperless)	Primary phone	Secondary phone

Section 5 › Dependent Information — spouse or registered domestic partner (RDP)

Please complete this section for spouse or RDP to be covered on this dental plan.

Relationship ☐ Spouse ☐ RDP	Last name	First name	M.I.

Date of birth *(mm/dd/yyyy)*	Social Security number	Gender ☐ M ☐ F

Race

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Caucasian ☐ Hispanic or Latino ☐ Native Hawaiian or other Pacific Islander
☐ Other (please specify) _____

Language preference

☐ English ☐ Spanish ☐ Other (please specify) _____

Section 6 > Dependent Information — children

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

Last name	First name	
Date of birth *(mm/dd/yyyy)*	Social Security number	Gender ☐ M ☐ F

Last name	First name	
Date of birth *(mm/dd/yyyy)*	Social Security number	Gender ☐ M ☐ F

Last name	First name	
Date of birth *(mm/dd/yyyy)*	Social Security number	Gender ☐ M ☐ F

Last name	First name	
Date of birth *(mm/dd/yyyy)*	Social Security number	Gender ☐ M ☐ F

Last name	First name	
Date of birth *(mm/dd/yyyy)*	Social Security number	Gender ☐ M ☐ F

Please explain relationship to the applicant for any member listed above whose last name is different from the applicant or is not a natural or adopted child of the applicant.

If any children listed above have a different race or primary language than the applicant, please list their name, race and primary language here.

Section 7 › Credit toward benefit waiting period (for new dental coverage)

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?
☐ No ☐ Yes. If yes, please provide the following:

Name of individual(s) enrolled in prior dental plan		
Prior insurance company	Prior insurance company phone	Prior subscriber ID
Coverage effective date *(mm/dd/yyyy)*	Coveage end date *(mm/dd/yyyy)*	

Section 8 › Payment method

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

☐ **eBill, our electronic billing service**. Access and pay your premium invoice online in myModa, your personalized member website. **Your premium invoices will be paperless,** and you can set up recurring payments or initiate payment each month. Setting up a myModa account is easy. Once you receive your ID card, visit modahealth.com and follow the instructions to create a myModa account.

☐ **Electronic funds transfer (EFT)**. **Please fill out the EFT authorization agreement below.** EFT initiates around the fifth of the month and typically takes one or two days to post to your account. Your initial payment may initiate on the 25th of the month. Your premium invoice will be paperless and located in the eBill section of myModa.

☐ **Paper bill**. If you select this option, we'll send you a paper bill in the mail every month. **If the bill needs to go to an address other than your mailing address, please note the billing address below.**

Billing address	City	State	ZIP

EFT authorization agreement

1. Complete and sign below as the account holder for monthly automatic premium deductions from your bank.
2. Attach a photocopy of a voided personal check from the account, or provide the bank routing and account numbers below.

Applicant		Account holder
Name of bank	Routing number	Account number

I authorize Delta Dental of Oregon to charge my 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 want to cancel your bank deductions, we must receive written notice 15 days before the next deduction date.

Section 9 > Agent of record (to be completed by agent only)

I (the agent) certify that 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 Delta Dental. I have informed the applicant that the effective date of coverage is assigned only by Delta Dental.

For you to become the agent of record, you must be actively appointed with Moda Health/Delta Dental. Please sign and date below.

Agent name	Agency name	Phone	Agent/Agency NPN
Jacquelin Sheiner	Coast Professional Services	541-957-7750	6785435

Address	City	State	ZIP
536 NE Winchester St. Ste B	Roseburg	OR	97470

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 the first payment is required to activate coverage.

Section 10 > Basic terms of enrollment

- I understand and agree that this application is not an offer of coverage, and coverage does not begin until this application is received and reviewed by Delta Dental and an effective date of coverage is assigned.
- I understand and agree that this application becomes a part of my plan.
- I understand that no benefits are available under this plan for services or supplies that were received prior to the effective date of coverage.
- I understand that acceptance for coverage requires that individuals listed on this application must be residents of the state of Oregon to apply for and maintain coverage under this plan.
- "Resident" means a person who lives in the state of Oregon and intends to live in the state permanently or indefinitely. Delta Dental may require proof of residency from time to time. Such proof shall include, but not be limited to, the street address of the individual's residence and not a post office box.
- I understand that I may receive benefits that are less than the amount billed by my provider when treatment is not received from a contracted provider.
- I have the right to examine and return the policy within 10 days of receipt.
- Potential changes due to state or federal mandates, effective in January, may alter the benefits or rates of my current plan.
- Regardless of my enrollment date, my plan rate will renew January 1.

Section 11 › Go paperless!

View your explanations of benefits (EOBs) online. Just check the box below, provide your email address in Section 4 and set up a myModa account once you receive your Moda Health ID card. Setting up a myModa account is easy. Just visit modahealth.com and follow the instructions to create a myModa account.

☐ **Send me an email notification when my claims have been processed and when my EOBs, with details about what was paid, are ready to view.**

Section 12 › Certification of completion and correctness

Be sure to sign and date the application below. Your spouse, RDP and any dependents over age 18 are required to sign the application.

I affirm that the answers given on this application are complete and correct to the best of my knowledge. I have provided these answers as part of the application procedure required by Delta Dental to enroll in its insurance coverage. I understand that if this application contains any intentional misrepresentations of material fact that Delta Dental may deny coverage, modify or cancel the contract, rescind the contract or take other legal action. I will promptly inform Delta Dental in writing if anything happens before my coverage takes effect that makes this application incomplete or incorrect. I understand and agree that no coverage will be in force until approved by Delta Dental. If approved, coverage will be in force as of the effective date determined by Delta Dental. Delta Dental 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.

Print name of responsible party[1] if child- or children-only policy X	Relationship[2]
Signature of applicant *(if applicant is under age 18, signature of parent/guardian)* X	Signature date
Signature of applicant's legal spouse or 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

1 *Responsible party: If you are an adult not covered by this plan and you bear financial responsibility or act as the primary caregiver for the subscriber and others covered by this plan, then you are the responsible party*

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

Ready to submit? Mail, fax or email this form to Delta Dental.
Mail: Delta Dental/Moda Health, Billing and Eligibility, 601 SW Second Ave., Portland, OR 97204-3156
Fax: 503-219-3696 **Email:** Scan and send to individualapp@modahealth.com.

New to Delta Dental of Oregon? Visit modahealth.com to log in to myModa and view your member handbook and bill. Once you sign up for myModa and go paperless (see Section 8), you'll receive an email when your first bill is ready.

Questions? Contact us at 855-718-1767.

modahealth.com

Dental plans in Oregon provided by Oregon Dental Service, dba Delta Dental Plan of Oregon.