

Thank you for choosing Moda Health and Delta Dental.

Please forward the completed copy to:
ModaGroupSales@modahealth.com

New Group Enrollment Checklist for Employers and Agents

Please note, if any of the below items are not completed in full, enrollment will be delayed

Is this an existing Moda Health or Delta Dental group with an active line of coverage? Yes No

- Group Application (completed and signed by the group and agent)
- Quote sheet for selected plans
- Enrollment forms/Waiver forms for all eligible employees
 - Please include hire dates on all enrollment forms/green enrollment spreadsheet
 - Enrollment forms must match census information
 - Moda Select plans are only available to employees living in the Portland metro area (Clackamas, Multnomah and Washington counties). Enrollment forms have been reviewed to verify zip codes (if choosing a Moda Select plan).
- Declinations for all employees waiving or opting out (applicable to groups with all levels of participation)
- First Month's Premium (paid electronically)
- ESA Agreement
- EFT (Electronic Funds Transfer) Authorization Form along with a copy of a voided check or bank statement
- Late Acknowledgement Agreement (if enrolling past the 10th of the month)

All new group enrollment materials must be received by
Moda Health and Delta Dental ***no later than the 10th of the month***
for a first of the following month's effective date.

Oregon Master Group Application

Groups Sized 1-50

Group name		Employer tax ID#
Effective date	Renewal date	Rate Finder Quote #
Section 1: Attestation		
Is the group a small employer based on the Group Size Determination Form?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this an employee only plan?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the group subject to COBRA? Count the employees 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 group is subject to COBRA.		<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the group subject to Medicare Secondary Payer (MSP) provision? Count the current total number of full-time employees, part-time employees, seasonal employees and partners. Do not count retirees, COBRA members, individuals on other continuation options or self-employed individuals. If the employee count is 20 or more, the group is subject to MSP.		<input type="checkbox"/> Yes <input type="checkbox"/> No
Will Moda Health cover out of state employees? Employees who reside in the state of Hawaii are not eligible to enroll for medical coverage. If yes, list state(s) and number of employees in each: <hr/> <hr/> <hr/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the group's principal business address in compliance with the ACA? Principal business address is the address required to be used for rating, per 45 CFR 147.102. It may be different than the address a business uses for billing, etc. For most small groups, principal business address is the address of a substantial worksite that is registered with the State. If the business address isn't registered with the State or doesn't represent a substantial worksite, then one of the following addresses should be used for rating. For plans with a statewide network <ul style="list-style-type: none"> The business address within the state where the greatest number of employees work. For plans with a partial-state network <ul style="list-style-type: none"> The business address within the plan's service area where the greatest number of employees work, live or reside as of the beginning of the plan year. If there is no such business address, the zip code that reflects where the greatest number of employees within the plan's service area reside as of the beginning of the plan year. 		<input type="checkbox"/> Yes <input type="checkbox"/> No
The group consents to the following statements. <ol style="list-style-type: none"> I have read and understand the information in this group application. For questions about the information on this group application, I have received advice and counsel from my agent or legal counsel. There is no coverage in effect until this Application and premium deposit are accepted by Moda Health and/or Delta Dental of Oregon an effective date is assigned. If this Application is not accepted, the premium deposit will be refunded. All eligible employees are enrolling in the selected Group Policy and all enrolling employees must meet the eligibility requirements specified above. Minimum premium contribution and participation requirements must be met and maintained for the group to remain eligible for coverage. Employees opting out due to other group or individual coverage are not counted toward the participation requirement. The group's designated representative has reviewed the creditable coverage status of prescription drug plans for Oregon small employer plans at https://modahealth.com/employers/compliance.shtml with the producer before selection of medical plans. 		<input type="checkbox"/> Yes <input type="checkbox"/> No

Section 1: Attestation - cont.

7. The group is responsible for providing the Initial Notice of HIPAA Special Enrollment Rights and Exclusion Periods to all employees on or before the date they enroll in the Group Policy.
8. The group is responsible for providing the Summary of Benefits and Coverage (SBC) to eligible employees at open enrollment and to new hires and newly eligible employees as required under the ACA.
9. The agent listed in this Application is the group’s Agent of Record to represent the group in matters of group insurance benefits provided by Moda Health/Delta Dental of Oregon. This appointment is in effect on the same day as the Application and will remain in force until rescinded in writing.
10. 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.
11. To the best of the group’s knowledge and belief, the statements in this attestation section and all the information provided in this Application is correct.
12. The group understands it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. Moda Health reserve the right to require documentation of employee status and any other criteria related to group and member plan eligibility.
13. The group understands the Moda Select PPO plans do not cover employees who reside outside of Moda Select service area (Clackamas, Multnomah and Washington counties). If the group only offers Moda Select PPO plans, the group affirms they will notify Moda Health and add a Connexus PPO plan when they have employees who reside outside of the Moda Select service area.

Section 2: Group information

The following characters ? | / \ * > < : are not accepted.

Legal name

Principal business address

City

State

ZIP

Physical business address

City

State

ZIP

Is the group’s billing information the same as their legal name and physical address?

Yes No

DBA name (appears on bills)

Mailing address

City

State

ZIP

Is the group administrator the same as the billing contact?

Yes No

Group administrator

Email address

Phone

Billing contact

Email address

Phone

NAICS code

What business entity type is the group registered as? (LLC, sole proprietor, s-corp., etc.)

1. What percentage of your medical premium is contributed by the employer? If choosing multiple plans, the minimum contribution is 50% of the plan with the lowest premium.

Your contribution for employee (minimum is 50%)	Your contribution for dependents
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2. What percentage of your dental premium is contributed by the employer?

If Standard Plan: Your contribution for employee (minimum is 50%) If Voluntary Plan: Your contribution for employee (minimum is 0%)	Your contribution for dependents
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Section 3: Eligibility

1. How many hours per week must employees work to be eligible for benefits? (17.5 minimum) _____

2. What is the eligibility period employees must complete before being eligible for benefits? _____

2a. Time served as a part-time employee will count towards the waiting period when the employee moves to full-time Yes No

2b. Is the group subject to ERISA (Employee Retirement Income Security Act of 1974)? *Note: In general, ERISA does not cover group health plans established or maintained by governmental entities, churches for their employees, or plans which are maintained solely to comply with applicable workers compensation, unemployment, or disability laws.* Yes No

2c. For initial enrollment only, do you want to waive the waiting period for all current eligible employees? Yes No

3. Registered domestic partners are eligible dependents. Is domestic partnership coverage also available by declaration? Yes No

If yes, do you cover: same gender/sex opposite gender/sex regardless of gender/sex

Section 4: Employee participation

1. Medical

- For groups of 1-4, minimum of 100% of eligible employees must participate.
- For groups of 5-50, minimum of 70% of eligible employees must participate.

Dental Only

- Delta Dental or Direct Option
- For dental only groups of 2-4, minimum of 100% of eligible employees and eligible dependents must participate.

Dental and Medical

- Delta Dental
- For groups of 1, minimum of 100% of eligible employees must participate.
- For groups of 5-50, minimum of 70% of eligible employees and 25% of eligible dependents must participate with 2 employees enrolling on each plan.

Voluntary Delta Dental or Direct Option

- For groups of 2-50, minimum of 2 enrolling employees and 25% eligible employees.

Voluntary Delta Dental and Direct Option (dual options)

- For groups of 4-50, minimum of 2 enrolling employees in each plan and 25% eligible employees.

Authorization Agreement For Electronic Funds Transfer (EFT) Debits

Transaction type

Binder/initial and recurring payments Recurring payments only Binder/initial payment only

Effective date	Date of transfer <input type="checkbox"/> 25th (prior month for future month's premium) <input type="checkbox"/> 1st
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Instructions

1. Complete the authorization form
2. If you have ACH security in place, please add company ID 3930989307 to your ACH filter list
3. For a checking account, please attach a VOIDED check
4. For a savings account, attach a deposit slip

Payment

I (we) hereby authorize Moda Health and/or Delta Dental hereinafter called COMPANY, to initiate debit entries to my (our) Checking account indicated below and the depository named below, hereinafter called DEPOSITORY, to debit the same to such account.

Depository name	Branch	
City	State	ZIP
Bank routing no.	Account no.	

DOLLARS  Fedex Details on back	
FOR _____	
 0000000186	 000000529
9-digit routing no.	Account no.

Agent information	
Agent name	Agency name
Agent NPN	Agency tax ID

By signing below, I agree that the signature will be the electronic representation of my signature and initials for all purposes when I (or my agent) use them on documents, including legally binding contracts.

Authorized signature for group X	Title
Authorized signer's printed name	Date
Authorized agent signature X	Date
Authorized agent's printed name	
Moda health/delta dental representative signature X	Date

Electronic Services Agreement

This Electronic Services Agreement (“Agreement”) states the terms and conditions that govern the use of online services by _____ (“Employer”) through Employer’s online account (the “Account”).

1. Employer Dashboard

Employer Dashboard includes the following (individually and collectively, the “Services”):

A. Online Services. Online Services include any or all of the following services dependent upon eligibility criteria: review of employee and dependent enrollment and claims data, electronic entry, modification, termination, designation of primary care physicians, ID card requests, and other group enrollment related functions that may become available from time to time.

Employers using electronic eligibility file processing to manage enrollment and eligibility will be able to access information on the dashboard, but will not be able to add, change or terminate eligibility through the Employer Dashboard. Other functions such as ID card requests, designation of primary care providers and other functions may be available from time to time.

B. eBill. eBill includes the electronic distribution of billing invoices and payment of premiums.

i. Participation. By signing this Agreement, Employer consents to the electronic distribution of billing invoices.

ii. Payment. Payment must be posted by the due date noted on the billing invoice. Please allow up to three days for processing of online payments. Immediate and past-due payments will not be accepted through eBill; Employer should contact their Membership Accounting specialist or Sales and Service representative for immediate or past-due payments.

Employer has the ability to schedule payments for specific dates. Scheduled payments can be changed or cancelled at any time prior to being processed. Moda Health and Delta Dental will not accept scheduled payments on eBill as proof of payment until that payment has been marked “PAID” on the payment history screen.

iii. Account Information. eBill uses email as the primary source of communication. Employer will be notified when statements are available online or if a payment cannot be processed. Employer may view or print invoices through the Account. Employer may change the group’s bill delivery preference or discontinue email notifications at any time by changing their preferences. Employer also has the ability to select to be notified when there is payment confirmation. Employer shall ensure that Employer email information is updated.

C. Other online features, included but not limited to; reporting when applicable, ability to generate or view enrollment census, etc.

D. Online access is based on the role assignments below:

Company Admin: This is the highest level of access available to an employer. Specifically, a Company Admin is able to access all features available online (enrollment, billing and claims data and/or reporting when applicable). Each group will have at least one Company Admin. The Company Admin has the ability to assign roles as outlined below within their organization and manage access to those roles as follows;

Group Admin: Allows access to view employee and dependent eligibility, make changes to enrollment including address changes, termination of coverage, and primary care provider assignments. The above services are not currently available to employers utilizing an electronic eligibility file. The Company Admin can determine if access to claims data or reporting data (when available) is permitted for this role.

Financial Admin: Allows access to view bills, make payments and receive notification of bills electronically. Able to view enrollment data, however there is no access to process enrollment changes or request ID cards. A Company Admin can determine if access to claims data or reporting data (when available) is permitted for this role.

Company Admin will remove any access for any employee who was granted access no later than the last day of employment with the employer.

2. Company Admin Contact Information

The Contact Person is the person within the Employer organization who is designated by the Employer to authorize user access to the Account. If Employer changes the Company Admin Contact Person, Employer shall notify Moda Health and/or Delta Dental in writing no later than five business days after such change.

Company admin contact person		
Phone number	Ext	Company admin email address

3. Agreement

Use or access of approved Services by Employer or Employer's authorized representatives constitutes agreement to the terms and conditions of this Agreement. Moda Health Plan, Inc. ("Moda Health") and Delta Dental Plan of Oregon and Delta Dental of Alaska ("Delta Dental") may amend or change this Agreement from time to time, in its sole discretion, by providing Employer written notice by electronic or regular mail, or by posting the updated terms on Moda Health and Delta Dental's website. Continued use of the Services following such change or amendment will be considered Employer's agreement to the change or amendment.

Employer may discontinue use of the Services at any time if these terms and conditions are unacceptable.

4. Confidentiality

Employer shall maintain the security and confidentiality of the information maintained through the Account, including individually identifiable health information of a member as defined in 45 CFR §160.103 (collectively the "Information"), as required by all applicable state and federal laws. Employer agrees not to use or further disclose the Information for any purpose except as necessary to carry out this Agreement and to administer Employer's health plan. Employer will use appropriate physical, technical and administrative safeguards to prevent use or disclosure of the Information other than as provided for by this Agreement. Employer will maintain confidentiality of user identifications and passwords and prevent any unauthorized individual(s) from accessing the Account and/or using Information in a manner contrary to this Agreement.

5. Access, Passwords, and Security

Employer agrees to follow the security and privacy protocols established by Moda Health and Delta Dental and described in the user guide, website terms of use, or other related documentation that may be provided by Moda Health and Delta Dental (collectively, the "Security and Privacy Protocols"), to ensure that all transactions are authorized and to protect all Information from improper access.

6. Reporting Violations

Employer agrees to immediately notify Moda Health and Delta Dental if Employer becomes aware of any of the following:

- a. Any loss or theft of access codes or passwords
- b. Any unauthorized use of any access codes or passwords
- c. Any unauthorized use of the Account
- d. Any loss, theft or unauthorized use of Information
- e. Any loss or theft of hardware which contains Information

Employer further agrees to make any and all reasonable efforts to correct or mitigate the effects of any such occurrences and to prevent reoccurrence.

7. Enrollment Materials

Employer agrees to retain all written and electronic enrollment materials, including but not limited to, enrollment forms, applications, personal data sheets, and any forms required to update or change employee information (collectively, "Enrollment Materials"), for a period of 10 years from the date they are received by Employer. Employer shall provide Moda Health and Delta Dental with reasonable access to such Enrollment Materials upon request.

8. Indemnification

Employer agrees to indemnify and defend Moda Health and Delta Dental from and against any and all claims, losses, damages, liability, costs and expenses (including but not limited to defense costs and reasonable attorneys' fees) arising from or related to Employer's violation of this Agreement, misuse of the Information, or violation of any third-party's rights, including violation of any proprietary right and invasion of any privacy rights. This obligation will survive the termination of this Agreement.

9. Termination

Moda Health and Delta Dental reserve the right to terminate Employer access to the Account, or any portion of the Services in its sole discretion, at any time, without notice and without limitation, for any reason whatsoever, including but not limited to unauthorized use of Employer access codes or passwords, misuse or unauthorized use of the Information, failure to adhere to policies set forth in the Security and Privacy Protocols, or breach of this Agreement.

10. Assignment

Employer may not assign its rights, interests or obligations or any part thereof under the Agreement without prior written permission of Moda Health and Delta Dental.

11. Severability

If any provision of this Agreement shall be invalid or unenforceable in any respect for any reason, the validity and enforceability of any such provision in any other respect and of the remaining provisions of this Agreement shall not be in any way impaired.

12. Terms of Use

Employer shall abide by any additional Terms of Use posted on the Moda Health and Delta Dental website.

Employer represents and warrants that the person signing this Agreement has the authority to do so, and is entering into this Agreement on behalf of Employer and all existing and future employees.

The individual signing this Agreement on behalf the Employer must be the owner of the business in a sole proprietorship; a partner in a partnership; the designated principal in a limited partnership, corporation or other licensed entity; an officer; or supervisor or manager at the Employer entity.

By signing this Agreement, Employer acknowledges that Employer has read, understands and accepts the terms and conditions as stated in this Agreement.

Employer	
Signature X	Title
Date	Tax identification #

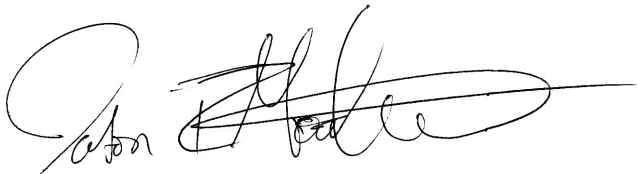
Welcome

Moda Health and Delta Dental of Oregon and Alaska normally requires new group applications be submitted and received by the 10th of the month prior to the effective date. At your direction, we have accepted the application for this group after the 10th.

Because we are accepting this information after the 10th, we are asking you to acknowledge that all aspects of your group's set-up may not be completed by the 1st. Your group's information may not be completely set up in the system, the member's identification cards may not be ready and in the member's hands prior to the effective date.

Moda Health and Delta Dental is committed to completing this process in a timely fashion and will commit to providing your group set-up as timely as possible. Again, thank you for your business!

Best Regards,



Jason Gootee

VP, Sales & Strategic Market Development

X

Group Administrator/Authorized Representative

X

Producer/Agent

Nondiscrimination notice

We follow federal civil rights laws. We do not discriminate based on race, religion, 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:

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.

Scott White coordinates our nondiscrimination work:

Scott White,
Compliance Officer
601 SW Second Ave.
Portland, OR 97204
855-232-9111
compliance@modahealth.com

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. Delta Dental is a trademark of Delta Dental Plans Association. Health plans provided by Moda Health Plan, Inc. Individual medical plans in Alaska provided by Moda Assurance Company.



