2021 Alaska Individual Medicare supplement application

Please mail your completed application to:
Moda Health Plan, Inc., Attn: Membership Accounting, 601 S.W. Second Ave., Portland, OR 97204-3156
Email: Scan and send to individualapp@modahealth.com.
phone 844-235-8012 • fax 503-219-3696 • modahealth.com/medicare

This application must be completed and signed in black or blue ink. All enrollment questions must be answered legibly and to the best of your knowledge. If your application is incomplete or unsigned, it will be returned to you and your effective date may be delayed.

Enrollment information

Last name	First name		Middle initial
Social Security no.	Gender	Date of birth	Age (65 and older at enrollment)

Alaska residence address

Residence street address		
City	State	ZIP
Home telephone no.	Borough	

Mailing address (if different)

Name (c/o)	Relationship to applicant		
Address	City	State	ZIP
Email address			
Primary language: ☐ English ☐ Spanish ☐ Other: _____	Have you used any tobacco products within the last 12 months? ☐ Yes ☐ No		

Health insurance Social Security Act

Please copy the information from your Medicare Identification Card into the area below and attach a copy of your Medicare Identification Card or the letter of verification from the Social Security Administration or Railroad Retirement Board. This information is required to process your application.

Medicare no.:	Entitled to:	Coverage starts:
Please attach a copy of your Medicare card.	Hospital (Part A) Medical (Part B)	_____/_____/_____ _____/_____/_____

Choose a Medicare supplement plan

☐ **Plan A**	☐ **Plan F** (Only applicants first eligible for Medicare before 1/1/2020 may purchase Plan F.)	☐ **Plan High-deductible F** (Only applicants first eligible for Medicare before 1/1/2020 may purchase high-deductible Plan F.)	☐ **Plan G**	☐ **Plan High-deductible G**	☐ **Plan N**

Requested future effective date: 1st of **month:** _____ **year:** _____

Statements

- It is an eligibility requirement at the time of enrollment that the applicant is age 65 and older and an Alaska resident.
- You do not need more than one Medicare supplement policy. If you currently have a Medicare supplement policy, you cannot be enrolled unless you intend to replace your current coverage.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility.
- Counseling services may be available to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB).

Please answer each of the questions to the best of your knowledge:

1. (a) Did you turn age 65 in the last six months?	☐ Yes ☐ No
(b) Did you enroll in Medicare Part B in the last six months?	☐ Yes ☐ No
(c) If yes, what is the effective date? _____ /_____ /_____	
2. Are you covered for medical assistance through the state Medicaid program? (NOTICE TO APPLICANT: If you are participating in a "spend-down program" and have not met your "share of cost," please answer **no** to this question.)	☐ Yes ☐ No
If yes,	
(a) Will Medicaid pay your premiums for this Medicare supplement policy?	☐ Yes ☐ No
(b) Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium?	☐ Yes ☐ No
3. (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave the end date blank. START: _____ /_____ /_____ END: _____ /_____ /_____	
(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?	☐ Yes ☐ No
(c) Was this your first time in this type of Medicare plan?	☐ Yes ☐ No
(d) Did you drop a Medicare supplement policy to enroll in the Medicare plan?	☐ Yes ☐ No
4. (a) Do you have another Medicare supplement policy in force?	☐ Yes ☐ No
(b) If so, with what company, and what plan do you have? _____	
(c) If so, do you intend to replace your current Medicare supplement policy with this policy?	☐ Yes ☐ No

5. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union or individual plan)? (a) If so, with what company and what kind of policy?_____ (b) What are your dates of coverage under the other policy? If you are still covered under the other policy, leave end date blank. START: _____ /_____ /_____ END: _____ /_____ /_____ **If you are replacing current Medicare supplement coverage, please complete the enclosed "Notice to Applicant Regarding Replacement of Medicare Supplement Coverage" form.**	☐ Yes ☐ No

Open enrollment

1. Are you applying for coverage within the six-month period beginning with the first day of the first month you enrolled for benefits under Medicare Part B? (You must also have Medicare Part A to enroll.)	☐ Yes ☐ No

If the answer above is "Yes," please attach proof of eligibility and do not complete the "Personal History Questions" section.

Protected enrollment periods

Complete this section if you are not applying during your open enrollment period.

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, as outlined in the scenarios below, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. **Please answer all questions.**

You are applying for coverage within 63 days from the date your previous Medicare coverage ended and:

1. Your Medicare Advantage plan or Program of All-Inclusive Care for the Elderly (PACE) terminates or no longer provides service in your area, or you move out of the service area.	☐ Yes ☐ No
2. You were covered by an employer's group health plan or a state Medicaid plan as described in Title XIX of the Social Security Act that provides health benefits, and the plan terminates your benefits or no longer provides benefits.	☐ Yes ☐ No
3. Your Medicare supplement policy and enrollment terminates because the insurer becomes insolvent or bankrupt.	☐ Yes ☐ No
4. Your Medicare supplement insurer has violated a material provision of the policy or the producer materially misrepresented the plan's provisions in marketing the plan.	☐ Yes ☐ No
5. You terminated your Medicare supplement policy and enrolled in a Medicare Advantage plan and voluntarily disenrolled from that plan within the first 12 months of enrolling. (You may re-enroll in the same Medicare supplement policy you had previously if available from the same issuer; however, if that Medicare supplement policy is not available, you may enroll in plans A, F, high-deductible F, G, high-deductible G or N from us.)	☐ Yes ☐ No
6. You joined a Medicare Advantage plan or a PACE program when you were first eligible for Medicare. (Within the first year of joining that plan, if you decide to disenroll, you may enroll in any of our Medicare supplement plans.	☐ Yes ☐ No

Insurance history

If you have had prior health coverage and you are applying within 63 days of prior coverage termination, you may be eligible for credit toward any pre-existing condition period. **Please complete the following:**

Insurance co.	Policy no./ID no.	Type of policy (Medicare, HMO, group, etc.)	
Employer name		Effective date	Termination date
List any prior coverage *(if above coverage was in force less than six months)*			

Personal History Questions - Complete this section only if you are NOT applying during a guaranteed issue period.

Guaranteed issue periods are listed on page 3 within the Protected enrollment periods.

1. Have you been prescribed or taken any prescription medications within the past 12 months? If "YES," please indicate below. If "NO," indicate "None." Agent - This is to assist in preparing the Applicant to answer questions in sections 4 through 6.

Name of Medication, Date Prescribed and Condition _____

(Example: Vytorin, 10/2009, High Cholesterol) _____

2. Height Ft._____In._____Weight Lbs._____

3. Have you ever been diagnosed with diabetes?	☐ Yes ☐ No
4. Have you ever:	
a. been advised by a physician to have or are you currently waiting for an organ transplant?	☐ Yes ☐ No
b. been diagnosed with, treated, or advised to receive treatment for Alzheimer's Disease, dementia, mental incapacity, organic brain disease or any other cognitive disorder?	☐ Yes ☐ No
c. been diagnosed with, treated or advised to receive treatment for Lou Gehrig's disease (ALS), Huntington's disease or any terminal medical condition?	☐ Yes ☐ No
d. been diagnosed with, treated or advised by a licensed member of the medical profession to receive treatment for Systemic Lupus, Osteoporosis with Fractures, or kidney disease or failure requiring dialysis?	☐ Yes ☐ No
e. used insulin to treat or control diabetes?	☐ Yes ☐ No
f. had any type of Diabetes with Complications including retinopathy, neuropathy, nephropathy, peripheral vascular disease, heart disease, stroke, transient ischemic attack (TIA), high blood pressure, or skin ulcers?	☐ Yes ☐ No
g. been in a diabetic coma or had or been advised to have an amputation due to disease or disorder?	☐ Yes ☐ No
h. been diagnosed with, treated or advised to receive treatment for Cirrhosis, Emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders?	☐ Yes ☐ No
i. to the best of your knowledge and belief, within the last 10 years, been told by a member of the medical profession that he or she had a diagnosis of AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or the HIV (Human Immunodeficiency Virus) infection?	☐ Yes ☐ No
j. been diagnosed, treated or advised to receive treatment for any neurological disease or disorder such as Myasthenia Gravis, Multiple or Lateral Sclerosis, or Parkinson's disease?	☐ Yes ☐ No

5. Within the past 2 years have you:	
a. been advised to or do you currently use a wheelchair?	☐ Yes ☐ No
b. been advised to enter or do you reside in a nursing home, assisted living facility, long term care facility, received hospice, attended an adult day care facility, required home health care, or been bedridden?	☐ Yes ☐ No
c. been admitted to a hospital 3 or more times or are you currently admitted to a hospital?	☐ Yes ☐ No
d. been diagnosed, treated or advised to receive treatment for cancer (other than basal cell carcinoma)?	☐ Yes ☐ No
e. been diagnosed, treated or advised to receive treatment for alcoholism or drug abuse, mental or nervous disorder requiring psychiatric care?	☐ Yes ☐ No
f. been diagnosed, treated or advised to receive treatment for heart attack, coronary or carotid artery disease (not including high blood pressure), peripheral vascular disease, congestive heart failure or enlarged heart, stroke, transient ischemic attacks (TIA) or heart rhythm disorders?	☐ Yes ☐ No
g. been diagnosed, treated or advised to receive treatment for degenerative bone disease impacting multiple joints, crippling/disabling or rheumatoid arthritis or been advised to have a joint replacement?	☐ Yes ☐ No
h. been advised to have surgery, medical tests, treatment or therapy that has not yet been performed or undergone testing by a medical professional for which the results have not yet been received?	☐ Yes ☐ No
6. Have you been advised by a physician that surgery may be required within the next 12 months for cataracts or have you used or been advised to use oxygen equipment, respirator or a catheter?	☐ Yes ☐ No

If any question in 4, 5 and 6 is answered "YES," please STOP.
The Applicant is NOT eligible for underwritten Medicare Supplement.

For producer use only

Producers must list any other medical or health insurance policies sold to the applicant.
List policies sold that are still in force: _____
List such policies sold in the past five years that are no longer in force: _____

I (the producer) have explained the eligibility provisions to the applicant. I have not made any statements about benefits, conditions or limitations of the policy except through written material furnished by Moda Health.
I CERTIFY THAT THE INFORMATION SUPPLIED TO ME BY THE APPLICANT HAS BEEN TRULY AND ACCURATELY RECORDED HERE.

Producer name (print or type)			
Agency name		Telephone no.	
Street address	City	State	ZIP
Producer's signature (required)			Date

Note to agent: Payment does not have to be included with the application, but the first payment is required to activate coverage.

Authorization

Be sure to sign and date the application below. Signature applies to "Certification of completeness and correctness," "Authorization for release of information" and "Applicant's statement."

Certification of completion and correctness

I affirm that, to the best of my knowledge, the answers given in this application are complete and correct. I am providing these answers as part of the application procedure required by Moda Health to enroll in its insurance coverage. I understand that if this application contains any material misstatements or omissions, Moda Health may, within the first two years of coverage, deny coverage, modify or cancel the policy, and/or take any other legal action available to it by law. I will promptly inform Moda Health in writing if anything happens before my coverage takes effect that makes this application incomplete or incorrect. Moda Health may phone me to clarify answers on this application. As the applicant, I understand I have the right to inspect the information in my file.

Authorization for release of information

To any physician; healthcare provider; hospital; insurance or reinsurance company; the Medical Information Bureau, Inc. (MIB) or other insurance information exchange:

I authorize you to give medical information (including alcohol, chemical dependency, mental treatment or HIV treatment) you have about me to Moda Health or its representatives. This authorization takes effect on the date shown below. This authorization shall be valid for 24 months from the date following my signature below unless the authorization is revoked. I have the right to revoke this authorization in writing at any time by sending a written request to Moda Health, Privacy Office at 601 S.W. Second Ave., Portland, OR 97204 and stating that I am revoking the authorization. Any uses or disclosures already made with my permission cannot be taken back. A photocopy of this authorization is as valid as the original.

Applicant's statement

I understand that if this application contains material misstatements or omissions, Moda Health may do any or all of the following:

- Cancel the policy as though it were never effective
- Deny benefits under the "pre-existing" clause of the policy, if applicable
- Take any other legal action available to it by law

I understand that my producer is not authorized to make any statements about the benefits, conditions or limitations of the policy except through written materials furnished by Moda Health. If my producer completed any answers on my behalf, I have reread all answers and verified that they are true and complete. I understand that only Moda Health can determine whether to issue a policy to me, and that my producer has no authority to do so.

I am enrolled in Medicare due to age (65 and over). I understand that I am applying for Moda Health Medicare supplement coverage. My signature below also acknowledges that I have received the Moda Health Medicare Supplement packet.

I understand that during a guaranteed issue period, my effective date will be the first day of the month following receipt of my application or other requested future effective date. If I am applying for coverage during a non-guaranteed issued period, my effective date will be the first day of the month following Moda Health approval, and I will be notified in writing within 60 days of receipt of my application. I further understand that each Moda Health Medicare Supplement plan includes a six-month waiting period for pre-existing conditions. Credit toward the waiting period will be given day for day for prior coverage.

I understand, upon acceptance, that this application becomes part of the policy.

Signature of applicant	Date

Please mail your completed application to:

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Email: Scan and send to individualapp@modahealth.com.
phone 844-235-8012 • fax 503-219-3696 • modahealth.com/medicare

Payment method

We offer three payment options for you to choose from.

1. Electronic fund transfer (EFT), see authorization agreement below.
2. Automatic eBill payment through your Member Dashboard.
3. Personal check, money order or cashier's check.

EFT authorization agreement

EFT initiates on the fifth of the month or the following business day and typically takes one or two days to post to your account. Your initial payment may initiate on a later date in the event that the enrollment is processed after the 5th of the month. Your premium invoice will be paperless and located in the eBill section of your Member Dashboard.

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 Moda Health 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.

Billing options

If you are setup for EFT your premium invoice will be paperless. If you are not setup for EFT you will be setup for paper invoices. You may change your billing preference to paperless by going to the eBill section of your Member Dashboard.

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

Notice to applicant regarding replacement of medicare supplement insurance or medicare advantage

Moda Health Plan, Inc.
601 S.W. Second Ave.
Portland, OR 97204

Save a copy of this notice. It may be important to you in the future.

According to your application, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by Moda Health. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find the purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement to applicant by issuer, agent, broker or other representative:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

- ☐ Additional benefits.
- ☐ No change in benefits, but lower premiums.
- ☐ Fewer benefits and lower premiums.
- ☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- ☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.
- ☐ Other, (please specify) _____

1. Note: If Moda Health does not, or is otherwise prohibited from imposing pre-existing condition limitations to the policy being applied for, please skip to statement 2 below. Health conditions that you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Signature of applicant	Date
Printed Name of Applicant	

Signature of Agent, Broker, or other Representative *	Date
Printed Name of Agent, Broker, or other Representative	

* Signature not required for direct response sales.

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:

Medicare Customer Service,
877-299-9062 (TDD/TTY 711)

Medicaid Customer Service,
888-788-9821 (TDD/TTY 711)

Customer Service for all other plans,
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

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

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.

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 بولتے ہیں تو لسانی (URDU) اعانت آپ کے لیے بلا معاوضہ دستیاب ہے۔ 1-877-605-3229 (TTY: 711) پر کال کریں

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。

modahealth.com

અગત્યનું: 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)

moda HEALTH

DELTA DENTAL

Delta Dental of Oregon & Alaska