Enrollment Application and Change of Information Form
Medical Only (51+)

Moda Health use only
Group Number _____
Subscriber Number _____

*Group/Employer _____ *Group ID:_____ *Subgroup ID or Name:_____ *Class:_____

*** Coverage:**

☒ Medical Coverage

Type of Application

☐ New Enrollment or Rehire Effective Date: _____

☐ Open Enrollment

☐ Term Dependent Effective Date: _____
Reason: _____
List Dependent(s) to Term in Dependent section.

☐ COBRA/Continuation
Effective Date: _____
Reason: _____

Changes

☐ Address Change ☐ Name Change
Old Name: _____ New Name:_____

☐ **Add Dependent (s) –** List Dependent (s) to add in Dependent Section. Dependent adds require a qualifying event date unless added during open enrollment.

Newborn Birth Date:_____
Adoption Place Date: _____
(Adoption paperwork required with enrollment)
Marriage Date: _____
Domestic Partnership Affidavit Date:_____
(Marriage certificate and Domestic Partner Affidavit required with enrollment

Court Appointed Guardian Date: _____
(Court order of legal guardianship is required with enrollment
Loss of Group Coverage Date:_____
(CCC required with enrollment)
Returned to Full-Time Student Status Date:_____

State Registered Domestic Partner Date:_____
(Registered domestic partnership certificate required with enrollment)

Please complete this form and sign on the back. Please type or print legibly in ink. Thank you!

* Employee First Name: M.I. *Last	* Birthday Date mm/dd/yy	* Gender	* Date of Employment mm/dd/yy
		☐ M ☐ F	

* Employee Mailing Address: *City *State *Zip	*Employee Social Security #	Home Phone Number

Primary Language	Email Address
☐ English: ☐ Spanish ☐ Other_____	

Relationship code: SP = Spouse, DP = Domestic Partner, RDP = Registered Domestic Partner (DP and RDP only if applicable to your plan)

Add	Term	* Name * First M.I. *Last	*Birth Date	*Gender	*Relationship	*Social Security Number	*Primary Language (If different from employee)	Email Address
☐	☐			☐ M ☐ F	☐ Spouse ☐ DP ☐ RDP			
☐	☐			☐ M ☐ F	Child	N/A		N/A
☐	☐			☐ M ☐ F	Child	N/A		N/A
☐	☐			☐ M ☐ F	Child	N/A		N/A
☐	☐			☐ M ☐ F	☐ Child ☐ Ward	N/A		N/A

Other Health Coverage (Coordination of Benefits)

Will employee or any dependents have **other** health coverage?	☐ Medical ☐ No Other Medical Coverage

*Enrollment will be delayed if fields noted in red or with an asterisk are not filled out

OVER ⇨⇨⇨

Moda Health Enrollment Application

It is VERY important that the employee sign and date below. Thank you!

Are any of the dependent(s) a fulltime college student and/or not living with the employee? If yes, please provide the state, zip code and school name if applicable.

Dependent name: _____State _____ Zip code _____
School Name _____

Dependent name: _____State _____ Zip code _____
School Name _____

Dependent name: _____State _____ Zip code _____
School Name _____

Dependent name: _____State _____ Zip code _____
School Name _____

Pre-existing Condition Exclusion

Were you or any of your dependents covered through another group or individual health plan at any time during the past 90 days before your effective date of coverage under this plan or the first day of any required group eligibility waiting period under this plan?

☐ No

☐ Yes. If yes, please attach your Certificate of Creditable Coverage from your current or prior health plan. A pre-existing period may be reduced by any prior creditable health coverage. You may also submit pay stubs that reflect a premium deduction, explanation of benefit forms, a benefit termination notice from Medicare or Medicaid, or verification by a provider that you had prior health coverage.

Covered Dependent Children Definition

A child is eligible for coverage if he/she meets the dependent eligibility requirements of the employee's plan. See your Member Handbook for details.

The following are eligible dependent children:

- Your natural child
- Your step-child or adopted child
- Children placed with you for adoption
- Newborns born to a covered dependent, for whom you are financially responsible (legal guardianship is required for coverage after the first 21 days)
- Children related by blood or marriage for whom you are the legal guardian. (You will need to attach a signed court order showing legal guardianship)
- Your domestic partner's natural child or adopted child (if applicable to your employer plan)
- Your Registered domestic partner's natural child or adopted child (if applicable to Your employer plan)

Fraud Statement:

It is a crime to knowingly provide false, incomplete, or misleading information to a carrier for the purpose of defrauding the carrier. Penalties include imprisonment, fines, and denial of healthcare benefits.

Please read and sign below.

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law.* Health information requested or disclosed may be related to treatment or services performed by:

- A physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- A clinic, hospital, long term care or other medical facility;
- Any other institution providing care, treatment, consultation, pharmaceuticals or supplies or
- A health carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports dental records, or hospital records (including nursing records and progress notes).

This acknowledgement does not apply to obtaining information regarding HIV/AIDS, Psychotherapy Notes, Alcohol/Drug and Genetic Testing. A separate authorization will be used for information related to these health conditions.

* For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Notice of Privacy Practices. A copy is available by calling the Privacy Office at 503-243-4492.

REQUIRED

I certify that the information provided on this form is true and correct to the best of my knowledge. I acknowledge that my enrollment form will be delayed if all the red fields are not filled out entirely.

*** x** _____ *** Date:** _____