2022 Open Enrollment- Terminated coverage for self & dependent(s) on this dental plan

Dental Enrollment Application
and Change of Information Form

Willamette Dental Insurance, Inc.
6950 NE Campus Way, Hillsboro, Oregon 97124

Willamette Dental Group

Please print your answers clearly in ink and fill out both sides of this form so we can process your application quickly. Thank you.

1 I'm filling out this application because I am...

☐ a new applicant

☐ a retiree

☒ a current member: (select a box below)
- ☐ changing my name
- ☐ changing my address
- ☐ changing my dependents
- ☒ terminating my coverage

due to...
- ☒ open enrollment
- ☐ qualifying event - Type of qualifying event: 31
  Date of qualifying event: End Coverage 12/31/2021

☐ a COBRA member: (select a box below)
- ☐ 18 months
- ☐ 29 months
- ☐ 36 months

Date of Continuation Qualifying Event: _____

2 My employer information is...

Name of Employer	Group ID	Effective Date	
City of Springfield		1/01/2022	
Address	City	State	Zip Code
225 Fifth St	Springfield		97477
Work Telephone Number	Occupation	Date of Hire	

3 My information is...

Self (Last, First, Middle Initial)	Social Security Number	Gender ☐ M ☐ F
Home Address	City/State/Zip	Home Telephone Number
E-mail Address	Date of Birth	Old Name, if applicable

4 I want to enroll my...

Legal Spouse or Domestic Partner (Last, First, Middle Initial)	Social Security Number	Gender ☐ M ☐ F
	Date of Birth ☐ Husband/Wife ☐ Dom. Part.	☐ Add ☐ Delete
Dependent Child (Last, First, Middle Initial)	Social Security Number	Gender ☐ M ☐ F
	Date of Birth	☐ Add ☐ Delete
Dependent Child (Last, First, Middle Initial)	Social Security Number	Gender ☐ M ☐ F
	Date of Birth	☐ Add ☐ Delete
Dependent Child (Last, First, Middle Initial)	Social Security Number	Gender ☐ M ☐ F
	Date of Birth	☐ Add ☐ Delete

Please continue application on back...

Dental Enrollment Application Continued...

Willamette
Dental Group

5 Additional dependents...

Dependent Child (Last, First, Middle Initial)	Social Security Number	Gender ☐ M ☐ F
	Date of Birth	☐ Add ☐ Delete
Dependent Child (Last, First, Middle Initial)	Social Security Number	Gender ☐ M ☐ F
	Date of Birth	☐ Add ☐ Delete

6 Other dental insurance I have...

Are you or any of your dependents covered by another dental plan?

☐ Yes ☐ No

If yes, name of enrollee: _____

Name of Carrier: _____ Policy Number: _____

7 Signatures

I hereby apply for coverage through Willamette Dental Insurance, Inc. for myself and for my listed dependents.

I authorize my employer to make payroll deductions from my salary or wages in the amount required, if any, to cover my contribution to coverage with Willamette Dental Insurance, Inc. I authorize any provider of health services to give Willamette Dental Insurance, Inc., upon request, any information concerning the health, condition, or treatment of any person included under such coverage whenever such information is considered necessary for the proper disposition of a claim in fulfillment of obligations imposed on Willamette Dental Insurance, Inc. by State or Federal law.

I certify that all information supplied in this application is true and complete to the best of my knowledge. I agree to advise Willamette Dental Insurance, Inc. of any change in status within 60 days from the date of change. Limited to two years within filing this form, I understand that my coverage may be null and void if I have provided any information which is false or misleading regarding myself or my dependents on this form or any form filed in conjunction with this plan.

Signature of Primary Applicant	Date of Signature

2022 Open Enrollment

Enrollment application & change of information form

Dual Dental (1 – 99)

moda HEALTH

DELTA DENTAL

Delta Dental of Oregon & Alaska

Moda Health use only

Group number _____ Subscriber number _____

To expedite your application, please print legibly in black or blue ink and return as instructed. Please complete all sections of this application. *If the application is incomplete or additional information is required, your effective date may be delayed.*

Section 1 › Application type

Outside of the open enrollment period, you would need a special enrollment reason to enroll or make changes (for example, add dependents or switch plans). If you are enrolling or making changes due to a special enrollment event, please specify the event below and provide documentation of your life event. The reason I am applying or making a change is:

Open enrollment

Date of event: 12 / 31 / 2021

- ☐ New policy/subscriber
- ☐ Add dependent on existing plan
- ☐ Plan change only
- ☐ *Waiver of coverage (see Section 7)*

Changes *(these can be made outside of open enrollment)*

- ☐ Name change
  New name: _____
  Old name: _____
- ☐ New address
  (please write new address in Section 3)

Effective Date 1/01/2022

Special enrollment

Date of event: _____ / _____ / _____

- ☐ Marriage
- ☐ Registration of domestic partner (RDP)
- ☐ Birth, adoption or placement for adoption
- ☐ Loss of coverage because I turned 26
- ☐ Loss of coverage due to end of marriage or registered domestic partnership (RDP)
- ☐ Involuntary loss of group coverage
- ☐ COBRA/continuation ended due to exhausting benefit
- ☐ Other _____

Section 2 › Coverage

- ☒ **Dental coverage**
  - ☐ Basic Dental Plan
  - ☐ Basic Dental Plus+(with ortho) Plan

Group name	Subgroup	Group no.	Class
City of Springfield		10001700	

Section 3 › Employee information

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

Section 4 › Dependent children eligibility information

Children are eligible to enroll for coverage through age 25. Please see your Member Handbook for additional eligibility information. The following are eligible dependent children:

- Your or your spouse's natural or adopted child
- Children placed with you for adoption
- Newborns born to a covered dependent, for whom you are financially responsible (Guardianship is limited to grandchild beyond 31 days from birth if his/her parent is not a covered dependent under the plan. Proof is required.)
- 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 domestic partners by affidavit can enroll in your employer's plan)
- Your Registered domestic partner's natural or adopted child

** Enrollment will be delayed if fields with an asterisk are not filled out.*

Section 5 › Dependents

Relationship code: **SP** = spouse, **DP** = domestic partner, **RDP** = registered domestic partner *(DP and RDP only if applicable to your plan)*
Please use additional form if needed.

Add	Term	Dependent first name*	Dependent last name*	Social Security no.*	Date of birth* *(mm/dd/yyyy)*	Gender*	Relationship*	Primary language *(if different from employee)*
☐	☐					☐ M ☐ F	☐ SP ☐ DP ☐ RDP	
☐	☐					☐ M ☐ F	Child[1]	
☐	☐					☐ M ☐ F	Child[1]	
☐	☐					☐ M ☐ F	☐ Child[1] ☐ Ward	

Section 6 › Other insurance (coordination of benefits)

Will employee or any dependents have other insurance? ☐ Yes ☐ No

If your Group's size is less than 20 employees, Medicare will be assumed to be the primary payer and we will coordinate benefits as the secondary payer even if you have not elected coverage under Medicare. When your Group's size is 20 employees or more, Medicare will be considered the secondary payer.

Section 7 › Waiver of coverage information NA

Please include the names of all eligible members who will NOT be enrolling. *Please use additional form if needed.*

Person waiving	Reason for waiver	Health plan name	Policy no.	Employer group name
	☐ Individual ☐ Employer group ☐ Medicare ☐ Other _____			
	☐ Individual ☐ Employer group ☐ Medicare ☐ Other _____			

Notice: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may, in the future, be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends.* In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after marriage, birth, adoption or placement for adoption.

** If prior coverage was under Medicaid or a children's health insurance program (CHIP) you must request enrollment within 60 days after the coverage ends.*

Section 8 › Authorization (please read and sign below)

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (people 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.[2] 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;
- An insurance 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.
It is a crime to knowingly provide false, incomplete, or misleading information to a health carrier for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of health coverage.

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 fields with an asterisk are not filled out entirely.

Employee signature*	Signature date*
X	

** Enrollment will be delayed if fields with an asterisk are not filled out.*
1 Please list only eligible dependent children. See Section 5 for dependent children qualifications.
2 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 503-952-5033.

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.

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. Health plans provided by Moda Health Plan, Inc. Individual medical plans in Alaska provided by Moda Assurance Company. 42677508 (9/19)

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

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。

અગત્યનું: જો તમે (ભાષાંતર કરેલ ભાષા અહીં દર્શાવવો) 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)

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