



CareAssist Individual dental plan application

Delta Dental use only Group number _____

Please complete all sections of this application. If the application is incomplete or additional information is required, your effective date may be delayed. Illegible and incomplete applications will be returned. We must receive your complete submission prior to the requested effective date.

Section 1 > Eligibility and residency

To be eligible to apply for one of our Oregon individual dental plans, you must be an Oregon resident and reside 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 2 years unless they had continuous group dental coverage since leaving.

Section 2 > Plan selection

- Delta Dental PPO
\$0 deductible

Section 3 > Application type

- New dental policy

Section 4 > Subscriber information

Last name		First name		M.I.
Date of birth (mm/dd/yyyy)		Social Security no.		Gender <input type="checkbox"/> M <input type="checkbox"/> F
Race <input type="checkbox"/> Alaska Native <input type="checkbox"/> American Indian <input type="checkbox"/> White <input type="checkbox"/> Other (please specify) _____		Language preference <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (please specify) _____		
Residence address		City	State	ZIP
Mailing address (if different)		City	State	ZIP
Email address	Primary phone		Secondary phone	

Section 5 > Credit toward benefit waiting period (for new dental coverage)

For applicants 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 enrolled in prior dental plan		
Carrier name	Carrier subscriber ID	Carrier telephone number
Effective (mm/dd/yyyy)	Termed (mm/dd/yyyy)	



Section 6 > 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 is dependent on: Individual listed on this application must be a resident 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 Jan. 1.

Section 7 > Certification of completion and correctness

Be sure to sign and date the application within this section.

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 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 policy	Relationship ²
Signature of applicant (or parent or legal guardian if applicant is under age 18) X	Signature date

1 *Responsible party: If you are an adult not covered by this plan and you 1) bear financial responsibility and/or 2) act as the primary caregiver for the subscriber 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 view your member handbook and bill. You'll receive an email when your first bill is ready.

Questions? Contact us at 855-718-1767.

modahealth.com