Oregon Optional Supplemental Dental Benefit Enrollment Application

PROVIDENCE
Medicare Advantage Plans
A division of Providence Health Assurance

Provide Your Information

LAST NAME _____ FIRST NAME _____ MEMBER ID (IF CURRENT MEMBER) _____

__ __/__ __/__ __ DATE OF BIRTH _____ E-MAIL ADDRESS _____ ( ) - PHONE NUMBER

ADDRESS _____

CITY _____ COUNTY _____ STATE _____ ZIP CODE _____

Choose Dental Coverage*

Oregon:

☐ **Basic:** Choice 001, Choice 002, Compass, Enrich and Latitude plans only. $33.70 will be added to your medical premium.

☐ **Basic Wrap:** Bridge 1, Bridge 2, Extra 001, Extra 002, Focus, Prime and Timber plans only. $29.40 will be added to your medical premium.

☐ **Enhanced:** Choice 001, Choice 002, Compass, Enrich and Latitude plans only. $46.50 will be added to your medical premium.

☐ **Enhanced Wrap:** Bridge 1, Bridge 2, Extra 001, Extra 002, Focus, Prime and Timber plans only. $42.20 will be added to your medical premium.

For Select Medical plan only:

☐ **Basic Wrap:** $33.70 will be added to your medical premium.

☐ **Enhanced Wrap:** $46.50 will be added to your medical premium.

Will you have other dental coverage? ☐ Yes ☐ No If "yes," please list your other coverage below:

NAME OF OTHER INSURANCE PROVIDER _____ ID # FOR THIS COVERAGE _____ GROUP # FOR THIS COVERAGE _____

*Dental coverage is administered by Dominion Dental Services. I understand enrollment in the plan listed above is optional. I also understand that I must maintain my coverage in Providence Medicare Advantage Plans in order to be enrolled in the optional plan selected. Additionally, I understand that I must pay the optional plan premium in order to maintain my coverage. I will read the optional benefit plan information when I receive it and learn my responsibilities as a member and what services are covered by the plan. I further understand and agree that my signature on this enrollment form serves as my legal commitment to the Plan and its terms. Further, this signature represents my authorization for the release of information regarding services provided to me. Information can be released to practitioners and the organizations providing services, for the purpose of investigation or evaluation of care in connection with a complaint. I hereby certify that I have read, or had read to me, the completed application, and I realize that any false statement or misrepresentation in the application may result in loss of supplemental coverage under the policy.

Please contact Providence Medicare Advantage Plans at 1-800-603-2340 (TTY users should call 711) if you need information in an accessible format or language other than English. Our office hours are seven days a week, 8 a.m. to 8 p.m. (Pacific Time).

Applicant Signature

SIGNATURE _____ TODAY'S DATE __ __ / __ __ / __ __

If you are the authorized representative, please sign above and provide the following information:

NAME _____

ADDRESS _____

CITY _____ COUNTY _____ STATE _____ ZIP CODE _____

PHONE NUMBER ( ) - _____ RELATIONSHIP TO ENROLLEE _____

NOTE: Generally, your coverage will begin the first of the month following the receipt of your completed application. Elections made during the Annual Enrollment Period will not be effective until 01/01/2021.

Providence Medicare Advantage Plans is an HMO, HMO-POS and HMO SNP with Medicare and Oregon Health Plan contracts. Enrollment in Providence Medicare Advantage Plans depends on contract renewal.