Optional Supplemental Benefit Enrollment Application

Dental Coverage*	Routine Vision Coverage^
☐ Basic Option - $33.70 per month ☐ Enhanced Option - $48.20 per month Premium will be added to your medical premium.	☐ $8.80 per month Premium will be added to your medical premium.

Current members of Providence Medicare Advantage Plans, please provide your member ID number: ______________________________

Last name: ____________________ **First Name:** ____________________

Birth date: ____________________**Contact Number:** ____________________

Address: ______________________________

City/State/Zip: ______________________________

Email address: ______________________________

Will you have other coverage? ☐ Yes ☐ No ☐ Dental only ☐ Vision only ☐ Dental & Vision
If "Yes", please list your other coverage:

Name of other insurance provider: ______________________________

ID# for this coverage: ____________________ Group # ____________________

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.

Signature: ______________________________**Today's date:** ____________________
If you are the authorized representative please sign above and complete the fields below:

Relationship to Enrollee: ______________________________

Printed Name: ____________________ Phone number: ____________________

Please note: Your coverage will begin the first of the month following receipt of your completed application.

Providence Medicare Advantage Plans is an HMO, HMO-POS, and HMO SNP plan with a Medicare and Oregon Health Plan contract. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Premiums may change on January 1 of each year. You must continue to pay your Medicare Part B premium.

* Dental coverage is administered by Dominion Dental Services. ^ Vision coverage is administered by VSP.
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