

Enhanced Dental Enrollment Form

Note: If you're enrolling to become a member or are a member of a Priority Health Medicare Advantage plan you can add the Enhanced Dental benefit to your coverage. This option is in addition to the standard dental benefits offered on the following plans **Priority**Medicare ValueSM (HMO-POS), **Priority**MedicareSM (HMO-POS) or **Priority**Medicare SelectSM (PPO). You're not required to enroll in this Enhanced Dental option. You have 60 calendar days from your effective date with a Priority Health Medicare plan to elect this option. By completing this form you will be enrolled in the enhanced optional dental plan and agree to pay an additional monthly premium of \$12.79. Once you are enrolled, you will receive information from Delta Dental including an ID card and certificate of coverage.

If you do want to add enhanced dental, there are 2 ways to enroll:

- Use our secure online form at priorityhealth.com. Type "delta" in the search box.
- Complete and mail this form in the enclosed postage-paid reply envelope.

If you do not have a postage-paid reply envelope, you can send your completed form to:

Priority Health
1231 East Beltline, N.E.
MS 1175
Grand Rapids, MI 49525

To enroll in the Enhanced Dental Plan, please provide the following information:

Priority Health Subscriber ID (if you are already a member)

Last name	First name	M.I.	Coverage effective date ____/____/____ MM DD YYYY
Birth date ____/____/____ MM DD YYYY	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Home phone number	
Permanent residence street address (P.O. Box is not allowed)			
City	County	State	ZIP code

Email address (optional)

I hereby authorize Priority Health to enroll me in this dental plan. I understand that I will have to pay an additional monthly premium of \$12.79 for these benefits.

Paying your plan premium:

You have 2 payment choices to choose from (select one):

- Get a bill monthly and pay the plan directly by mail.
- Electronic funds transfer (EFT) from your bank account each month. **You must enclose a VOIDED check**, otherwise you'll be billed directly for your monthly premium. **If you pay your Medicare Advantage premium by EFT or monthly billing now, you'll automatically use the same method to pay for this enhanced dental plan.**

Note: Social Security deduction is **not** a payment option available for the enhanced dental plan. If you are on Social Security deductions and do not pick an option, you will be billed.

You cannot change how you pay for your Medicare Advantage plan premium with this form. If you want to change how you pay for your Medicare Advantage plan premium, call Priority Health customer service at 888-389-6648 (TTY users should call 711), 8 a.m. – 8 p.m., 7 days a week.

Please read and sign below:

By completing this enrollment application, I agree to the following:

The Enhanced Dental plan is an optional benefit offered by Priority Health Medicare, which has a contract with the federal government. I understand that in order to enroll in the Enhanced Dental plan I must have either a **Priority** Medicare Value, **Priority** Medicare or **Priority** Medicare Select plan. I also understand my enrollment in this optional dental plan is voluntary and is not required for me to keep my Priority Health Medicare plan.

Enrollment in the Enhanced Dental plan is generally for the entire year. Once I'm enrolled I may voluntarily disenroll from this optional benefit by giving advance notice in writing. I'll be disenrolled effective on the first of the month after Priority Health Medicare receives my signed and completed disenrollment request. I won't need to pay monthly premiums for this optional benefit for any month after my disenrollment date. If I pre-paid an entire year for this optional benefit, I'll receive a pro-rated refund for the portion of the year after my disenrollment date.

I understand that I may be involuntarily disenrolled if I do not pay my monthly premium by the first day of the month. If we have not received your Enhanced Dental Plan premium by the first of the month, we will send you a notice telling you that your membership in the Enhanced Dental Plan will end if we do not receive your premium within 90 calendar days

I understand that Enhanced Dental is offered through Delta Dental and that benefits apply to services provided by a Delta Dental PPO or Premier participating dentist. If I use a non-participating Delta Dental provider the plan will cover the benefit at the benefit level listed in my Delta Dental Explanation of Benefits (EOB).

The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I'll be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that this person is authorized under state law to complete this enrollment.

Signature _____	Today's date: ____/____/____ MM DD YYYY
-----------------	---

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

Name: _____

Address: _____

Phone number: _____ Relationship to enrollee: _____

Office Use Only:

Subscriber ID: _____ Effective date of coverage: ____/____/____

Not eligible: _____ Reason: _____

Processing rep: _____ Date processed: ____/____/____

