PacificSource Medicare

PacificSource Community Health Plans
2965 NE Conners Avenue, Bend OR 97701
541.385.5315 888.863.3637
Medicare.PacificSource.com

# 2016 Optional Preventive Dental Enrollment Form

**For current Idaho members adding preventive dental to their Medicare Advantage plan.**

## Please provide your information:

| | | | |
|---|---|---|---|
| Last Name | First Name | | MI |
| Requested Effective Date | PacificSource Medicare Member ID (or Medicare ID) Number | | |
| Permanent Residence Street Address (**PO Box not allowed**) | City | State | ZIP Code |
| Mailing Address (only if different from above) | City | State | ZIP Code |
| Birth Date | Phone | Email (optional) | |

## Check this box to add dental to your PacificSource Medicare Advantage plan.

☐ $24 per month in addition to my monthly plan premium.

## Please read all sections of this document before signing:

I understand that generally, I can only enroll in this voluntary supplemental plan during the Annual Enrollment Period (October 15 – December 7). There may be other times I can enroll. Call PacificSource Medicare for more information. By completing this form, I agree to add dental, which is in addition to my monthly PacificSource Medicare plan premium. I understand that additional dental coverage is subject to the terms and conditions stated in my Evidence of Coverage. I understand I will be responsible for paying this extra amount in addition to my monthly premium through the current payment option I have selected.

**Signature: _____ Today's Date: _____**

Relationship to beneficiary: ☐ Self ☐ Authorized Representative ☐ Other _____

**If you are the authorized representative, you must sign above and complete the following:**

Name: _____ Address: _____

Phone Number: _____ Relationship to Enrollee: _____

I understand 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 form means I have read and understand the contents of this form. If signed by an authorized individual, this signature certifies that: 1) this person is authorized under state law to complete this enrollment, and 2) documentation of this authority is available upon request from Medicare.

## Contact information:

If you have questions, please contact us at (541) 385-5315 in Bend, (541) 225-3771 in Springfield, (208) 433-4612 in Boise, (888) 863-3637 Toll-Free, or (800) 735-2900 TTY. Our hours are:

- October 1 to February 14: 8:00 a.m. to 8:00 p.m. local time zone, seven days a week.
- February 15 to September 30: 8:00 a.m. to 8:00 p.m. local time zone, Monday - Friday.

## Send completed enrollment forms to us:

- **Fax**: (541) 382-4217 or (855) 382-4217 toll-free
- **Email**: medicareapplications@pacificsource.com
- **Mail**: PacificSource Medicare, PO Box 7469, Bend, OR 97708
- **Enroll Online**: www.Medicare.PacificSource.com

PacificSource Community Health Plans is an HMO/PPO plan with a Medicare contract. Enrollment in PacificSource Medicare depends on contract renewal. You must continue to pay your Medicare Part B premium. Premium may change on January 1 of each year.

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