Mail or Fax to:
P.O. Box 30196
Salt Lake City, UT 84130-0196

Fax: 801-442-0357
Ph#: 855-442-9940

selecthealthadvantage.org

SelectHealth Advantage (HMO) Optional Supplemental Benefits Enrollment/Disenrollment Form

The information below describes the Optional Supplemental Benefits you may choose to add to your plan. Enrollment in one of these packages is not required to enroll in SelectHealth Advantage.

A. MEMBER INFORMATION

Name ____

Member ID# (found on your ID Card) ______________________________

Ph# (_______)__________________________

Street Address ____

City______________________________ State __________ ZIP ______________

B. ENROLL IN OPTIONAL SUPPLEMENTAL BENEFITS

Check the appropriate box below to indicate your enrollment in the Optional Supplemental Benefit package of your choice. **Please note:** If you enroll in Optional Supplemental Benefits when you first enroll in SelectHealth Advantage, your effective date is the same as your effective date for SelectHealth Advantage. If you enroll within 30 days of your effective date for SelectHealth Advantage, your Optional Supplemental Benefit coverage will be effective the first of the month following the date this completed form is received by SelectHealth.

☐ **Package #1: Delta Dental Idaho Advantage: $1,000 Annual Plan Coverage Limit**

Monthly premium: $45

This comprehensive dental plan offers coverage for both preventive and corrective services. There are no waiting periods. Services are only covered when you use providers that participate in the Delta Dental Idaho Advantage network.

☐ **Package #2: Delta Dental Idaho Advantage Plus Eyewear: $1,200 Annual Plan Coverage Limit ($1,000 dental + $200 eyewear)**

Monthly premium: $50

This comprehensive dental plan offers the same coverage for both preventive and corrective dental services as package #1. This package also provides coverage for vision hardware through the EyeMed Vision Care® network of providers.

C. DISENROLL FROM OPTIONAL SUPPLEMENTAL BENEFITS

☐ I hereby request disenrollment from my SelectHealth Advantage Optional Supplemental Benefits received under contract by SelectHealth. I understand that this disenrollment will be effective on the last day of the month this request is received by SelectHealth.

D. SIGNATURE

By signing, you agree to the enrollment or disenrollment requested above and acknowledge that your monthly premium will change. To disenroll from the Optional Supplemental Benefits of your SelectHealth Advantage plan, please mark the box in section “C” above before signing.

Member Signature ______________________________________ **Date** ____________

H1994_4231_FINAL_ID Approved

E. IMPORTANT INFORMATION

- This information is not a complete description of benefits. Contact the plan for more information.
- Limitations, copayments, and restrictions may apply.
- Benefits, premiums, and/or copayments/coinsurance may change on January 1 of each year.
- You must continue to pay your Medicare Part B premium.
- This information is available for free in other languages. If you have questions regarding this form or your benefits, contact Member Services at 855-442-9940 (toll-free) Monday through Sunday from 8:00 a.m. to 8:00 p.m. TTY/TDD users should call 800-377-3529 or 711. Member Services also has free language interpreter services available for non-English speakers.
- Esta información está disponible de forma gratuita en otros idiomas. Si usted tiene preguntas sobre este formulario o sus beneficios, contacte a los Servicios para Miembros al 855-442-9900 (llamada gratuita) el lunes al domingo de 8:00 a.m. a 8:00 p.m. los usuarios de TTY/TDD deben llamar al 800-377-3529 o al 711. Los Servicios para Miembros también tiene disponibles los servicios de intérprete de idioma gratis para miembros que no hablan inglés.
- SelectHealth is an HMO plan sponsor with a Medicare contract. Enrollment in SelectHealth Advantage depends on contract renewal.

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