

2017 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.

\$22 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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