



# 2018 Optional Preventive Dental Enrollment Form

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

## Please provide your information

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ MI \_\_\_\_\_

Requested Effective Date \_\_\_\_\_ PacificSource Medicare Member (or Medicare) ID No. \_\_\_\_\_

**Permanent Residence (PO Box not allowed)** Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ County \_\_\_\_\_

**Mailing Address (only if different from above)** Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ County \_\_\_\_\_

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Email \_\_\_\_\_

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

\$24 per month in addition to my monthly 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 and you signed this form, complete the following:**

Name \_\_\_\_\_ Address \_\_\_\_\_

Phone \_\_\_\_\_ 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.

## Submit your completed enrollment form

**Send completed enrollment form to us at:**

**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](http://www.Medicare.PacificSource.com)

## Questions?

**If you have questions, please call our Customer Service Department toll-free at (888) 863-3637 or (800) 735-2900 TTY. We're always happy to help you.**

October 1 - February 14: 8:00 a.m. - 8:00 p.m., seven days a week

February 15 - September 30: 8:00 a.m. - 8:00 p.m., Monday - Friday



PacificSource Community Health Plans is an HMO/PPO plan with a Medicare contract. Enrollment in PacificSource Medicare depends on contract renewal. You will need to keep your Medicare Parts A and B. You must continue to pay your Medicare Part B premium.

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