2024 Supplemental Dental Enrollment Form

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

Please provide your information

First name ______________________ Last name ______________________ M.I. ______

Birth date ______________ Phone ______________ Requested effective date ______________

Email ______________________________ 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 ______________

Check the box next to the dental coverage you wish to add to your PacificSource Medicare Advantage plan (please choose only one)

Comprehensive dental $63 per month* (Explorer Rx 17 only)

Preventive dental $36 per month* (Explorer Rx 17 only)

Note: You may enroll in either plan, but not both. If you are currently enrolled in a PacificSource Medicare dental plan, and chose the other option, you will be automatically disenrolled from your current plan when you are enrolled in your new plan option.

*Both supplemental preventive and comprehensive dental are available for purchase on this plan: Explorer Rx 17 in Missoula County.

Please read all sections of this document before signing

By completing this form, I agree to add supplemental dental coverage. I understand that this additional coverage is subject to the terms and conditions stated in my Evidence of Coverage. I also understand I will be responsible for paying the monthly dental premium in addition to my monthly PacificSource Medicare medical plan premium through my current payment option.

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.

Paying your plan premiums

You can pay your monthly plan premium with one of the options below. Note: If you don't select an option, we'll keep your current option or send you a bill.

Get a monthly bill

Automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check
I get monthly benefits from Social Security RRB

Automatic deduction from your checking account each month. Please include a voided check or provide the following:

Account holder name ____________________ Bank routing number ____________________

Bank account number ____________________ Account type: Checking Savings

Automatic deductions are made on the 5th day of every month. Deductions include any outstanding balance on your account. If the deduction falls on a weekend or holiday, the deduction will occur the next business day. Please provide a voided check (deposit slips not accepted). You can stop deductions from your account by notifying us at the phone number or address on this page at least 30 days prior to the deduction date.

Credit card: Once you're enrolled, we'll send you information about setting up credit card payments.

Submit your completed enrollment form

Send completed enrollment form 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: Medicare.PacificSource.com

Questions?

If you have questions, please call our Customer Service Department toll-free at **888-863-3637,** TTY: 711. We accept all relay calls. We're available:

October 1 – March 31: 8:00 a.m. – 8:00 p.m., seven days a week
April 1 – September 30: 8:00 a.m. – 8:00 p.m., Monday – Friday

PacificSource Community Health Plans is an HMO, HMO D-SNP, and PPO plan with a Medicare contract and a contract with Oregon Health Plan (Medicaid). 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.