

# 2023 Supplemental Dental Enrollment Form

For current Oregon 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 \_\_\_\_\_ PacificSource 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 \_\_\_\_\_

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

Preventive dental \$32 per month\*                      Comprehensive dental \$57 per month

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.

\*Supplemental preventive dental is available for purchase on these plans: Essentials Rx 41 in Lane, Coos, and Curry counties; Explorer Rx 7 in Coos and Curry counties.

## My other insurance information\*\*

Do you, or any person listed on this enrollment form, have other dental insurance coverage, including commercial (employer group or individual dental insurance), or Medicare Advantage dental coverage?

Yes                      No (If no other coverage, skip to the next section.)

Name of other insurance company(ies), including address and phone number, if available:  
\_\_\_\_\_

Name(s) of individual(s) covered: \_\_\_\_\_

Date coverage began: \_\_\_\_\_ Date coverage ended: \_\_\_\_\_

Is coverage active?    Yes                      No    Policy number: \_\_\_\_\_

If group insurance, name of group: \_\_\_\_\_

\*\*Please attach proof of other dental coverage.

## 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 (including any late enrollment penalty that you currently have or may owe) 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. If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it.

**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.

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay PacificSource Medicare the Part D-IRMAA.

**Submit your completed enrollment form**

**Send completed enrollment form to us:**

**Fax:** 541-382-4217 or 855-382-4217 toll-free      **Mail:** PacificSource Medicare, PO Box 7469, Bend, OR 97708  
**Email:** [MedicareApplications@PacificSource.com](mailto:MedicareApplications@PacificSource.com)      **Enroll Online:** [Medicare.PacificSource.com](http://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.