2022 Supplemental Dental Enrollment Form

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

PacificSource Medicare

Please provide your information

First Name _____ Last Name _____ MI _____

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 $24 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.

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 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 at:

Fax: 541-382-4217 or 855-382-4217 toll-free

Mail: PacificSource Medicare | PO Box 7469 | Bend, OR 97708

Email: MedicareApplications@PacificSource.com

Enroll Online: Medicare.PacificSource.com

Questions?

If you have questions, please call our Customer Service Department toll-free at **888-863-3637; TTY 711**, and 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.