# 2019 Optional Preventive Dental Enrollment Form

**For current Oregon and Washington 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

$28 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 31). 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

## 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 - 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/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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