PacificSource Medicare

2018 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 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 under¬stand 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 - 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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