PriorityHealth

# Optional Enhanced Dental and Vision Package Enrollment Form

As a member of a Priority Health Medicare plan, you have the opportunity to add the Enhanced Dental and Vision package to your coverage. You're not required to enroll in this optional benefit. You have two months from the effective date of your Priority Health Medicare plan to elect this package.

## Premiums

**Priority**Medicare Key℠ (HMO-POS)
**Priority**Medicare Vital℠ (PPO)
**Priority**Medicare + Kroger℠ (PPO)
**Premium: $29.00**

**Priority**Medicare℠ (HMO-POS)
**Priority**Medicare Value℠ (HMO-POS)
**Priority**Medicare Merit℠ (PPO)
**Priority**Medicare Select℠ (PPO)
**Priority**Medicare Ideal℠ (PPO)
**Priority**Medicare Edge℠ (PPO)
**Priority**Medicare Compass℠ (PPO)
**Priority**Medicare ONE℠ (HMO-POS)
**Premium: $38.00**

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Note: You do not have to complete this form to receive the standard dental and vision benefits that are part of your Priority Health Medicare Advantage coverage. By completing this form, you are agreeing to enroll in the Enhanced Dental and Vision plan package that corresponds with your Medicare Advantage plan and agree to pay the additional monthly premium. Once you are enrolled, you will receive additional information via mail.

**To add the Enhanced Dental and Vision package, there are three easy ways to enroll:**

- Use our secure online form at *priorityhealth.com/enrollDV*.
- Call us toll-free at 888.356.1355, from 8 a.m.–8 p.m., seven days a week. TTY users should call 711.
- Complete this form and mail it in the enclosed postage-paid reply envelope. Or, you can mail the form to: Priority Health, 1231 East Beltline, N.E., MS 1175, Grand Rapids, MI 49525.

**Eligibility for enrollment**

You must be a current Priority Health member to enroll. This plan will be effective on either the same date as your Medicare Advantage plan or the first of the month after your application is received.

To confirm eligibility, choose one of the following:

☐ My Priority Health Medicare Advantage plan (Effective date ___/_____/___ ) was within two months of today's date.

☐ I am electing to enroll during the annual enrollment period (form must be received by Priority Health between October 15 and December 7).

☐ I am an existing member who would like to enroll using my grace period of January and February.

| **To enroll, please provide the following information:** | | | |
|---|---|---|---|
| Priority Health Medicare Subscriber ID or Medicare number (required) | | | |
| Last name | First name | M.I. | |
| Birth date | | Sex | |
| Phone number that we may use to contact you | | ☐ Landline<br>☐ Cellphone | |
| Permanent residence street address (P.O. Box is not allowed) | | | |
| City | County | State | ZIP code |
| Email address | | | |

**Paying your plan premium**

The way you choose to pay your Medicare Advantage premium will automatically be the same method that's used to pay for this Enhanced Dental and Vision package.

You cannot change how you pay for your Medicare Advantage plan premium with this form. If you want to change how you pay for your Medicare plan premium, call Priority Health customer service toll-free at 888.389.6648, from 8 a.m. – 8 p.m., seven days a week. TTY users should call 711.

**Please read and sign below**

**By completing this enrollment application, I agree to the following:** The Enhanced Dental and Vision package is an optional benefit offered by Priority Health Medicare, which has a contract with the federal government. I understand that in order to enroll in the Enhanced Dental and Vision package I must have either a **Priority**Medicare (HMO-POS), **Priority**Medicare Value (HMO-POS), **Priority**Medicare Merit (PPO), **Priority**Medicare Select (PPO), **Priority**Medicare Key (HMO-POS), **Priority**Medicare Ideal (PPO), **Priority**Medicare Edge (PPO), **Priority**Medicare Vital (PPO), **Priority**Medicare Compass (PPO), **Priority**Medicare + Kroger (PPO) or **Priority**Medicare ONE (HMO-POS) plan. I also understand my enrollment in this optional Enhanced Dental and Vision package is voluntary and is not required for me to keep my Priority Health Medicare plan.

Enrollment in the Enhanced Dental and Vision package is generally for the entire year. Once I'm enrolled I may voluntarily disenroll from this optional benefit by giving advanced notice in writing. I'll be disenrolled effective on the first of the month after Priority Health Medicare receives my signed and completed disenrollment request. I won't need to pay monthly premiums for this optional benefit for any month after my disenrollment date. If I pre-paid an entire year for this optional benefit, I'll receive a prorated refund for the portion of the year after my disenrollment date. I understand that if Priority Health has not received my premium by the first of the month, they will send a notice letting me know that my membership in the Medicare Advantage plan and/or Enhanced Dental and Vision package may end if they do not receive my premium in full within 90 calendar days.

I understand that the dental and vision services included in this package are offered through vendors contracted with Priority Health Medicare. Benefit/coverage details, the amount you pay when using participating and non-participating providers, limits/exclusions, etc. can be found in the Evidence of Coverage document. The dental benefit is offered through Delta Dental. In-network benefits apply to services provided by a Delta Dental Medicare Advantage PPO or Medicare Advantage Premier participating dentist, in Michigan, Ohio or Indiana. Out-of-network benefits apply to services provided by any provider who does not participate in the Delta Dental Medicare Advantage PPO or Medicare Advantage Premier network in Michigan, Ohio or Indiana. The vision benefit is offered through EyeMed. In-network benefits apply to services provided by an EyeMed participating provider. Services provided by non-participating EyeMed providers are reimbursable up to a set dollar amount. Enrollment in this plan is generally for the entire calendar year. Although, I may leave this plan at any time. Please contact us or refer to your EOC (Chapter 4, Section 2.2) for instructions on how to disenroll. This form cannot be used to disenroll from the Enhanced Dental and Vision package.

The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I'll be disenrolled from the plan. I understand that 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 application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that this person is authorized under state law to complete this enrollment.

| Signature ***(Required)*** | Today's date |
|---|---|
| Agent signature<br><br>*You cannot change the Agent of Record for this Medicare Advantage plan with this form.* | Today's date |

**If you are the authorized representative, you must sign above and provide the following information:**

Name

Address

Phone number Relationship to enrollee