2025 Optional Supplemental Dental Benefit Enrollment Application

Providence Medicare Advantage Plans

Provide Your Information

LAST NAME | FIRST NAME | MEMBER ID (IF CURRENT MEMBER)

__ __/__ __/__ __ | E-MAIL ADDRESS (OPTIONAL) | ( ) -

DATE OF BIRTH | PHONE NUMBER

PERMANENT RESIDENCE STREET ADDRESS (DO NOT ENTER A P.O. BOX)

CITY | COUNTY (OPTIONAL) | STATE | ZIP CODE

Mailing Address, if different from your permanent address (P.O. Box allowed)

ADDRESS

CITY | STATE | ZIP CODE

Choose Dental Coverage*

☐ **Basic:** $37.50 will be added to your medical premium.

☐ **Enhanced:** $53.50 will be added to your medical premium.

Will you have other dental coverage? ☐ Yes ☐ No If "yes," please list your other coverage below:

NAME OF OTHER INSURANCE PROVIDER | ID # FOR THIS COVERAGE | GROUP # FOR THIS COVERAGE

*Dental coverage is administered by Delta Dental. I understand enrollment in the plan listed above is optional. I also understand that I must maintain my coverage in Providence Medicare Advantage Plans in order to be enrolled in the optional plan selected. Additionally, I understand that I must pay the optional plan premium in order to maintain my coverage. I will read the optional benefit plan information when I receive it and learn my responsibilities as a member and what services are covered by the plan. I further understand and agree that my signature on this enrollment form serves as my legal commitment to the Plan and its terms. Further, this signature represents my authorization for the release of information regarding services provided to me. Information can be released to practitioners and the organizations providing services, for the purpose of investigation or evaluation of care in connection with a complaint. I hereby certify that I have read, or had read to me, the completed application, and I realize that any false statement or misrepresentation in the application may result in loss of supplemental coverage under the policy.

Please contact Providence Medicare Advantage Plans at 1-800-603-2340 (TTY users should call 711) if you need information in an accessible format or language other than English. Our office hours are seven days a week, 8 a.m. to 8 p.m. (Pacific Time).

Applicant Signature

SIGNATURE | TODAY'S DATE (__/__/__)

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

NAME

ADDRESS

CITY | COUNTY (OPTIONAL) | STATE | ZIP CODE

( ) -

PHONE NUMBER | RELATIONSHIP TO ENROLLEE

NOTE: Generally, your coverage will begin the first of the month following the receipt of your completed application. Elections made during the Annual Enrollment Period will not be effective until 01/01/2025.

Submit your completed and signed form using one of the three options below.

- By mail:
  Providence Medicare Advantage Plans
  P.O. Box 5548
  Portland, OR 97228-5548
- Scan and fax pages to: 503-574-8653
- Scan and email pages to: provMedicare@providence.org