selecthealth ADVANTAGE

Mail or Fax to:
P.O. Box 30196
Salt Lake City, UT 84130-0196
Fax: 801-442-0357
Ph#: 855-442-9940
selecthealth.org/medicare

SelectHealth Advantage® (HMO) Optional Supplemental Benefits Enrollment/Disenrollment Form

The information below describes the Optional Supplemental Benefits you may choose to add to your plan. Enrollment in one of these packages is not required to enroll in SelectHealth Advantage.

A. MEMBER INFORMATION

Name _____

Member ID/Medicare Number (found on your ID Card) _____

Ph# (_____)_____ **Requested Effective Date** _____/_____/_____

Street Address _____

City_____ State _____ ZIP _____

B. ENROLL IN OPTIONAL SUPPLEMENTAL BENEFITS

Check the appropriate box below to indicate your enrollment in the Optional Supplemental Benefit package of your choice. **Please note:** If you enroll in Optional Supplemental Benefits when you first enroll in SelectHealth Advantage, your effective date is the same as your effective date for SelectHealth Advantage. If you enroll within 30 days of your effective date for SelectHealth Advantage, your Optional Supplemental Benefit coverage will be effective the first of the month following the date this completed form is received by SelectHealth.

SelectHealth Advantage ESSENTIAL | WASATCH

❑ Comprehensive Dental: **$35/month** ❑ Comprehensive Dental Plus Eyewear: **$40/month**

SelectHealth Advantage ENHANCED | WASATCH

❑ Comprehensive Dental: **$28/month** ❑ Comprehensive Dental Plus Eyewear: **$33/month**

CACHE VALLEY

❑ Comprehensive Dental: **$35/month** ❑ Comprehensive Dental Plus Eyewear: **$40/month**

SOUTHWEST & CENTRAL UTAH

❑ Comprehensive Dental: **$35/month** ❑ Comprehensive Dental Plus Eyewear: **$40/month**

Premium Payment Option ❑ EFT (please fill out the EFT Authorization form) ❑ Direct Bill ❑ SSA ❑ RRB

C. DISENROLL FROM OPTIONAL SUPPLEMENTAL BENEFITS

❑ I hereby request disenrollment from my SelectHealth Advantage Optional Supplemental Benefits received under contract by SelectHealth. I understand that this disenrollment will be effective on the last day of the month this request is received by SelectHealth.

D. SIGNATURE

By signing, you agree to the enrollment or disenrollment requested above and acknowledge that your monthly premium will change. To disenroll from the Optional Supplemental Benefits of your SelectHealth Advantage plan, please mark the box in section "C" above before signing.

Member Signature _____ **Date** _____

E. IMPORTANT INFORMATION

- This information is not a complete description of benefits. Call Member Services at **855-442-9940** (TTY: 711) for more information.
- This information is available for free in other languages. If you have questions regarding this form or your benefits, contact Member Services at **855-442-9940** (toll-free) Monday through Sunday from 8:00 a.m. to 8:00 p.m. TTY/TDD users should call **800-377-3529** or 711. Member Services also has free language interpreter services available for non-English speakers.
- Esta información está disponible de forma gratuita en otros idiomas. Si usted tiene preguntas sobre este formulario o sus beneficios, contacte a los Servicios para Miembros al **855-442-9900** (llamada gratuita) el lunes al domingo de 8:00 a.m. a 8:00 p.m. los usuarios de TTY/TDD deben llamar al **800-377-3529** o al 711. Los Servicios para Miembros también tiene disponibles los servicios de intérprete de idioma gratis para miembros que no hablan inglés.
- SelectHealth is an HMO plan sponsor with a Medicare contract. Enrollment in SelectHealth Advantage depends on contract renewal.
- SelectHealth complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
- ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-855-442-9900** (TTY: 711).
- 注意：如果您使用繁體中文，您可以免費獲得語 言援助服務。請致電 **1-855-442-9900** (TTY: 711)。