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 Utah 2020 Enrollment/Disenrollment Form

The information below describes the Optional Supplemental Benefits you may choose to add to your plan. Enrollment in these benefits 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

SELECTHEALTH DENTAL COMPREHENSIVE BENEFIT - UTAH

Check the box below if you would like to enroll in the SelectHealth Dental Comprehensive Benefit package. This comprehensive dental plan offers additional coverage for basic and major services. Preventive services are already covered with your SelectHealth Advantage plan.

Premium Amount	$28	
Dental Deductible	$0	
Annual Maximum Plan Payment	$1,000	Combined with preventive
Preventive and Diagnostic		Already covered in your plan
Oral Examinations, Cleanings, and x-rays	$0 copay	
Basic	You pay 50% coinsurance	Things like fillings, extractions, endodontic, and periodontal treatment
Major	You pay 50% coinsurance	Things like crowns, dentures, and implants
Orthodontics	Not covered	

❑ I want to enroll in the SelectHealth Dental Comprehensive Benefit for an additional monthly premium.
Premium Payment Option ❑ EFT (please fill out an EFT Authorization form) ❑ Direct Bill ❑ SSA ❑ RRB

C. DISENROLL FROM OPTIONAL SUPPLEMENTAL BENEFITS

❑ I want to disenroll from the SelectHealth Dental Comprehensive Benefit. 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.

Member Signature ______________________________ **Date** ______________

E. IMPORTANT INFORMATION

- **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 the first month 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.
- Services are only covered when you use providers that participate in the SelectHealth Dental Advantage network with the exception of emergency services, which are covered from any eligible provider (see chapter 4, section 2.2 of your Evidence of Coverage for additional details).
- 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 **1-855-442-9940** (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 **1-855-442-9940** (TTY: 711).

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