CENTRAL HEALTH MEDICARE PLAN

Supplemental Dental Benefit Plan Enrollment Form:

Application Addendum

Applicant Name: _____

This form may be used by enrollees who want to add a Supplemental Dental Benefit Plan to their Central Health Medicare Plan.

- You may enroll in the Supplemental Dental Benefit Plan annually during Medicare's Annual Enrollment Period (October 15–December 7), or within 90 days from your plan effective date.
- The Supplemental Dental Benefit Plan is not available with all Central Health Medicare Plans. Eligible plans and associated monthly premiums are listed below.

Eligible Plan Name	Optional Supplemental Dental Benefit Plan		
	Monthly Premium	Annual benefit limit for in-network services	Annual benefit limit for out-of-network services
Central Health Medicare Plan (HMO) 001	**$45**	**$3,000**	**$1,500**
Central Health Focus Plan (HMO C-SNP) 006	**$45**	**$3,000**	**$1,500**
Central Health Ventura Medicare Plan (HMO) 008	**$45**	**$3,000**	**$1,500**
Central Health San Mateo Medicare Plan (HMO) 018	**$45**	**$3,000**	**$1,500**
Central Health Savings Plan (HMO) 019	**$45**	**$3,000**	**$1,500**
Central Health Jade Plan (HMO) 022	**$45**	**$3,000**	**$1,500**
Central Health Premier Plan I (HMO) 023	**$45**	**$3,000**	**$1,500**
Central Health Embrace Care Plan (HMO C-SNP) 025-1	**$21**	**$3,000**	**$1,500**
Central Health Embrace Care Plan (HMO C-SNP) 025-2	**$21**	**$3,000**	**$1,500**
Central Health Classic Care Plan I (HMO) 027	**$21**	**$3,000**	**$1,500**
Central Health Classic Care Plan II (HMO) 028	**$21**	**$3,000**	**$1,500**
Central Health Part B Savings Plan (HMO) 029	**$21**	**$3,000**	**$1,500**
Central Health Valor Care Plan (HMO) 030	**$21**	**$3,000**	**$1,500**

The monthly premium for the Supplemental Dental Benefit Plan is paid in addition to your Medicare Part B premium. If you fail to pay the monthly premium for the Supplemental Dental Benefit Plan, you will lose the Supplemental Dental Benefit Plan but will remain enrolled in Central Health Medicare Plan. You may enroll again during Medicare's next Annual Enrollment Period.

CENTRAL HEALTH MEDICARE PLAN

Check the box below to add the extra coverage to your plan:

☐ **I would like to add the Supplemental Dental Benefit Plan to my Central Health Medicare Plan.**

PLEASE READ AND SIGN

I understand that this enrollment is for the Supplemental Dental Benefit Plan that will be in addition to my Central Health Medicare Plan benefits. Enrollment in the Supplemental Dental Benefit Plan is limited to certain times of the year.

I understand that as a new member of Central Health Medicare Plan, I may only add the Supplemental Dental Benefit Plan within 90 days from my plan effective date for coverage beginning the first of the following month.

I understand that if I fail to pay the monthly premium for the Supplemental Dental Benefit Plan, I will lose the benefit/coverage but will remain enrolled in Central Health Medicare Plan. I may enroll again during Medicare's Annual Enrollment Period.

I understand I may request to disenroll at any time from this optional benefit by contacting Member Services at the telephone number listed on the bottom of this form. I will be disenrolled on the first of the month, after the month that Central Health Medicare Plan receives my disenrollment request.

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, 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 by Central Health Medicare Plan or by Medicare.

By signing, I agree to the enrollment election requested above and to the additional monthly premium required.

Member Last Name: _____ Member First Name: _____

Member ID Number (optional): _____ Medicare Number: _____

Member Signature: _____ Date: _____

Please select how you would like to pay the monthly premium for your Supplemental Dental Benefit Plan.
☐ Send me a bill every month.
☐ Take it automatically out of my bank account every month. (Please provide information below if you choose this method. Your monthly premium will be taken from your account on the 25th of every month.)

Bank Name: _____ Routing Number: _____

Account Number: _____

For individuals helping enrollee with completing this form, please sign above and provide the following information:

Name: _____

Address: _____

Phone: (_____) _____

Relationship to Enrollee: _____

Please return this completed form with your application:
Fax: 1-626-388-2371
Mail: Central Health Medicare Plan
PO Box 22800
Long Beach, CA 9080
Attention: Enrollment Department

For more information or for assistance with this form, please call Member Services at 1-866-314-2427 (TTY: 711) , 8:00 AM – 8:00 PM PT, 7 days a week (October 1 – March 31) and Monday – Friday (April 1 – September 30).