

Supplemental Dental Benefit Plan Enrollment Form:

Application Addendum	dendum	Add	lication	qqA
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Applicant Name:	
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.

Optional Supplemental Dental Benefi			ntal Benefit Plan
Eligible Plan Name	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.



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 ele	ction requested above and to the additional monthly premium required.		
Member Last Name:	Member First Name:		
Member ID Number (optional):	Medicare Number:		
Member Signature:	Date:		
☐ Send me a bill every month.☐ Take it automatically out of my bank	y the monthly premium for your Supplemental Dental Benefit Plan. account every month. (Please provide information below if you mium will be taken from your account on the 25th of every month.)		
Bank Name:	Routing Number:		
Account Number:			
For individuals helping enrollee with information:	completing this form, please sign above and provide the following		
Name:			
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).