# OPTIONAL SUPPLEMENTAL BENEFIT ENROLLMENT/DISENROLLMENT FORM

Johns Hopkins Advantage MD (HMO and PPO) is pleased to offer supplemental dental benefits to members. Enrollment in optional supplemental dental benefits is not required to enroll in Johns Hopkins Advantage MD.

## MEMBER INFORMATION

| First Name: | Middle Initial: | Last Name: |
|---|---|---|
| Member ID Number (located on the front of your ID card): | | Phone Number: |

Once enrolled, your coverage will continue unless you opt out or stop paying. We will bill you each month, if your payment is not received by the end of the grace period, this coverage will end.

## ADDING OPTIONAL SUPPLEMENTAL COVERAGE **(select all that apply)**

- ☐ I am a current member of **Johns Hopkins Advantage MD** and want to add the optional supplemental dental benefit to my plan for an extra $23 per month.
- ☐ I understand this will increase my monthly premium. My new premium will be:
  - ☐ Johns Hopkins Advantage MD (HMO) $68 per month
  - ☐ Johns Hopkins Advantage MD PPO (PPO) $118 per month
  - ☐ Johns Hopkins Advantage MD Primary (PPO) $28 per month
  - ☐ Johns Hopkins Advantage MD Plus (PPO) $178 per month
- ☐ I understand my current premium payment method (electronic funds transfer or check) will remain the same.

## REMOVING OPTIONAL SUPPLEMENTAL COVERAGE

- ☐ I am a current member of Johns Hopkins Advantage MD and want to remove optional supplemental coverage from my plan. I understand my monthly premium will decrease by $23.

## SIGNATURE

I have carefully read and understand that my monthly premium will change based on my choice to add or remove the optional supplemental coverage. The above stated amounts do not include any Medicare late enrollment penalties for which I may be currently responsible.

**Signature*_____________________________________ Date: _________________________**

*Or the signature of the person authorized to act on your behalf under the laws of the State where you live. If signed by an authorized individual (as described above), this signature certifies that: 1) This person is authorized under State law to complete this disenrollment and 2) documentation of this authority is available upon request by Johns Hopkins Advantage MD or by Medicare.

If you are the authorized representative, you must provide the following:

| First Name: | Middle Initial: | Last Name: |
|---|---|---|
| Address: | | |
| City: | State: | Zip: |
| Phone Number: | Relationship to enrollee: | |

Please mail or fax the completed form to:

Johns Hopkins Advantage MD
P.O. Box 3538
Scranton, PA 18505
Fax: 855-206-9203.

If you have questions about this form or need more information, please contact Member Services at 1-877-293-5325 (TTY: 711), Oct. 1 to March 31, 8 a.m. to 8 p.m., 7 days a week. April 1 to Sept. 30, 8 a.m. to 8 p.m., Monday through Friday. On weekends and holidays, you may need to leave a message.

Johns Hopkins Advantage MD (PPO) and Johns Hopkins Advantage MD (HMO) comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Johns Hopkins Advantage MD does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Foreign Language Assistance; Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-293-5325 (TTY: 711); Chinese: 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 1-877-293-5325 (TTY: 711)。

Johns Hopkins Advantage MD is an HMO and PPO plan with a Medicare contract. Enrollment in Johns Hopkins Advantage MD depends on contract renewal.