Optional Supplemental Benefits (OSB) Enrollment Form For Comprehensive Dental

BayCarePlus Medicare Advantage (HMO) offers optional comprehensive dental benefits to our members for an additional monthly plan premium.

- You may enroll in OSB during Medicare's Annual Enrollment Period (AEP), and up to 30 days before or after the effective date of your initial enrollment.
- Requests made during Medicare's AEP (October 15 – December 7) will have a January 1 effective date. For requests made outside of your AEP election, **BayCare**Plus Medicare Advantage will notify you of your effective date of coverage.
- This form may only be used by our current members who are adding OSB to their existing **BayCare**Plus Medicare Advantage plan.
- This form may only be used when there are no other changes to your existing plan.

Member Name: ____________________

BayCarePlus Member ID: ____________________

Medicare ID# (From your Red, White and Blue Medicare Card): ____________________

Date of Birth (MM/DD/YYYY): ____________________

Please check the box to add Optional Supplemental Benefits:

I am currently enrolled in a plan and wish to add OSB.

☐ Comprehensive Dental Services ($30 per month)

The premium for OSB is paid in addition to your monthly plan premium.

BayCarePlus
Medicare Advantage

Paying your plan premiums

Whether you are enrolled in a premium or non-premium plan, you may pay your plan premium and any applicable Late Enrollment Penalty (LEP) and/or OSB **by automatic deduction from your Social Security (SSA) or Railroad Retirement Board (RRB) benefit check.** You may also choose to pay by Electronic Funds Transfer (EFT) or check via mail each month.

The payment option you select here will override any previous payment option you might have made, and will determine how you pay your total premium, which may include a plan premium as well as the OSB premium and any LEP that is applicable.

If you do not select an option below you will default to Direct Pay and receive a monthly invoice, unless you currently pay your premiums and/or LEP via SSA or RRB benefit check, in which case your OSB premium will also be withheld via this method.

Please select a premium payment option:

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: ____ Social Security ____ RRB

It can take up to 90 days to receive SSA/RRB withhold acceptance. SSA/RRB will begin deducting on the date of acceptance. Members will receive an invoice for any months prior to the withhold acceptance date by SSA/RRB, which will be their responsibility to pay. In limited circumstances, Medicare may not allow for the SSA/RRB deduction option and may instruct the plan to directly bill the member. If this occurs, you will be notified in writing.

☐ Electronic Funds Transfer (EFT) from your bank account each month.

If you choose to have the funds taken directly out of your checking account, this is referred to as Electronic Funds Transfer (EFT). If you elect this method of payment, you will receive a letter from the plan requesting a Voided Check be returned with the letter for account setup. Do not submit a voided check at time of enrollment. Your request will be processed within 60 business days of receipt of returned voided check and letter. Premiums are deducted from your bank account on the 2nd day of the month for the current month's coverage.

☐ Direct Pay

You will receive a monthly invoice containing payment instructions.

By completing this application form:

☐ I understand this enrollment for OSB is in addition to my current **BayCare**Plus Medicare Advantage plan benefits and that the monthly premium for OSB is in addition to my Medicare premium, **BayCare**Plus Medicare Advantage plan premiums, and any applicable Late Enrollment Penalty (LEP) that may apply.

☐ I understand the OSB are only available to members enrolled in a **BayCare**Plus Medicare Advantage plan and that disenrollment from a **BayCare**Plus Medicare Advantage plan will result in automatic disenrollment from the OSB.

☐ I understand that I must get covered care from in-network providers, except for emergency or urgently needed services. If I receive services from an out-of-network provider, I will be responsible for all costs associated with those services.

☐ I understand that if I disenroll from OSB, I won't be eligible to enroll again until the next **BayCare**Plus Medicare Advantage valid OSB enrollment period.

☐ I understand that if I fail to pay the monthly premium for OSB, I will lose OSB but will remain enrolled in **BayCare**Plus Medicare Advantage.

I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), 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 Medicare.

<table>
<tr><td colspan="2">Signature:</td><td colspan="2">Today's Date:</td></tr>
<tr><td colspan="4">If you are the authorized representative, sign above and fill out these fields:</td></tr>
<tr><td>Name:</td><td>Relationship to Enrollee:</td><td colspan="2">Phone Number:</td></tr>
<tr><td>Address:</td><td>City:</td><td>State:</td><td>Zip Code:</td></tr>
</table>

Please return completed application to:
BayCare Select Health Plans
P.O. Box 12487
St. Louis, MO 63132

Please call (866) 947-5821 (TTY: 711) for more information, including free language translation services, regarding your BayCare Select Health Plans plan. Our telephone lines are open 8am to 8pm, seven days a week. You may receive a messaging service on weekends from April 1 through September 30 and holidays. Please leave a message and your call will be returned the next business day. BayCare Select Health Plans is an HMO plan with a Medicare contract. Enrollment in BayCare Select Health Plans depends on contract renewal. You must continue to pay your Medicare Part B premium.

FOR AGENT/OFFICE USE ONLY:

Name of Agent/Broker (if assisted in enrollment): ______________________________

Agent/Broker ID: ______________________________

Agent/Broker Signature: ______________________________ Date: ______________

Application Confirmation Number: ______________________________

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