BayCarePlus
Medicare Advantage

Optional Supplemental Benefits Enrollment Form

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

- You may enroll in the Optional Supplemental Benefits during Medicare's Annual Enrollment Period (AEP), and up to 30 days before or after the effective date of your 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 Optional Supplemental Benefits 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: _____

Member ID: _____

Medicare ID#: _____

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 Optional Supplemental Benefits.

☐ Comprehensive Dental Services ($14 per month)

The premium for Optional Supplemental Benefits is paid in addition to your monthly plan premium.

By completing this application form:

☐ I understand this enrollment for optional supplemental benefits is in addition to my current **BayCare**Plus Medicare Advantage plan benefits and that the monthly premium for the optional supplemental benefits is in addition to my Medicare premium and **BayCare**Plus Medicare Advantage plan premiums that may apply.

☐ I understand the optional supplemental benefits are only available to members enrolled in a **BayCare**Plus Medicare Advantage plan.

☐ 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 my continued enrollment in the optional supplemental benefits is contingent upon continued enrollment in the **BayCare**Plus Medicare Advantage plan. Disenrollment from the **BayCare**Plus Medicare Advantage plan will result in automatic disenrollment from the optional supplemental benefits.

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

☐ I understand that I may disenroll from the optional supplemental benefits at any time and that disenrollment from the optional supplemental benefits will not disenroll me from my **BayCare**Plus Medicare Advantage plan. If I disenroll from the Optional supplemental benefits, I won't be eligible to enroll again until the next **BayCare**Plus Medicare Advantage valid optional supplemental benefits enrollment period.

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.

Signature: _____ Date: _____

If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

Phone: _____

Relationship to Member: _____

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Please return completed application to:

BayCare Select Health Plans
P.O. Box 12487
St. Louis, MO 63132

Please call (866) 947-5820 (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.

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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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