Optional Supplemental Dental Package – 2023

Enrollment Form

As a member of the MyTruAdvantage Medicare Advantage (MA) plan, you have the opportunity to add optional dental coverage. You are not required to enroll in this optional supplemental benefit. This benefit must be chosen within 60 days of the effective date for the MyTruAdvantage Medicare plan.

**This option is in addition to the standard dental benefits offered with your plan and has a separate maximum benefit amount.*

Note: Complete this form when you agree to enroll in the optional plan *and* agree to pay an additional monthly premium of **$25.00**.
Do not complete this form to receive the standard dental benefits that are part of your MyTruAdvantage coverage.

To Enroll in the Optional Supplemental Dental Package

There are two easy ways to add this optional dental benefit to your MyTruAdvantage Choice (PPO), MyTruAdvantage Choice Plus (PPO), MyTruAdvantage Select (HMO), or MyTruAdvantage Select Plus (HMO) Medicare Advantage plans:

1. ***Call*** us toll-free at **1-844-425-4280 for additional information. (TTY users should call 1-800-743-3333 or 711).**

Hours are:

- October 1 – March 31:
  - 7 Days a week, 8:00 a.m. – 8:00 p.m., Local Time
  - On Thanksgiving and Christmas Day, leave a message and it will be returned within 1 business day
- April 1 – September 30:
  - Monday – Friday, 8:00 a.m. – 8:00 p.m., Local Time
  - On weekends and holidays, leave a message and it will be returned within 1 business day

2. Complete this form and mail it to: MyTruAdvantage, P.O. Box 428, Columbus, IN 47202.

Eligibility for enrollment in the Optional Supplemental Dental Package

You must be an approved/current MyTruAdvantage member to enroll. This plan will be effective on either the same date as your Medicare Advantage plan or the first of the month after this application is received.

To confirm eligibility, choose one of the following:

- ☐ My MyTruAdvantage Medicare Advantage plan effective date is within 60 days of today's date. My MA plan's effective date ___/_____/___.
- ☐ I am enrolling on 1/1/2023, during the annual election period (form must be received by MyTruAdvantage between October 15 – December 7).

To enroll in the Optional Supplemental Dental Package, please provide us with the following information:	
MyTruAdvantage Member ID or Medicare number:	Permanent residence street address (P.O. Box not allowed)
Last name, First name, M.I.:	City:
Birth Date: __ __/__ __/__ __ __ __ Sex:	County:
Phone number that we may use to contact you: Landline: Cellphone:	State/Zip Code: Email Address(optional):

Paying your Optional Supplemental Dental Package premium

The way you choose to pay your Medicare Advantage plan premium will automatically be the same method that's used to pay for this optional supplemental dental benefit. You cannot change how you pay for your Medicare Advantage plan premium with this form. For information about how you pay for your Medicare Advantage plan premium, call Member Services at 1-844-425-4280. (TTY users should call 1-800-743-3333 or 711).

Please Read and Sign Below
By completing this enrollment application, I agree to the following: This is an optional benefit offered by MyTruAdvantage, which has a contract with the federal government. I understand that in order to enroll for this optional benefit I must have a MyTruAdvantage Medicare Advantage plan. I also understand my enrollment in this optional benefit is voluntary and is not required for me to keep my MyTruAdvantage Medicare plan. I understand that if MyTruAdvantage has not received my plan premium by the first of the month, they may send a notice letting me know that my membership in the plan may end if they do not receive my premium in full within 90 calendar days.

I understand that the dental services included in the package are offered through Delta Dental. Benefit/coverage details, the amount you pay when using participating and non-participating providers, limits/exclusions, etc. can be found in the Certificate of Coverage document online at www.MyTruAdvantage.com. In-network benefits apply to services provided by a Delta Dental Medicare Advantage Choice (PPO), Medicare Advantage Choice Plus (PPO), Medicare Advantage Select (HMO), Medicare Advantage Select Plus (HMO) participating dentist in Indiana.

Please contact Member Services for instructions on how to disenroll. This form cannot be used to disenroll from the Optional Supplemental Dental Package.

The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I'll be disenrolled from the plan. 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 (as described above), this signature certifies that this person is authorized under state law to complete this enrollment.

Signature:	Today's Date:

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

Name: _____
Address: _____
Phone Number: _____
Relationship to enrollee:_____

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment): _____
Plan ID#: _____
Effective Date of Coverage: _____
☐ICEP/IEP ☐AEP: ☐SEP (type): ☐Not Eligible:
Eligibility for this dental plan is based on enrollment in the MyTruAdvantage plan with a 60 day grace period. MA effective date _____ Within grace period? Y☐ N☐
If not eligible explain:

MyTruAdvantage has HMO and PPO plans with a Medicare contract. Enrollment in MyTruAdvantage depends on contract renewal. MyTruAdvantage complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.844.425.4280 (TTY: 711) 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 1.844.425.4280 (TTY: 711).
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