PRIMETIME
HEALTH PLAN
A Medicare Advantage Organization

PrimeTime Health Plan is a Medicare Advantage organization with a Medicare contract

Optional Supplemental Benefits Enrollment Form

H3664H3620_CY2013A Approved 09162012

PRIMETIME
HEALTH PLAN
A Medicare Advantage Organization

Optional Supplemental Benefits Enrollment Form

This Enrollment Form is for current PrimeTime Health Plan Members that want to add the Optional Supplemental Dental and Vision Benefits to their Medicare Advantage Benefits.

The premium charge of $14.50 per month, for these additional benefits, will be added to your current plan premium. If you would like to make changes to your current billing option, please contact PrimeTime Health Plan. PrimeTime Health Plan will notify you of your effective date of coverage.

You must continue to pay your Medicare Part B premium.

YOUR PERSONAL INFORMATION

Last Name: _____ First Name: _____ MI: _____

Permanent Residence Street Address (P.O. Box is not allowed): _____

_____

City: _____ State: _____ Zip Code: _____ County: _____

Home Phone: (_____) _____ Birth Date: _____

MAILING ADDRESS *(Only if different from your Permanent Residence Address)*

MM/DD/YYYY

_____

City: _____ State: _____ Zip Code: _____

MEDICARE ADVANTAGE INFORMATION

Medicare Claim Number: _____ Group Number: _____

Please continue to page 2 to complete the enrollment. *(Signature is required)*

For questions, please contact PrimeTime Health Plan at 330-363-7407 or 1-800-577-5084 (TTY users should call 330-363-7460 or 1-800-617-7446). Our Call Center is open Monday through Friday from 8:00a.m. to 8:00p.m., E.S.T. Our Lobby is open Monday through Friday from 8:00a.m. to 4:30p.m., E.S.T.

PrimeTime Health Plan is a Medicare Advantage organization with a Medicare contract.

PLEASE READ AND SIGN BELOW

By completing this Supplemental Enrollment Form, I agree to the following:
PrimeTime Health Plan is a Medicare Advantage Plan and has a contract with the Federal Government. I will need to keep my Medicare Parts A & B. I understand that I can be in only one Medicare Advantage Plan at a time. I understand that to be eligible for the Optional Supplemental Benefits, I **must** remain a member of PrimeTime Health Plan. If I disenroll from PrimeTime Health Plan, I will be automatically disrenrolled from the Optional Supplemental Benefits. If I discontinue payment of the Optional Supplemental Benefits, my benefits will be downgraded and will not include the Optional Supplemental Dental and Vision Benefits.

I understand that this enrollment is for Supplemental Dental and Vision Benefits that will be in addition to my current Medicare Advantage Benefits. Enrollment in the Optional Supplemental Benefits is limited to certain times of the year. You may disenroll at anytime from this option by submitting your request in writing. You will be disenrolled the first of the month, after the month that PrimeTime Health Plan receives your disenrollment request in writing.

Services authorized by PrimeTime Health Plan and other services contained in my PrimeTime Health Plan Evidence of Coverage Document (also known as a member contract or subscriber agreement) will be covered. **Without authorization, NEITHER MEDICARE NOR PRIMETIME HEALTH PLAN WILL PAY FOR SERVICES not contained in my Evidence of Coverage Document.**

Release of Information: By joining this Medicare Health Plan, I acknowledge that PrimeTime Health Plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that PrimeTime Health Plan will release my information to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. 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 will 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 enrollment form means that I have read and understand the contents of this enrollment form. If signed by an authorized individual (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 from Medicare.

YOUR SIGNATURE: _____ **DATE:** _____
If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

Phone: (_____) _____ Relationship to Enrollee: _____

If you need information in another language or in another format (like Braille, audiotape, or large print), please contact PrimeTime Health Plan at 330-363-7407 or 1-800-577-5084 (TTY users should call 330-363-7460 or 1-800-617-7446). Our Call Center is open Monday through Friday from 8:00a.m. to 8:00p.m., E.S.T. Our Lobby is open Monday through Friday from 8:00a.m. to 4:30p.m., E.S.T.