

Dental Plus 2027 Enrollment Form

This Enrollment Form is for current Martin's Point Generations Advantage Essential (HMO) members who want to add the Martin's Point Generations Advantage Dental Plus coverage. This additional benefit is administered through Northeast Delta Dental with a monthly premium amount of \$75. The Martin's Point Generations Advantage Dental Plus option is NOT available for Prime (HMO), Alliance (HMO), or Select (LPPO) plans.

ENROLLMENT PERIOD AND EFFECTIVE DATE: Current members may enroll in this optional supplemental benefit at any point in the year. Enrollment is limited to ONCE per year with the benefit becoming effective the first of the month following the receipt date of the application.

Section 1 – All fields on pages 1 and 2 are required (unless marked optional)

Dental Plus for Essential (HMO) plan

\$75 per month plan premium

Your personal information:

FIRST name as it appears on your Medicare card:		Generations Advantage Member ID Number:	
LAST name as it appears on your Medicare card:		Birth date (MM/DD/YYYY): / /	
Middle initial (Optional):		Phone number: ()	
Email (Optional):			
Permanent Residence Street Address (do not enter a PO Box):			
City:	State:	ZIP Code:	
Mailing address if different from your permanent address (PO Box allowed.):			
City:	State:	ZIP Code:	

Section 2: Paying Your Dental Plus Premium

You can pay your monthly Dental Plus plan premium by setting up monthly automatic recurring payments to be deducted from your Social Security or Railroad Retirement Board checks, transferred from your bank account, or charged to your credit card. You may also make one-time online payments or pay your premiums by check..

If you have questions, please contact our Member Services Department at 1-866-544-7504 (TTY: 711). They are available 8am–8pm, every day from Oct. 1–Mar. 31 and weekdays from Apr. 1–Sep. 30.

Please select a premium payment option:

(If you don't select a payment option, you will receive a bill each month by mail.)

☐ **Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.** I get my monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security or RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

☐ **Electronic Funds Transfer (EFT) from your bank account each month.** Please enclose a VOIDED check or provide the following:

Name of Account Holder: _____

Bank Routing Number: _____ Bank Account Number: _____

Account Type: ☐ Checking ☐ Savings

☐ **Credit/Debit Card automatically charged each month.** Please provide the following information:

Card Type: ☐ Visa ☐ MasterCard ☐ Other: _____

Name of Account Holder (as it appears on card): _____

Account Number: _____ Exp. Date: ____/____/____

☐ **Get a bill each month and pay by mailed check or one-time online payments.**

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose, and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Section 3: Please read and sign below

By completing this optional supplemental benefit enrollment application, I agree to the following:

1. I agree to add the Martin's Point Generations Advantage Dental Plus option for \$75 per month, which is in addition to any monthly plan premium I may already pay.
2. I understand that the Martin's Point Generations Advantage Dental Plus option is subject to the terms and conditions stated in my Evidence of Coverage.
3. I understand that, in order to be eligible for the Martin's Point Generations Advantage Dental Plus option, I must remain a member of the Martin's Point Generations Advantage Essential (HMO) plan. If I disenroll from the Martin's Point Generations Advantage Essential (HMO) plan, I will be automatically disenrolled from the Martin's Point Generations Advantage Dental Plus option.
4. The plan is administered by Northeast Delta Dental. Services must be performed by providers in the Northeast Delta Dental network in ME, NH, and VT. For additional questions regarding this benefit, please contact Member Services.
5. I understand that I may voluntarily disenroll from the Martin's Point Generations Advantage Dental Plus option by giving advance notice in writing. I will be disenrolled effective on the first of the month after Martin's Point Generations Advantage receives my signed and completed disenrollment request. I will be restricted from re-enrolling in the Martin's Point Generations Advantage Dental Plus option for the remainder of the plan year.
6. If I fail to pay the monthly premium for the Martin's Point Generations Advantage Dental Plus option, I will lose this optional supplemental benefit, but will remain enrolled in the Martin's Point Generations Advantage Essential (HMO) plan.
7. The information in 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.
8. 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.

Signature:

Today's date:

If you are the authorized representative, sign above and fill out these fields:

Full name: _____ Street address: _____

City, State, ZIP Code: _____

Phone number: _____ Relationship to enrollee: _____

Section 4: Please mail this completed form to:

Generations Advantage Enrollment
Martin's Point Health Care
PO Box 9746
Portland, ME 04104

DISENROLLMENT: If you wish to disenroll from Dental Plus, you must submit a written disenrollment request by fax to (207) 828-7818 or mail to Generations Advantage Enrollment, Martin's Point Health Care, PO Box 9746, Portland ME 04104.

Martin's Point Generations Advantage is a health plan with a Medicare contract offering HMO and Local PPO products. Enrollment in a Martin's Point Generations Advantage plan depends on contract renewal. You must continue to pay your Medicare Part B premium if not otherwise paid for by Medicaid or another third party. Please call Martin's Point Generations Advantage at 1-877-510-1656 (TTY: 711) if you need this information in another language or format.