



# 2019 Optional Supplemental Benefits Selection Form

Date: \_\_\_\_\_ Member name: \_\_\_\_\_

Member number: \_\_\_\_\_

I'd like to add the optional supplemental benefit plan to my ATRIO Silver Rx (Willamette) (PPO) Plan. I understand that there are certain times during the year that ATRIO Health Plan members can enroll:

If you are currently a member of ATRIO Silver Rx (Willamette) and have not elected optional supplemental benefits, you may do so during the Annual Enrollment Period (AEP) or within the 30 days following January 1st.

If you are brand new to our plan, you will have an additional 30 days from your original effective date of coverage to elect optional supplemental benefits if you did not do so during enrollment. If we do not receive your request for optional supplemental benefits within 30 days from your original effective date, you will need to wait until the next AEP or the following January to elect the optional supplemental benefits.

This form is to be used only when there are no other changes to your existing medical plan.

**Check the box below to add extra coverage to ATRIO Silver Rx (Willamette) (PPO) Plan.**

<input type="checkbox"/>	<p><b>Routine vision and preventive dental benefit package: \$31</b></p> <p>Routine Eye Exam (up to 1 every year) - \$35 copay in-network and out-of-network</p> <p>Routine Eyewear (every two years) - \$100 limit</p> <p>Preventive Dental - \$35 in-network and out-of-network (\$500 limit)</p>
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### Your Plan Premium Options

If you need to change the way you are currently paying your plan premium, please contact Customer Service at the number at the bottom of this form.

### Conditions of Enrollment

By completing this form, I agree to add the optional supplemental benefit package for the above selected monthly premium amount, which is in addition to my monthly base ATRIO premium. I understand that the additional coverage is subject to the terms and conditions stated in my ATRIO Silver Rx (Willamette) (PPO) Evidence of Coverage.

I understand that my signature (or the signature of the person authorized to act on my behalf under State law) on this application means that I have read and understand the contents of this application. If signed by an authorized individual, this signature certifies that this person is authorized under State law to complete this enrollment, and documentation of this authority is available upon request by ATRIO Health Plans or Medicare.

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: \_\_\_\_\_

If you have any questions, please call ATRIO Health Plans Customer Service at 1-877-672-8620, daily 8:00 a.m. to 8:00 p.m. (Pacific Time). TTY/TDD users should call 1-800-735-2900

**Please return this completed form to:**

**MAIL: ATRIO Health Plans, 2965 Ryan Drive SE – Salem, OR 97301**

**IN PERSON: 2965 Ryan Drive SE, Salem**

**FAX: 866-238-1736**

**Office Use Only:**

**Name of staff member/agent/broker (if assisted enrollment):** \_\_\_\_\_

**Plan ID#:** \_\_\_\_\_ **Effective Date of Coverage:** \_\_\_\_\_

**ICEP/IEP:** \_\_\_\_\_ **AEP:** \_\_\_\_\_ **SEP (type):** \_\_\_\_\_ **Not Eligible:** \_\_\_\_\_

ATRIO Health Plans has PPO and HMO D-SNP plans with a Medicare Contract. Enrollment in ATRIO Health Plans depends on contract renewal. Enrollment in ATRIO Health Plans depends on contract renewal.

ATENCIÓN: Si usted habla a español, servicios de asistencia de idioma, de forma gratuita, están disponibles para usted. Llamar al 1-877-672-8620 (TTY: 1-800-735-2900).