My**Priority** dental and vision enrollment form

Priority Health

DELTA DENTAL

eyeMed

Existing MyPriority health coverage:
You can only enroll in a My**Priority**® Delta Dental and/or My**Priority** EyeMed plan at the time of enrollment or annual renewal, or if you qualify for a special enrollment period. Continuation of the coverage must remain in effect until the end of the contract year or upon termination of the policy. **Mid-year removal of dental or vision coverage is prohibited.**

Choose a dental plan (pick one):

☐ My**Priority** Delta Dental – Standard

☐ My**Priority** Delta Dental – Enhanced

Today's date: ___/___/___

☐ My**Priority** EyeMed – Medium

☐ My**Priority** EyeMed – High

Today's date: ___/___/___

Monthly premiums per person

Members	MyPriority Delta Dental – Standard	MyPriority Delta Dental – Enhanced
1	$30.71	$41.76
2	$61.42	$83.52
3	$92.13	$125.28

Members	MyPriority EyeMed – Medium	MyPriority EyeMed – High
1	$7.93	$11.85
2	$15.86	$23.70
3	$23.79	$35.55

Enter basic information for every person you'd like to enroll in dental and/or vision.
You can choose dental and/or vision for any member of your family, but your selected plan will be the same for everyone.

Subscriber information			
First name	Last name	Date of birth / /	Add dental: ☐ Yes ☐ No
Contract number	Email		Add vision: ☐ Yes ☐ No
Phone number that we may use to contact you ( ) ☐ Landline (home phone) ☐ Cell phone		Alternate number that we may use to contact you (optional) ( ) ☐ Landline (home phone) ☐ Cell phone	

Dependent information (your spouse and eligible children you wish to enroll)			
Spouse/child first name	Spouse/child last name	Date of birth / /	Dental: ☐ Vision: ☐
Child first name	Child last name	Date of birth / /	Dental: ☐ Vision: ☐
Child first name	Child last name	Date of birth / /	Dental: ☐ Vision: ☐
Child first name	Child last name	Date of birth / /	Dental: ☐ Vision: ☐

If you need to add additional dependents please use a separate form.

continued>

I confirm that I am enrolling myself and dependents selected above in the My**Priority** Delta Dental – Standard or My**Priority** Delta Dental – Enhanced Plan and/or the My**Priority** EyeMed – Medium or My**Priority** EyeMed – High Plan. I understand the coverage I am selecting will not take effect until issued by Priority Health.

Subscriber signature _____ Date _____

For dental plan details, visit ***priorityhealth.com/mypriioritydental***.
For vision plan details, visit ***priorityhealth.com/myprioityvision***.

Submitting this form

You can submit this completed form three ways:

Email: ***mypriority@priorityhealth.com***

Mail: Priority Health
1231 East Beltline Ave. NE
Grand Rapids, MI 49525-4501

Fax: 248.324.2973
Attention: MyPriority