

My**Priority** dental and vision enrollment form



Existing My**Priority** 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** EyeMed – Medium
- ☐ My**Priority** Delta Dental – Enhanced
 ☐ My**Priority** EyeMed – High

Today's date: ____/____/____ Today's date: ____/____/____

Monthly premiums per person

Members	My Priority Delta Dental – Standard	My Priority Delta Dental – Enhanced
1	\$32.44	\$44.10
2	\$64.88	\$88.20
3	\$97.32	\$132.30

Members	My Priority EyeMed – Medium	My Priority 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.

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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/myprioritydental.
For vision plan details, visit priorityhealth.com/mypriorityvision.

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