Enhanced Dental and Vision package disenrollment form

Please carefully read and complete the following information before signing and dating this disenrollment form.

Member information		
Last name	First name	Middle initial
Date of birth (MM/DD/YYYY) ___ ___ / ___ ___ / ___ ___ ___ ___	Best phone number to reach you ( )	Priority Health Subscriber ID *(preferred)* ___ ___ ___ ___ ___ ___ ___ ___ ___ - 00

Choose an effective date	
☐ I elect to disenroll during the Annual Enrollment Period (October 15th–December 7th) and I will be disenrolled effective January 1 of the upcoming plan year.	☐ I elect to disenroll during the calendar year and I will be disenrolled the first of the following month after Priority Health receives my completed disenrollment form.

I hereby acknowledge by signing below that I wish to disenroll from the Priority Health Optional Enhanced Dental and Vision package. I understand that if I disenroll, I cannot re-enroll in this enhanced plan until the next enrollment period for which I am eligible. Disenrolling in the Optional Enhanced Dental and Vision package does not disenroll you from your Priority Health Medicare Advantage plan. If you disenroll from the Optional Enhanced Dental and Vision package, you will continue to have embedded dental and vision coverage included as part of your Medicare Advantage plan. Refer to your Evidence of Coverage document for details. If you have any questions contact Customer Care at 888.389.6648 (TTY users call 711). From Oct. 1–Mar. 31, we're available seven days a week from 8 a.m.–8 p.m. ET. From Apr. 1–Sept. 30, we're available Mon.–Fri. from 8 a.m.–8 p.m. and Sat. 8 a.m.–noon ET. You can also log in to your member account at ***priorityhealth.com*** to send us a message.

Signature	
Member signature **X** _____	Today's date ___ ___ / ___ ___ / ___ ___ ___ ___

A paper form can only be accepted with a handwritten signature.
Electronic, digital or typed signatures are not permitted per the Centers for Medicare and Medicaid services.

If you are the authorized representative, you must sign above and provide the following information			
Last name	First name	Best phone number to reach you ( )	
Street address			Unit/Apt/Lot no.
City		State	ZIP code
Relationship to member: ☐ Power of attorney ☐ Legal guardian ☐ Conservator			

You may submit this authorized representative documentation by either scan and email or mail legal documents to: Priority Health, MS 1115 1231 E. Beltline, Grand Rapids, MI 49525 or email ***MedicareCS@priorityhealth.com***. You may also create a member account and send the documentation via secure message.

How to submit this completed form		
Scan and email *(preferred)*: ***PH-MedicareEnrollment@priorityhealth.com***	Mail: **Priority Health** **MS 1175, 1231 East Beltline Ave NE** **Grand Rapids, MI 49525**	Fax: **616.942.7204**