Enhanced Dental and Vision package disenrollment form

Priority Health

If you have any questions or need help, please contact Priority Health Medicare. By phone, call toll-free at 888.389.6648 (TTY users call 711). We're available from 8 a.m. to 8 p.m., seven days a week. Or visit ***prioritymedicare.com*** and select **Contact Us**.

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	Best phone number to reach you
___ ___ / ___ ___ / ___ ___ ___ ___	( )

Priority Health Subscriber ID *(preferred)*	— or —	Medicare Beneficiary ID Number
___ ___ ___ ___ ___ ___ ___ ___ ___ - 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 Service at 888.389.6648 (TTY users call 711). We're available from 8 a.m. to 8 p.m., seven days a week.

Signature

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

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 ☐ Other: _____

We require documentation to verify legal guardianship agreements. Please scan and email or mail legal documents to: MedicareCS@priorityhealth.com — or — Priority Health, MS 1115, 1231 E Beltline, Grand Rapids, MI 49525

How to submit this completed form

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