

# Comprehensive Dental Rider Enrollment Form

Please type or print in ink.

## Enrollee Information

First name: \_\_\_\_\_ Middle initial: \_\_\_\_\_

Last name: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Phone: \_\_\_\_\_

### Mailing address (if different from permanent address):

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

- I currently have, or I am currently making arrangements to have, my UCare medical premiums withheld from my Social Security check.
- I currently have, or I am currently making arrangements to have, my UCare medical premiums billed monthly or automatically deducted from my savings or checking account.
- My UCare medical premiums are paid through my former employer. (*Applies to Group members only.*)

**Release of information:** By joining this Comprehensive Dental Rider, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

Your signature: \_\_\_\_\_ Today's date: \_\_\_\_\_

<p>If you are the authorized representative, you must provide the following information:</p> <p>Name: _____ Address: _____</p> <p>Phone number: _____ Relationship to enrollee: _____</p> <p><i>Note: Please include a copy of the Power of Attorney agreement or other legal document.</i></p>
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<p><b>OFFICE USE ONLY</b></p> <p>Group Number: _____</p> <p>Group Name: _____</p> <p>Effective Date: _____</p>
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**Your Social Security number:**

\_\_\_\_\_

**UCare's Comprehensive Dental Rider is only available to UCare Secure, UCare for Seniors Classic, and select UCare for Seniors Group members.**

**Please indicate:**

- I am enrolling in one of the plans listed above.
- I am currently a member of one of the plans listed above.

**My member ID number is:**

\_\_\_\_\_

**Retain the bottom (yellow) copy for your records. Send the top (white) copy to UCare.**

*UCare Minnesota and UCare Wisconsin, Inc. are Medicare Advantage organizations with Medicare contracts.*

