Optional Supplemental Benefits Enrollment Form

Stanford Health Care Advantage (HMO) offers optional benefits to our members for an additional monthly plan premium.

- You may enroll in the optional supplemental benefits during Medicare's Annual Enrollment Period from October 15 through December 7.
- Requests made during Medicare's Annual Enrollment Period will have a January 1st effective date.
- This form may only be used by our current members who are adding the optional supplemental benefits to their existing Stanford Health Care Advantage Platinum or Gold plan.
- This form may only be used when there are no other changes to your existing plan.

Member Name: _____

Member ID: _____

Please check the box to add optional supplemental benefits:
I am currently enrolled in a Stanford Health Care Advantage plan and wish to add optional supplemental benefits.

☐ Dental and Vision Services ($20 per month)

The premium for optional supplemental benefits is paid in addition to your monthly plan premium and the Medicare Part B premium.

By completing this application form:

☐ I understand this enrollment for optional supplemental benefits is in addition to my current Stanford Health Care Advantage Platinum or Gold plan benefits. Enrollment in the optional supplemental benefits is limited to certain times of the year.

☐ I understand that as a current member of the Stanford Health Care Advantage Platinum or Gold plan, I may only add the optional supplemental benefits during the Annual Enrollment Period from October 15 to December 7 each year for coverage beginning January 1st of the following year.

☐ I understand that I must get covered care from network providers, except for emergency or urgently needed services.

☐ I understand that if I fail to pay the monthly premium for the optional supplemental benefits, I will lose the supplemental benefits but will remain enrolled in Stanford Health Care Advantage Platinum or Gold.

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☐ I understand that I can disenroll from the optional supplemental benefits at any time. If I disenroll, I will not be eligible to enroll until the next annual election period for coverage effective the following year.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on the application means that I have read and understand the contents of this application. If signed by an authorized individual, this signature certifies that: 1) this person is authorized under State law to complete this enrollment, and 2) documentation of this authority is available upon request by Stanford Health Care Advantage or by Medicare.

Member Signature: _____ Date: _____

If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

Phone: _____

Relationship to Member: _____

After you have completed this form, please fax it to 1-650-498-8724 or mail it to:
Stanford Health Care Advantage, PO Box 2336, Dublin, CA 94568-9802

If you have any questions, please call Member Care Services at 1-855-996-8422 (TTY: 711), 8 am to 8 pm, seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

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FOR AGENT/OFFICE USE ONLY:

Name of Agent/Broker (if assisted in enrollment): _____

Agent/Broker ID: _____

Agent/Broker Signature: _____ Date: _____

Stanford Health Care Advantage is a HMO with a Medicare contract. Enrollment in Stanford Health Care Advantage depends on contract renewal.

Stanford Health Care Advantage complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Stanford Health Care Advantage cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Stanford Health Care Advantage 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-996-8422 (TTY: 711). ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-996-8422 (TTY: 711). 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-996-8422（TTY：711）。