



Medicare Advantage Optional Supplemental Benefit Enrollment Application

Extra Care

Extra Care- \$5.00 per month (this amount will be added to your medical premium)

Summit Health Extra Care combines services you may need from time to time that are not covered under your Summit Health Medicare Advantage Plan, like routine chiropractic services, acupuncture and naturopathic services. Please see your Evidence of Coverage for more information.

Please provide the following:

Summit Member ID

First name

Last name

Date of birth

Phone number

Address

City

State

Zip

Email address

I understand that enrollment in the plan listed above is optional and that I must maintain my coverage in my Summit Health Medicare Advantage plan in order to be enrolled in Extra Care. I understand that I must continue to pay my Part B premium, my Summit Health Medicare Advantage premium, and my Extra Care premium to maintain my Extra Care coverage. I further understand and agree that my signature on this enrollment form serves as my legal commitment to the plan and its terms. Further, this signature represents my authorization for the release of information regarding services provided to me. Information can be released to practitioners and the organizations providing services, for the purpose of investigation or evaluation of care in connection with a complaint. I hereby certify that I have read the completed application and that any false statement or misrepresentation in the application may result in loss of supplemental coverage under the policy.

Signature _____

Date _____

If you are the authorized representative please sign above and complete the fields below

Relationship to enrollee _____

Printed Name _____

Phone Number _____

Please note: Your coverage will begin the first of the month following the receipt of your completed application. Elections made during the Annual Enrollment Period will not be effective until 01/01/2021.