ADVANTAGE MD
Johns Hopkins Medicine Medicare Plan

Optional Supplemental Enrollment/Disenrollment Form

I am a current member of Johns Hopkins Advantage MD and wish to **add/remove** the optional supplemental benefit.

Last Name:	First Name:	Middle Initial:	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.
Medicare#			
Birth Date:	Sex: ☐ Male ☐ Female	Phone Number: ( )	

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

Supplemental Benefit Purchase Options

- Advantage MD Plus (PPO) and Advantage MD (HMO)
  For an extra $25 per month, members can purchase an optional supplemental package that includes both comprehensive dental and fitness benefits.

Adding Optional Supplemental Coverage

I am a current member of Johns Hopkins Advantage MD (PPO)/(HMO). I wish to add optional supplemental coverage to my current plan. My new monthly premium will be:

Δ Johns Hopkins Advantage MD (HMO) $55 per month
Δ Johns Hopkins Advantage MD Plus (PPO) $155 per month

Removing Optional Supplemental Coverage

Δ I am a current member of Johns Hopkins Advantage MD. I wish to remove optional supplemental coverage from my current plan.

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I have carefully read and understand that:

1. My monthly premium will **increase/decrease** by **adding/removing** optional supplemental dental coverage to/from my current plan.
2. The above stated premium amounts **do not include any Medicare late enrollment penalties for which I may be currently responsible.**
3. My current premium payment method will remain the same.

Signature*:_____ Date: _____

*Or the signature of the person authorized to act on your behalf under the laws of the State where you live. If signed by an authorized individual (as described above), this signature certifies that: 1) This person is authorized under State law to complete this disenrollment/enrollment and 2) documentation of this authority is available upon request by Johns Hopkins Advantage MD or by Medicare.

If you are the authorized representative, you must provide the following information:
Name: _____
Address:_____
Phone Number: (_)_____-_____
Relationship to Enrollee _____

Please mail or fax the completed form to Johns Hopkins Advantage MD P.O. Box 3538 Scranton, PA 18505, fax: 855-206-9203. If you have questions about this form or need more information, please contact Customer Service at 1-877-293-5325 (TTY 711), Oct. 1 through March 31 - Monday through Sunday, 8 a.m. to 8 p.m. and April 1 through Sept. 30 - Monday through Friday, 8 a.m. to 8 p.m.

Johns Hopkins Advantage MD is a Medicare Advantage plan with a Medicare contract offering HMO and PPO products. Enrollment in Johns Hopkins Advantage MD depends on contract renewal.

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