

MyPriority dental and vision enrollment form



Existing MyPriority health insurance:

You can only enroll in a MyPriority® Delta Dental and/or MyPriority EyeMed plan at the time of enrollment or annual renewal, or if you qualify for a special enrollment period.

Choose a dental plan (pick one):

- ☐ MyPriority Delta Dental – Standard
☐ MyPriority Delta Dental – Enhanced

Choose a vision plan (pick one):

- ☐ MyPriority EyeMed – Medium
☐ MyPriority EyeMed – High

Today's date: ____ / ____ / ____

Today's date: ____ / ____ / ____

Enter basic information for every person you'd like to enroll in dental and/or vision. You can choose dental and/or vision for any member of your family, but your selected plan will stay the same for everyone.

Monthly premiums per person

Members	MyPriority Delta Dental – Standard	MyPriority Delta Dental – Enhanced
1	\$27.29	\$37.11
2	\$54.58	\$74.22
3	\$81.87	\$111.33

Members	MyPriority EyeMed – Medium	MyPriority EyeMed – High
1	\$7.93	\$11.85
2	\$15.86	\$23.70
3	\$23.79	\$35.55

Subscriber information

First name	Last name	Date of birth / /	Add dental: <input type="checkbox"/> Yes <input type="checkbox"/> No
Contract number	Email	Add vision: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Phone number that we may use to contact you () <input type="checkbox"/> Landline (home phone) <input type="checkbox"/> Cell phone		Alternate number that we may use to contact you (optional) () <input type="checkbox"/> Landline (home phone) <input type="checkbox"/> Cell phone	

Dependent information (your spouse and eligible children you wish to enroll)

Spouse/child first name	Spouse/child last name	Date of birth / /
Child first name	Child last name	Date of birth / /
Child first name	Child last name	Date of birth / /
Child first name	Child last name	Date of birth / /

If you need to add additional dependents please use a separate form.

I confirm that I am enrolling myself and dependents selected above in the MyPriority Delta Dental – Standard or MyPriority Delta Dental – Enhanced Plan and/or the MyPriority EyeMed – Medium or MyPriority EyeMed – High Plan. I understand the coverage I am selecting will not take effect until issued by Priority Health.

Subscriber signature

Date

You will receive new membership cards within 7–10 business days following enrollment and processing.

For dental plan details, visit priorityhealth.com/myprioritydental. For vision plan details, visit priorityhealth.com/mypriorityvision.

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Submitting this form

You can submit this completed form three ways:

Mail to: Priority Health
Individual Operations
27777 Franklin Road, Ste 1300
Southfield, MI 48034

Fax to: 248.324.2973
Attention: MyPriority

Email to: mypriority@priorityhealth.com