SummaCare®
Health Insurance

DELTA DENTAL

Delta Dental of Ohio Optional Supplemental
2026 Plan Enrollment Form

Only complete this form if you want to add the Optional Supplemental Dental Plan and you are not currently enrolled in the Optional Supplemental Dental Plan.

Please complete the information in this form and return it to SummaCare using the provided postage-paid envelope and mail to:

SummaCare
Attention: Medicare Eligibility
P.O. Box 3620
Akron, Ohio 44309-3620

Your Information

First Name: _____ Last Name: _____

Birth Date (MM/DD/YYYY):_____ Sex: **O** M **O** F

Medicare Number (as it appears on your Medicare card):_____

SummaCare Member ID Number (as it appears on your SummaCare ID card):_____

Your Plan: **O** Amber (HMO) **O** Topaz (HMO) **O** Quartz (HMO) **O** Garnet (HMO)
O Ruby (HMO) **O** Sapphire (HMO-POS) **O** Emerald (HMO-POS)

Requested Effective Date: _____

If you are the authorized representative and/or have Power of Attorney (POA), you must sign below and provide the following information along with your POA form:

Name: _____ Phone Number: _____

Address: _____

Relationship to Enrollee: _____

Sales Agent Name: _____

Code: _____

By signing and returning this form, I hereby authorize SummaCare to enroll me in the Delta Dental of Ohio optional supplemental plan. **I understand that I will have to pay SummaCare an additional $37 monthly premium for this plan.**

Signature: _____ Date: _____

SummaCare is an HMO and HMO-POS health plan with a Medicare contract. Enrollment in SummaCare depends on contract renewal.
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