CarePartners of Connecticut MEDICARE ADVANTAGE

CarePartners of Connecticut (HMO) Dental Option Enrollment Form

This Enrollment Form is for new and current members that want to add the CarePartners of Connecticut Dental Option to their existing coverage under CarePartners of Connecticut HMO (available for the CareAdvantage Prime plan). This additional benefit is administered through Dominion Dental Services, Inc. The monthly premium charge of $19 will be added to your current plan premium.

Current members can purchase Optional Supplemental Benefits during the following election periods: From October 15 through December 7 for a January 1 effective date; or from January 1 through January 31 for a February 1 effective date.

New members can purchase these Optional Supplemental Benefits within the first month of their enrollment. Benefits will become effective the first of the following month.

A Personal information

First name:

Middle initial:

Last name:

Member ID number:

Birth date: (mm/dd/yyyy) / /

Primary phone number: - -

☐ This is a mobile number

Alternate phone number: (optional) - -

☐ This is a mobile number

We suggest providing your mobile number so that we can provide the most timely information and updates.

Email address: (optional)

Permanent street address: (P.O. box is not allowed)

City:

State:

Zip code:

Mailing address: (only if different from your permanent address)

City:

State:

Zip code:

B Paying your plan premium

The monthly premium for the CarePartners of Connecticut Dental Option will be added to your current CarePartners of Connecticut plan premium and paid using the same method you choose to pay the plan premium. If you would like to change the way you pay your plan premium, please contact our Customer Service Department at **1-888-341-1507 (TTY: 711)**.

Please continue to page 2. A signature is required to complete your enrollment in the CarePartners of Connecticut Dental Option. ›

C Please read and sign below

By completing this optional supplemental benefit enrollment application, I agree to the following:

1. I agree to add the CarePartners of Connecticut Dental Option for $19 per month, which is in addition to my monthly plan premium.
2. I understand that the CarePartners of Connecticut Dental Option is subject to the terms and conditions stated in my CarePartners of Connecticut HMO *Evidence of Coverage*.
3. I understand that in order to be eligible for the CarePartners of Connecticut Dental Option, I must remain a member of CarePartners of Connecticut HMO Plan. If I disenroll from CarePartners of Connecticut HMO Plan, I will be automatically disenrolled from the CarePartners of Connecticut Dental Option.
4. Dental benefits for members of CarePartners of Connecticut are administered by Dominion Dental Services, Inc. For questions regarding your benefits or provider network, please contact Customer Service.
5. I understand that I may voluntarily disenroll from the CarePartners of Connecticut Dental Option by giving advance notice in writing. I will be disenrolled effective on the first of the month after CarePartners of Connecticut receives my signed and completed disenrollment request.
6. If I fail to pay the monthly premium for the CarePartners of Connecticut Dental Option, I will lose this optional supplemental benefit, but will remain enrolled in the CarePartners of Connecticut HMO Plan.
7. The information in this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
8. 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 this enrollment form means that I have read and understand the contents of this enrollment form. If signed by an authorized individual (as described above), 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 from Medicare.

Signature: _____ Today's date (mm/dd/yyyy): ___ / ___ / _____

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

Full name:

Street address:

City: State: Zip code:

Phone number: ___ - ___ - _____ Relationship to Enrollee:

D Please mail this completed form to:

CarePartners of Connecticut
705 Mount Auburn Street
P.O. Box 9178
Watertown, MA 02472-1508

For more information, contact Customer Service at **1-888-341-1507 (TTY: 711)**. Representatives are available 8:00 a.m.–8:00 p.m., 7 days a week from October 1 to March 31 and Monday–Friday from April 1 to September 30.

CarePartners of Connecticut complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-341-1507 (TTY: 711).