CarePartners of Connecticut MEDICARE ADVANTAGE

2023 CarePartners of Connecticut (HMO) Short Enrollment Request Form

Send your completed and signed form to:

CarePartners of Connecticut
P.O. Box 483
Canton, MA 02021-9936

A Personal information

First name:

Middle initial:

Last name:

Member ID number:

Primary phone number: - -

☐ This is a mobile number

Alternate phone number: (optional) - -

☐ This is a mobile number

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

Email address:

Permanent street address: (P.O. Box not allowed unless you do not have a permanent residence)

City:

State:

Zip code:

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

City:

State:

Zip code:

B Please provide your plan information

The chart below shows available plans for our service area and standard monthly plan premiums (**in bold**). Please note, CarePartners of Connecticut HMO plans are NOT available in Fairfield County. The chart also shows plan premiums with the CarePartners of Connecticut Dental Option included (*in italics*). To enroll in the CarePartners of Connecticut Dental Option, complete the *Optional Supplemental Benefit* section below.

Hartford, Litchfield, Middlesex, New Haven, New London, Tolland, and Windham Counties	Plan Premium	*With Dental Option*
○ CareAdvantage Preferred (HMO)	**$0/month**	*N/A*
○ CareAdvantage Prime (HMO)	**$39/month**	*$59*

Name of the plan you are currently a member of:

CarePartners of Connecticut (HMO) ______

Current monthly premium: $ ______

Name of the plan you would like to change to:

CarePartners of Connecticut (HMO) ______

New monthly premium: $ ______

Requested effective date:
(mm/dd/yyyy; must be in the future) __ / 0 1 / ____

☐ **I understand that this plan has different health benefits and a different monthly premium. I have reviewed my new plan premium in the chart above.**

OPTIONAL SUPPLEMENTAL BENEFIT: CarePartners of Connecticut Dental Option

The CarePartners of Connecticut Dental Option can only be elected along with a medical plan. The CarePartners of Connecticut Dental Option is **$20 per month** for the *CareAdvantage Prime* plan. The CarePartners of Connecticut Dental Option is **NOT available for the *CareAdvantage Preferred* plan**. The chart above shows plan premiums with the CarePartners of Connecticut Dental Option included (*in italics*).

☐ **Yes, I would like to add the CarePartners of Connecticut Dental Option.**

C Please choose a CarePartners of Connecticut contracted primary care physician (PCP)

If you don't have a PCP, we will automatically assign one to you. You can change your PCP at any time after you enroll.

Primary care physician: ______

Are you a current patient? ○ Yes ○ No

D Paying your plan premium

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. DON'T pay Tufts Health Plan Medicare Preferred the Part D-IRMAA.

If you don't select a payment option, you will get a bill each month.

For plans with a $0 premium: If you currently owe a late enrollment penalty or have selected the optional supplemental dental benefit, we need to know how you prefer to pay it. You can pay by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month. **If you do not owe a late enrollment penalty or have not selected the optional supplemental dental benefit, a payment option is not required**.

People with limited incomes may qualify for *Extra Help* to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this *Extra Help*, contact your local Social Security office, or call Social Security at **1-800-772-1213**. TTY users should call **1-800-325-0778**. You can also apply for *Extra Help* online at **www.socialsecurity.gov/prescriptionhelp**.

If you qualify for *Extra Help* with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

Please select a premium payment option:

◯ Get a bill each month.

◯ Electronic Funds Transfer (EFT) from your bank account each month.

(If this option is selected, an *EFT Authorization Form* will be mailed to you. Please continue to pay your monthly premium until we notify you of your enrollment in the EFT program.)

◯ Automatic deduction from your monthly Social Security benefit check.

◯ Automatic deduction from your monthly Railroad Retirement Board (RRB) benefit check.

The Social Security/RRB deduction may take two or more months to begin. There may be a delay in withholding your premium due to the Social Security Administration's monthly processing schedule, as the start date of premium withholding cannot be retroactive. If there is a delay, you will be billed directly for the first 1–2 months until your premium is deducted from your Social Security or RRB benefit check. You are responsible for paying all premiums due until premium withholding begins. If you do not pay your premium for the month(s) before premium withholding begins, you may be disenrolled from CarePartners of Connecticut. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

Please continue ›

E Please select eligibility for enrollment period

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period. Please read the following statements carefully and check the box if the statement applies to you (check all that apply). By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on: (mm/dd/yyyy) ___ / ___ / ______
- ☐ I am moving into, live in, or recently moved out of a long-term care facility (for example, a nursing home or long-term care facility). I moved on: (mm/dd/yyyy) ___ / ___ / ______
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid). I had this change on: (mm/dd/yyyy) ___ / ___ / ______
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get *Extra Help* paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ Other reason: (please describe Special Election Period) ______

F Ethnicity and race, alternative languages, and accessible formats

Are you of Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ I choose not to answer

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ I choose not to answer

Preferred written language: ______

Preferred spoken language: ______

Select one if you want us to send you information in an accessible format: ○ Braille ○ Large print ○ Audio CD

*Please contact CarePartners of Connecticut at **1-844-399-7483 (TTY: 711)** if you need information in an accessible format or language other than what is listed above. 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.*

Please continue ›

G Please read and sign below.

1. CarePartners of Connecticut is a plan that has a contract with the Federal government.
2. I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with CarePartners of Connecticut, he/she may be paid based on my enrollment in CarePartners of Connecticut.
3. I understand that beginning on the date CarePartners of Connecticut coverage begins, I must get all of my health care from CarePartners of Connecticut, except for emergency or urgently needed services or out-of-area dialysis.
4. Services authorized by CarePartners of Connecticut and other services contained in my CarePartners of Connecticut *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR CAREPARTNERS OF CONNECTICUT WILL PAY FOR THE SERVICES.
5. 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 Member Services.

Release of Information

1. By joining this Medicare health plan, I acknowledge that CarePartners of Connecticut will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations.
2. I also acknowledge that CarePartners of Connecticut will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.
3. The information on 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.
4. I understand that people with Medicare aren't covered under Medicare while out of the country except for limited coverage near the U.S. border.

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 application means that I have read and understand the contents of this application. 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: ____________________

OFFICE/BROKER USE ONLY

Name of staff member/agent/broker, if assisted in enrollment: (please print)

Agent NPN:

Agency Name:

Date application received: (mm/dd/yyyy)

Effective date of coverage: (mm/dd/yyyy)

Plan ID#:

	Plan	ID
◯	CareAdvantage Preferred	**H5273-001**
◯	CareAdvantage Prime	**H5273-002**

Enrollment period:

☐ ICEP/IEP ☐ AEP ☐ OEP ☐ SEP (type:) ☐ Not eligible

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).