CarePartners of Connecticut
MEDICARE ADVANTAGE

2023 CarePartners of Connecticut Individual Enrollment Request Form

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan.

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit **Medicare.gov** to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional—you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:

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

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call CarePartners of Connecticut at **1-844-399-7483 (TTY: 711)**.

Or, call Medicare at **1-800-MEDICARE (1-800-633-4227**). TTY users can call 1-877-486-2048.

En español: Llame a CarePartners of Connecticut al **1-844-399-7483 (TTY: 711)** o a Medicare gratis al **1-800-633-4227** y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

Section 1 All fields in this section are required (unless marked optional)

First name:

Middle initial: (optional)

Last name:

Title: (optional)

◯ Mr. ◯ Mrs. ◯ Ms.

Birth date: (mm/dd/yyyy)

Sex:

◯ M ◯ F

Primary phone number:

☐ This is a mobile number (optional)

Alternate phone number: (optional)

☐ This is a mobile number (optional)

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

Email address: (optional)

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

City:

State:

Zip code:

Mailing address, if different from your permanent address: (P.O. Box allowed)

City:

State:

Zip code:

Emergency contact: (optional)

Phone number: (optional)

Relationship to you: (optional)

SELECT THE PLAN YOU WANT TO JOIN

Requested effective date:
(mm/dd/yyyy; must be in the future) _____

The chart below shows available plans for our service area and standard monthly plan premiums (**in bold**). Please note, CarePartners of Connecticut 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) (H5273)	**$0/month**	*N/A*
◯ CareAdvantage Prime (HMO) (H5273)	**$39/month**	*$59*
◯ CarePartners Access (PPO) (H0342)	**$0/month**	*N/A*

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* or *CarePartners Access* plans.** 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.**

YOUR MEDICARE INFORMATION

Please take out your red, white, and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.
- **Or** attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name: (as it appears on your Medicare card; optional)

Medicare number:

Is entitled to:

HOSPITAL (Part A) Effective date: (optional; mm/dd/yyyy)

MEDICAL (Part B)

ANSWER THESE IMPORTANT QUESTIONS

◯ **Yes**
◯ **No**

1. Will you have other prescription drug coverage (like VA, TRICARE) in addition to CarePartners of Connecticut?
If yes, please list your other coverage and your member and group numbers for this coverage.

Name of other coverage:

Member number for this coverage:

Group number for this coverage:

◯ **Yes**
◯ **No**

2. OPTIONAL: Are you a resident in a long-term care facility, such as a nursing home?
If yes, please provide the following information and see question 5 on the following page.

Name of institution:

Phone number:

Street address:

City:

State:

Zip code:

◯ **Yes**
◯ **No**

3. OPTIONAL: Are you enrolled in your State Medicaid program?
If yes, please provide your Medicaid number.

Medicaid number:

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.

☐ **1.** Annual Enrollment Period (AEP). Your plan effective date will be January 1.

☐ **2.** I am new to Medicare.

☐ **3.** I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP) from January 1 through March 31.

☐ **4.** 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) _____

☐ **5.** 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). If you currently reside in a long-term care facility, please answer question 2 on the previous page.

I moved on: (mm/dd/yyyy) _____

☐ **6.** I am leaving employer or union coverage.

I will leave this coverage on: (mm/dd/yyyy) _____

☐ **7.** 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) _____

☐ **8.** I recently had a change in my *Extra Help* paying for Medicare prescription drug coverage (newly got *Extra Help*, had a change in the level of *Extra Help,* or lost *Extra Help*).

I had this change on: (mm/dd/yyyy) _____

☐ **9.** 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.

☐ **10.** I recently returned to the United States after living permanently outside of the U.S.

I returned to the U.S. on: (mm/dd/yyyy) _____

☐ **11.** I recently obtained lawful presence in the United States.

I got this status on: (mm/dd/yyyy) _____

☐ **12.** I recently was released from incarceration.

I was released on: (mm/dd/yyyy) _____

☐ **13.** I recently left a PACE program.

I left this program on: (mm/dd/yyyy)

☐ **14.** I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's).

I lost my drug coverage on: (mm/dd/yyyy)

☐ **15.** I belong to a pharmacy assistance program provided by my state.

☐ **16.** My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ **17.** I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan.

My enrollment in that plan started on: (mm/dd/yyyy)

☐ **18.** I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan.

I was disenrolled from this SNP on: (mm/dd/yyyy)

☐ **19.** I was affected by a weather-related emergency or major disaster as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

☐ Other reason: (please describe Special Election Period)

If none of these statements apply to you or you're not sure, *please contact CarePartners of Connecticut at* ***1-844-399-7483 (TTY: 711)*** *to see if you are eligible to enroll. We are open 7 days a week, 8 a.m.–8 p.m. (April 1–September 30: Monday through Friday, 8 a.m.–8 p.m.)*

Important Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in CarePartners of Connecticut.
- By joining this Medicare Advantage Plan, I acknowledge that CarePartners of Connecticut will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time—and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my CarePartners of Connecticut coverage begins, I must get all of my medical and prescription drug benefits from CarePartners of Connecticut. Benefits and services provided by CarePartners of Connecticut and contained in my CarePartners of Connecticut "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor CarePartners of Connecticut will pay for benefits or services that are not covered.
- 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.
- 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.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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 by Medicare.

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

If you're the authorized representative, sign above and fill out these fields.

Full name:

Street address:

City: State: Zip code:

Phone number: Relationship to Enrollee:

Section 2 All fields in this section are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

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. Our office hours are 7 days a week, 8 a.m.–8 p.m. (April 1–September 30: Monday through Friday, 8 a.m.–8 p.m.).*

List your primary care physician (PCP):

Are you a current patient?

◯ Yes ◯ No

For HMO Plans: Please choose a CarePartners of Connecticut HMO-contracted primary care physician (PCP). If you don't list a PCP here, we will automatically assign one to you. You can change your PCP at any time after you enroll.
For PPO Plans: As a member of our plan, you do not have to choose a PCP. However, we strongly encourage you to choose one.

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**.

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.

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#:

◯ CareAdvantage Preferred	**H5273-001**
◯ CareAdvantage Prime	**H5273-002**
◯ CarePartners Access	**H0342-001**

Enrollment period:

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

PRIVACY ACT STATEMENT The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

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).