

# CarePartners of Connecticut (HMO) Dental Option Enrollment Form.

P.O. Box 9178  
Watertown, MA 02472

This Enrollment Form is for current members that want to add the CarePartners of Connecticut Dental Option to their existing coverage under CarePartners of Connecticut HMO (available for CareAdvantage Prime and CareAdvantage Premier plans). This additional benefit is administered through Dominion Dental Services, Inc. The monthly premium charge of \$15 will be added to your current plan premium. CarePartners of Connecticut will notify you of your effective date of coverage.

## 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

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)**.

**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 \$15 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:

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Servicehip 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, or sex. CarePartners of Connecticut does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

**CarePartners of Connecticut:**

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact CarePartners of Connecticut at 1-888-341-1507 (TTY: 711).

If you believe that CarePartners of Connecticut has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

**CarePartners of Connecticut, Attention:**

Civil Rights Coordinator, Legal Dept.  
705 Mount Auburn St.  
Watertown, MA 02472  
Phone: 1-844-301-4010 ext. 48000 (TTY: 711)  
Fax: 1-617-972-9048  
Email: [OCRCoordinator@carepartnersct.com](mailto:OCRCoordinator@carepartnersct.com)

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the CarePartners of Connecticut Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

**U.S. Department of Health and Human Services**  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019 (TDD: 1-800-537-7697)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

[carepartnersct.com](http://carepartnersct.com) | 1-888-341-1507 (TTY: 711)

**English:** ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-888-341-1507 (TTY: 711).

**Arabic:** ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-341-1507 (رقم هاتف الصم والبكم: 711).

**Albanian:** KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-888-341-1507 (TTY: 711).

**Chinese:** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-341-1507 (TTY: 711)。

**Farsi:** توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با تماس بگیرد. 1-888-341-1507 (TTY: 711)

**French:** ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-341-1507 (TTY : 711).

**German:** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-341-1507 (TTY: 711).

**Greek:** ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-888-341-1507 (TTY: 711).

**Gujarati:** સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-888-341-1507 (TTY: 711).

**Haitian Creole:** ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-888-341-1507 (TTY: 711).

**Hindi:** ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-341-1507 (TTY: 711) पर कॉल करें।

**Italian:** ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-341-1507 (TTY: 711).

**Japanese:** 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-341-1507 (TTY: 711) まで、お電話にてご連絡ください。

**Khmer (Cambodian):** ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អូល គឺអាចមានសំរាប់បំរើអ្នក។ ថ្ងៃ ទី១៧ 1-888-341-1507 (TTY: 711)

**Korean:** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-341-1507 (TTY: 711) 번으로 전화해 주십시오.

**Laotian:** ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-888-341-1507 (TTY: 711).

**Navajo:** Díí baa akó nínízin: Díí saad bee yánílt'igo Diné Bizaad, saad bee áká'ánída'áwo'dęę, t'áá jiikeh, éí ná hóló, koji' hódíílnih 1-888-341-1507 (TTY: 711).

**Polish:** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-341-1507 (TTY: 711).

**Portuguese:** ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-888-341-1507 (TTY: 711).

**Russian:** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-341-1507 (TTY: 711).

**Spanish:** ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-341-1507 (TTY: 711).

**Tagalog:** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-341-1507 (TTY: 711).

**Vietnamese:** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-341-1507 (TTY: 711).