

# 2021 CarePartners of Connecticut (HMO) Short Enrollment Request Form.

## A Personal information

First name:

Middle initial:

Last name:

Member ID number:

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Primary phone number:

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Alternate phone number: (optional)

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☐ This is a mobile number

☐ This is a mobile number

Email address:

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

City:

State:

Zip code:

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

City:

State:

Zip code:

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## 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)	<b>\$0/month</b>	<i>N/A</i>
CareAdvantage Prime (HMO)	<b>\$30/month</b>	<i>\$45</i>
CareAdvantage Premier (HMO)	<b>\$90/month</b>	<i>\$105</i>

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 **\$15 per month** for *CareAdvantage Prime* and *CareAdvantage Premier* plans. 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

**CareAdvantage Preferred plan only:** This plan has a \$0 premium. If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would 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 automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

**Plans with monthly premiums:** 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 automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

**All plans:** If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or Railroad Retirement Board (RRB). DO NOT pay CarePartners of Connecticut the Part D-IRMAA.

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](http://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.

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

### 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.

## 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. 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.

- |   |   |  |  |  |  |  |  |  |  |  |  |
|---|---|--|--|--|--|--|--|--|--|--|--|
| <input type="checkbox"/> 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)<br><table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>           |  |  |  |  |  |  |  |  |  |  |
|   |   |  |  |  |  |  |  |  |  |  |  |
| <input type="checkbox"/> 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)<br><table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>           |  |  |  |  |  |  |  |  |  |  |
|   |   |  |  |  |  |  |  |  |  |  |  |
| <input type="checkbox"/> 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)<br><table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table> |  |  |  |  |  |  |  |  |  |  |
|   |   |  |  |  |  |  |  |  |  |  |  |
| <input type="checkbox"/> I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get <i>Extra Help</i> paying for my Medicare prescription drug coverage, but I haven't had a change. |   |  |  |  |  |  |  |  |  |  |  |
| <input type="checkbox"/> Other reason: (please describe Special Election Period)  |   |  |  |  |  |  |  |  |  |  |  |

## F Alternative languages and accessible formats

Preferred written language:

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Preferred spoken language:

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Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:

☐ Spanish    ☐ Large print

*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 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. **Note to members also covered under VA Health Care:** To use VA benefits, you need to get care at a VA medical center or other VA locations, but you should not use your CarePartners of Connecticut ID card at the VA. You will use the CarePartners of Connecticut ID card when receiving services from CarePartners of Connecticut network providers (outside of the VA).
6. 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 Relations.

### 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):

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

Full name:

Street address:

City:

State:

Zip code:

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Phone number:

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Relationship to Enrollee:

## OFFICE/BROKER USE ONLY

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

Agent NPN:

Date application received  
(mm/dd/yyyy):

 /  / 

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

 /  / 

Plan ID#:

<input type="radio"/> CareAdvantage Preferred	<b>001</b>
<input type="radio"/> CareAdvantage Prime	<b>002</b>
<input type="radio"/> CareAdvantage Premier	<b>003</b>

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, 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

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 | 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. 1-888-341-1507 (TTY: 711) فراهم می باشد. با تماس بگیرد.

**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 નિઃશુલ્ક 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 yáníłt'igo Diné Bizaad, saad bee áká'ánída'áwo'dęę, t'áá jiikeh, éí ná hóló, koji' hódíłnih 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).