CarePartners of Connecticut

# 2021 CarePartners of Connecticut (PPO) Individual Enrollment 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 9178
Watertown, MA 02472

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 users can call 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 **1-844-399-7487 (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.

## 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)

Email address: (optional)

Permanent residence street address: (don't enter a P.O. Box)

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) ___ / **0 1** / ____

The chart below shows available plans for our service area and standard monthly plan premiums (**in bold**).
Please note, CarePartners of Connecticut (PPO) is NOT available in Fairfield County.

| Hartford, Litchfield, Middlesex, New Haven, New London, Tolland, and Windham Counties | Plan Premium |
|---|---|
| ◯ CarePartners Access (PPO) | **$0/month** |

## 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) / 01 /

**MEDICAL (Part B)** / 01 /

## 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. 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* ***1-844-399-7487*** (TTY users should call 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 or Medicare Prescription Drug 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.
- 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 people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- 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.
- 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.

Preferred written language:

Preferred spoken language:

Select one if you want us to send you information in a language other than English:

◯ Spanish

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 **1-844-399-7487** 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.) TTY users can call **711**.*

Please list the name of your primary care provider (PCP)

Are you a current patient?

◯ Yes ◯ No

**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. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay CarePartners of Connecticut the Part D-IRMAA.

**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.

## 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#:

| | |
|---|---|
| CarePartners Access | **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 and 1860D-1 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

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 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 بگیرید.

**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 ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 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, ໂດຍບໍ່ເສັ້ງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-341-1507 (TTY: 711).

**Navajo:** Díí baa akó nínízin: Díí saad bee yáníltí'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, 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).