care n care Insurance Company, Inc.

Southwestern Health Resources
Texas Health Resources | UT Southwestern Medical Center

2022

Care N' Care Classic (HMO)
Southwestern Health Select (HMO)

Optional Supplemental Benefit Enrollment Request Form

Enrollment Request Form

If you have questions about your enrollment request form, please call us at 1-877-374-7993, TTY users call 711. The Customer Experience Team is available to help October 1 to March 31, 8AM-8PM CST, seven days a week or April 1 to September 30, 8AM-8PM CST, Monday through Friday. Contact Care N' Care if you need information in another language or Format.

You are enrolling in the following Care N' Care Optional Supplemental Benefit:

❑ Dental Rider $25 per month

Care N' Care Member ID Number: _____

To Enroll in a Care N' Care Optional Supplemental Benefit, Provide the Following Information:			
LAST Name: FIRST Name: Middle Initial:			❑ Mr. ❑ Mrs. ❑ Ms.
Birth Date: (_ _/ _ _/ _ _ _ _) (M M/D D/ Y Y Y Y)	Sex: ❑ M ❑ F	Home Phone Number: ( ) -	Alternate Phone Number: ( ) -
Permanent Residence Street Address (P. O. Box is not allowed)			
City	State:	Zip Code:	County:
Mailing Address (only if different from your Permanent Residence Address):			
City:	State:	Zip Code:	County:
Emergency Contact:	**Phone Number:**	**Relationship to you:**	
E-Mail Address:			

Paying Your Optional Supplemental Benefit Premium

You can pay your monthly plan premium by mail, Social Security/RRB Deduction or by "Electronic Funds Transfer (EFT)"each month.

Please select a premium payment option:

❑ Receive a monthly invoice (the Care N' Care Optional Supplemental Benefit premium will be added to your Medicare Advantage invoice)

❑ Automatic deduction from your monthly Social Security or RRB benefit check. (The Social Security deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you an invoice for your monthly premiums.)

❑ Electronic funds transfer (EFT) from your bank account each month.

Please enclose a VOIDED check or provide the following:

Account holder name:_____Account type: ❑Checking ❑ Savings
Bank routing number: _ _ _ _ _ _ _ _ _ Bank account number: _ _ _ _ _ _ _ _ _ _ _ _ _

Please read and answer these important questions:

Some individuals may have other dental coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State assistance programs.

Will you have other supplemental dental coverage in addition to Care N' Care? ❑ Yes❑ No

If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage:	ID # for this coverage:	Group # for this coverage

2. Are you enrolled in your State Medicaid program? ❑Yes ❑ No
If yes, please provide your Medicaid number:

3. Do you or your spouse work? ❑ Yes ❑ No

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 Care N' Care at 1-877-374-7993 (TTY users should call 711) if you need information in another format or language than what is listed above. Our office hours are October 1 to March 31, 8AM-8PM CST, seven days a week or April 1 to September 30, 8AM-8PM, CST, Monday-Friday

Please Read and Sign Below

Care N' Care Insurance is an HMO and PPO plan with a Medicare contract. Enrollment in Care N' Care depends on contract renewal. You must continue to pay your Medicare Part B Premium.

By completing this enrollment application, I agree to the following:

It is my responsibility to inform Care N' Care of any dental coverage that I have or may get in the future. Once I enroll, I may make changes only at certain times of the year when an enrollment period is available (For Contract Year 2022, this is October 15 – December 7, 2021), or under certain special circumstances. I understand this contract automatically renews and that payments made are non-refundable for all insureds.

Care N' Care serves a specific service area. If I move out of the area that Care N' Care serves, I need to notify the plan so I can disenroll.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Care N' Care, he/she may be paid based on my enrollment in Care N' Care.

True and Complete Acknowledgement:

I understand, agree and represent: I have read this document or it has been read to me. The answers are true and complete. I have received and reviewed any state or federal disclosures. Neither I, nor any agent or producer has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, or waive any of Care N' Care's other rights and requirements. This product applied for is not an employer-sponsored group insurance plan and it does not comply with state or federal small employer laws. If this enrollment form for coverage is accepted, coverage will be effective on the date specified by Care N' Care. Acceptance of premium and fees does not guarantee coverage. I agree to automatic withdrawal from my specified bank account for premium payment and/or administrative fees if selected on this enrollment form. Any misrepresentation of material fact or omission on this enrollment form may be used by Care N' Care to void the Optional Supplemental Benefit Rider or modify the terms of coverage.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an enrollment form or files a claim containing a false or deceptive statement may be guilty of fraud.

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 by Care N' Care or by Medicare.

Signature:	**Today's Date:**
If you are the **authorized representative**, you must sign above & provide the following information:	

Name:	**Address:**	**Phone #:** ( ) -	**Relationship to Enrollee:**