care n care
Insurance Company, Inc.

2023

CARE N' CARE CHOICE (PPO) H6328-003
CARE N' CARE CHOICE PLUS (PPO) H6328-002
CARE N' CARE CHOICE PREMIUM (PPO) H6328-001
CARE N' CARE CHOICE MA-ONLY (PPO) H6328-005
CARE N' CARE CLASSIC (HMO) H2171-001
SOUTHWESTERN HEALTH SELECT (HMO) H2171-003

# 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: | | | |

**All fields on 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 Hispanic, Latino/a, or a 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**

## 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 ❑ Braille

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 2023, this is October 15 – December 7, 2022 ), 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 #:<br>(  )  - | Relationship to Enrollee: |
|---|---|---|---|

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# Discrimination is Against the Law

Care N' Care (HMO/PPO) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Care N' Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

**Care N' Care:**

- **Provides free aids and services to people with disabilities to communicate effectively with us, such as:**
  - Qualified sign language interpreters
  - 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 Care N' Care at 1-877-665-2622 (TTY: 711), 8am to 8pm, CST seven days a week from October 1 – March 31, or 8am to 8pm, CST, Monday through Friday April 1 – September 30

If you believe that Care N' Care 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: Care N' Care, Attn: Appeals and Grievances, 1603 Lyndon B. Johnson Freeway, Suite 300, Farmers Branch, TX 75234 , 1-877-665-2622 (TTY 711), or via fax at 817-810-5214.
You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Appeals and Grievances Department 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, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs. gov/ocr/office/file/index.html

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-374-7993 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

**Spanish:** Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-374-7993 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**Chinese Mandarin:** 我┌提供免┌的翻┌服┌, ┌助┌解答┌于健康或┌物保┌的任何疑 ┌。如果┌需要此翻┌服┌, ┌致┌ 1-877-374-7993 (TTY: 711)。我┌的中文工作人┌很┌意┌助┌。 ┌是一┌免┌服┌。

**Chinese Cantonese:** ┌對我們的健康或藥物保險可能存有疑問, ┌此我們提供免費的翻譯 服務。如需翻譯服務, 請致電 1-877-374-7993 (TTY: 711)。我們講中文的人員將樂意┌┌提供幫助。這 是一項免費服務。

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**Tagalog:** Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-374-7993 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

**French:** Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-374-7993 (TTY : 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-877-374-7993 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

**German:** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-374-7993 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-374-7993 (TTY: 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

**Russian:** Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-374-7993 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:** إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لديناً. للحصول على مترجم فوري، ليس علينا سوى الاتصال بنا على 1-877-374-7993 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

**Hindi:** हमारे सवास्थ्य या दवा की योजना के बारे में आपके कसिी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-374-7993 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हन्दिी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-374-7993 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

**Portugués:** Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-374-7993 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

**French Creole:** Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-374-7993 (TTY : 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

**Polish:** Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-374-7993 (TTY: 711). Ta usługa jest bezpłatna.

**Japanese:** ┌社の健康 健康保┌と┌品 ┌方┌プランに┌するご質問にお答えするため に、無料の通┌サ┌ビスがありますございます。通┌をご用命になるには、1-877-374-7993 (TTY: 711)にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサ┌ ビスです。