TUFTS Health Plan

Tufts Health Plan Medicare Preferred Dental Option Enrollment Form

This Enrollment Form is for new and current members that want to add the Tufts Health Plan Medicare Preferred Dental Option to their existing coverage under Tufts Medicare Preferred HMO. This additional benefit is administered through Dominion Dental Services, Inc. The monthly premium charge of $30 for *HMO Prime Rx, HMO Prime Rx Plus,* and *HMO Prime No Rx* plans; and $18.50 for *HMO Saver Rx*, *HMO Basic Rx*, *HMO Basic No Rx, HMO Value Rx, and HMO Value No Rx* plans will be added to your current plan premium.

Current members can purchase Optional Supplemental Benefits during the following election periods: From October 15 through December 7 for a January 1 effective date; or from January 1 through January 31 for a February 1 effective date.

New members can purchase these Optional Supplemental Benefits within the first month of their enrollment. Benefits will become effective the first of the following month.

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

We suggest providing your mobile number so that we can provide the most timely information and updates.

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 Tufts Health Plan Medicare Preferred Dental Option will be added to your current Tufts Medicare Preferred 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 Relations Department at **1-800-701-9000 (TTY: 711)**.

Please continue to page 2. A signature is required to complete your enrollment in the Tufts Health Plan Medicare Preferred Dental Option. ›

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 Tufts Health Plan Medicare Preferred Dental Option for $30 ($18.50 for *HMO Saver Rx*, *HMO Basic Rx*, *HMO Basic No Rx, HMO Value Rx, and HMO Value No Rx* members) per month, which is in addition to my monthly plan premium.
2. I understand that the Tufts Health Plan Medicare Preferred Dental Option is subject to the terms and conditions stated in my Tufts Medicare Preferred HMO *Evidence of Coverage*.
3. I understand that in order to be eligible for the Tufts Health Plan Medicare Preferred Dental Option, I must remain a member of Tufts Medicare Preferred HMO Plan. If I disenroll from Tufts Medicare Preferred HMO Plan, I will be automatically disenrolled from the Tufts Health Plan Medicare Preferred Dental Option.
4. The plan is administered by Dominion Dental Services, Inc., which operates under the trade name Dominion National. Services must be performed by providers in the Dominion PPO Network. For additional questions regarding this benefit, please contact Customer Relations.
5. I understand that I may voluntarily disenroll from the Tufts Health Plan Medicare Preferred Dental Option by giving advance notice in writing. I will be disenrolled effective on the first of the month after Tufts Health Plan Medicare Preferred receives my signed and completed disenrollment request.
6. If I fail to pay the monthly premium for the Tufts Health Plan Medicare Preferred Dental Option, I will lose this optional supplemental benefit, but will remain enrolled in the Tufts Medicare Preferred 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: ___ - ___ - ____ Relationship to Enrollee:

D Please mail this completed form to:

Tufts Health Plan
705 Mount Auburn Street
P.O. Box 9178
Watertown, MA 02472-1508

For more information, contact Customer Relations at **1-800-701-9000 (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.

Tufts Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-701-9000 (TTY: 711).