



TUFTS MEDICARE PREFERRED HMO TUFTS MEDICARE PREFERRED DENTAL OPTION ENROLLMENT FORM

PO Box 9178
Watertown, MA 02472

This Enrollment Form is for current members that want to add the Tufts Medicare Preferred Dental Option to their existing coverage under Tufts Health Plan Medicare Preferred.

This additional benefit is administered through Delta Dental of Massachusetts. The monthly premium charge of \$54.00 will be added to your current plan premium. Tufts Health Plan Medicare Preferred will notify you of your effective date of coverage.

To Enroll in the Tufts Medicare Preferred Dental Option, Please Provide the Following Information:			
Member ID:		Birth Date:	
Last Name:	First Name:		Middle Initial:
Permanent Street Address:			
City:		State:	ZIP Code:
County:		Home Phone Number: ()	
Mailing Address (Only if Different From Your Permanent Residence Address):			
Mailing Address:			
City:		State:	ZIP Code:

Paying Your Plan Premium
<p>The way you choose to pay your monthly plan premium will automatically be the same method that's used to pay for this dental plan.</p> <p>The premium charge of \$54.00 per month for the Tufts Medicare Preferred Dental Option will be added to your current 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).</p>
<p>Please continue to page 2. A signature is required to complete your enrollment in the Tufts Medicare Preferred Dental Option.</p>

Tufts Health Plan is an HMO plan with a Medicare contract. Enrollment in Tufts Health Plan depends on contract renewal.

Please Read and Sign Below

By completing this Optional Supplemental Benefit Enrollment Form, I agree to add the Tufts Medicare Preferred Dental Option for \$54.00 per month, which is in addition to my monthly plan premium. I understand that the Tufts Medicare Preferred Dental Option is subject to the terms and conditions stated in my Tufts Medicare Preferred HMO Evidence of Coverage.

I understand that in order to be eligible for the Tufts 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 Medicare Preferred Dental Option.

Delta Dental of Massachusetts is an Independent Licensee of the Delta Dental Plans Association. ®Registered Marks of the Delta Dental Plans Association. SMService Mark of Delta Dental Plan Association.

Important: Your dental benefit and coverage plan is called the “Tufts Medicare Preferred Dental Option,” which requires members to seek services from providers in the Delta Dental PPOSM network only. Your dental benefit under this plan **does not cover** dental services from Delta Dental providers who are outside of the PPO network or any out-of-network providers. For additional questions regarding this benefit or provider network, please contact customer service using the number listed on your card.

I understand that I may voluntarily disenroll from the Tufts 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. If I fail to pay the monthly premium for the Tufts Medicare Preferred Dental Option, I will lose this optional supplemental benefit, but will remain enrolled in the Tufts Medicare Preferred HMO Plan.

The information of 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 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: _____	Date: _____
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If you are the authorized representative, you must sign above and provide the following information:

Name: _____ Address: _____

Phone Number: (_____) _____ - _____ Relationship to Enrollee: _____

Please Mail This Completed Form to:

Tufts Health Plan
705 Mount Auburn Street
P.O. Box 9178
Watertown, MA 02471-9948

For More Information:

Please contact Customer Relations at 1-800-701-9000 (TTY: 711) with any questions. Representatives are available Monday - Friday, 8 a.m. to 8 p.m. (From October 1 - March 31, representatives are available 7 days a week, 8 a.m. to 8 p.m.) After hours and on holidays, please leave a message, and a representative will return your call on the next business day.

Tufts Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Tufts Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Tufts Health Plan:

- 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 Tufts Health Plan at 1-800-701-9000 (TTY: 711).

If you believe that Tufts Health Plan 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:

Tufts Health Plan, Attention:

Civil Rights Coordinator, Legal Dept.
705 Mount Auburn St. Watertown, MA 02472
Phone: 1-888-880-8699 ext. 48000 (TTY: 711)
Fax: 1-617-972-9048
Email: OCRCoordinator@tufts-health.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Tufts Health Plan 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>.

thpmp.org | 1-800-701-9000 (TTY: 711)

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-701-9000 (TTY: 711).

Arabic: ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-701-9000 (رقم هاتف الصم والبكم: 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 1-800-701-9000 (TTY: 711)。
Farsi: توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با تماس بگیرید. 1-800-701-9000 (TTY: 711)

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-701-9000 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-701-9000 (TTY: 711).

Greek: ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-701-9000 (TTY: 711).

Gujarati: સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-701-9000 (TTY: 711).

Haitian Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-701-9000 (TTY: 711).

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-701-9000 (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。1-800-701-9000 (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 ទូរស័ព្ទ 1-800-701-9000 (TTY: 711)

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-701-9000 (TTY: 711) 번으로 전화해 주십시오.

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-701-9000 (TTY: 711).

Navajo: Díí baa akó nínízin: Díí saad bee yánílt'igo Diné Bizaad, saad bee áká'ánída'áwođeę, t'áá jiikeh, éí ná hóló, koji' hódílnih 1-800-701-9000 (TTY: 711).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-701-9000 (TTY: 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-701-9000 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-701-9000 (TTY: 711).

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-701-9000 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-701-9000 (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 1-800-701-9000 (TTY: 711).