TUFTS Health Plan

a Point32Health company

Tufts Medicare Supplement Dental Option Enrollment Form

This Enrollment Form is for current members that want to add the Tufts Medicare Supplement Dental Option to their existing coverage under Tufts Medicare Preferred Supplement. This additional benefit is administered through Dominion Dental Services, Inc. The monthly premium charge of $35.00 will be added to your current plan premium. Tufts Medicare Preferred Supplement will notify you of your effective date of coverage.

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 and email address 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 Medicare Supplement Dental Option will be added to your current Tufts Medicare Supplement 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 Member Services Department at **1-800-701-9000 (TTY: 711)**.

Please continue to page 2. A signature is required to complete your enrollment in the Tufts Medicare Supplement 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 Medicare Supplement Dental Option for $35.00 per month, which is in addition to my monthly plan premium.
2. I understand that the Tufts Medicare Supplement Dental Option is subject to the terms and conditions stated in my *Tufts Medicare Preferred Supplement Policy*.
3. I understand that in order to be eligible for the Tufts Medicare Supplement Dental Option, I must remain a member of Tufts Medicare Preferred Supplement. If I disenroll from Tufts Medicare Preferred Supplement, I will be automatically disenrolled from the Tufts Medicare Supplement Dental Option.
4. Dental benefits for members of Tufts Health Plan Medicare Supplement are administered by Dominion Dental Services, Inc. For questions regarding your benefits or provider network, please contact Member Services.
5. I understand that I may voluntarily disenroll from the Tufts Medicare Supplement Dental Option by giving advance notice in writing. I will be disenrolled effective on the first of the month after Tufts Medicare Preferred Supplement receives my signed and completed disenrollment request.
6. If I fail to pay the monthly premium for the Tufts Medicare Supplement Dental Option, I will lose this optional supplemental benefit, but will remain enrolled in Tufts Medicare Preferred Supplement.
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
P.O. Box 483
Canton, MA 02021-9936

For more information, contact Member Services 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, or sex (including pregnancy, sexual orientation, and gender identity).
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-701-9000 (TTY: 711).