ConnectiCare

Optional Supplemental Benefit Add/Drop Form

First Name:	Last Name:	Member ID Number: **K**
Phone Number:	Email Address:	

I am currently active with the **ConnectiCare Passage (HMO)**, **ConnectiCare Choice (HMO)**, **ConnectiCare Flex (HMO-POS)**, or the **ConnectiCare Choice Part B Saver (HMO) Plan** and would like to add and/or drop Optional Supplemental Benefits.

Please check all that apply:

I want to add:

- ☐ Dental 1 (with $2,000 annual limit)
- ☐ Dental 2 (with $3,000 annual limit)
- ☐ Dental 3 (with $3,500 annual limit)

I want to drop:

- ☐ Dental 1 (with $2,000 annual limit)
- ☐ Dental 2 (with $3,000 annual limit)
- ☐ Dental 3 (with $3,500 annual limit)

Dental Optional Supplemental Benefit monthly premiums:

- Dental 1 $29 and Dental 2 $39 (PPO Comprehensive) – Choice Plan 2, Choice Plan 3, Flex Plan 3
- Dental 1 $39 and Dental 2 $49 (PPO Comprehensive and Preventive) – Choice Plan 1, Flex Plan 1, Flex Plan 2, Passage Plan 1, Choice Part B Saver
- Dental 3 $39 (Indemnity Comprehensive and Preventive) – Choice Part B Saver, Choice Plan 1, Choice Plan 2, Choice Plan 3, Flex Plan 1, Flex Plan 2, Flex Plan 3, Passage Plan 1

☐ I agree that I am submitting this request to add and/or drop Optional Supplemental Benefits.

Would you like the premium for this plan deducted from your Social Security Administration (SSA) or Railroad Retirement Board (RRB) monthly benefit check? ☐ Yes ☐ No

If you don't select premium deduction, you will receive a bill each month.

The effective date of enrollment and/or disenrollment is the first day of the month after the month in which the request was received.

ConnectiCare offers Optional Supplemental Benefits for an additional monthly plan premium. You must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party). Optional Supplemental Benefits are subject to the terms and conditions stated in your Evidence of Coverage.

I understand that the phone number and/or email I provided may be used by ConnectiCare or any of its contracted parties to contact me about my account, my health benefit plan, or related programs or services provided to me.

Proposed Effective Date:	Date Submitted:	Agent ID:

If you have any questions, you can call and speak to a Member Services representative at **800-224-2273** (TTY: **711**) 8 am to 8 pm, seven days a week.