DeltaCare® USA

CCHP Senior Program (HMO)
Dental Enrollment & Provider Selection Form

Complete this form if you are enrolled in the CCHP Senior Program (HMO) and want to enroll in the Optional Supplemental Dental Plan offered by Delta Dental of California. Please print clearly when completing the enrollment form and return to CCHP.

☐ ***If you are already a CCHP Senior Program (HMO) member***, you may add the optional dental benefits to your CCHP Senior Program (HMO) coverage by sending in the enrollment form

- during the Annual Election Period October 15, 2011 – December 31, 2011 for coverage to become effective on January 1, 2012,

☐ ***If you are a new enrollee to the CCHP Senior Program (HMO)*,** you can add the Optional Supplemental Dental Plan within 30 days of enrolling in the CCHP Senior Program (HMO). Your coverage is effective the first of the month following the date we receive your completed enrollment form.

☐ Yes, I would like to enroll in the CCHP Senior Program (HMO) Optional Supplemental Dental Plan for $14.60 a month, which is in addition to my Medicare Part B and CCHP Senior Program (HMO) monthly premiums. These premiums are paid to CCHP. You will receive a monthly bill which is separate from your monthly plan premium. This program is voluntary. All dental care must be received within the DeltaCare USA network. I may choose to drop coverage at any time. If I choose to drop the program, I may not reenter the program until the next Annual Open Enrollment Period. I understand that the dental coverage is provided by Delta Dental of California as described in the Evidence of Coverage.

CCHP Senior Program (HMO)	Group No.: 06609	Effective Date:

Applicant Information

Last Name	First Name	Middle	CCHP ID No.
Permanent Residence (*Street Address* ***ONLY*** *– No P.O. Box*)			Apt. #
City	Sate	Zip	County
Gender ☐ Male ☐ Female	Date of Birth (mm/dd/yyyy)	Home Phone ( ) -	Work Phone ( ) -
Dental Provider Selection	Provider Name		Provider/Facility No.

FM_DCUSA_Enroll_CA_6609 (08-11)

H0571_2012_34 CMS approved 10172011

Chinese Community Health Plan (CCHP) is a Medicare Advantage Organization with a Medicare contract.

The Optional Supplemental Dental Plan is only available to members enrolled in or applying for coverage in CCHP Senior Program.

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 CCHP or by Medicare.

Applicant Signature: ______________________________ **Today's Date:** ___________

If you are the authorized representative, you must sign above and complete the following information:

Name: ____

Address: ____

Phone Number: ________________________ Relationship to Enrollee: ________________

IMPORTANT: Can you read this document? If not, we can have somebody help you read it. For free help, please call Delta Dental at 1-866-247-2486 Monday through Friday between 5 a.m. and 6 p.m. Pacific time. You may also be able to receive this document in Spanish or Chinese. TTY/TDD users call 800-735-2929.

IMPORTANTE: ¿Puede leer este documento? Si no, podemos ayudarle. Para obtener ayuda gratis, llame a Delta Dental al 1-866-247-2486 Monday through Friday between 5 a.m. and 6 p.m. Pacific time. También puede recibir este documento en español o chino. Usuarios de TTY/TDD pueden llamar al 1-800-735-2929.

重要通知：您能讀這份文件嗎？如有問題，我們可請他人協助您。 如需免費協助，請電Delta Dental 1-866-247-2486 ，服務時間為太平洋地區標準時間週一至週五早上5點至下午6點。 您也能取得這份文件的西班牙文或中文譯本。 TTY/TDD專線使用者請撥1-800-735-2929 。

Return the signed form to:

CCHP
445 Grant Ave Suite 700
San Francisco, CA 94108
Attn: CCHP Senior Program (HMO)