TUFTS Health Plan
Medicare Preferred

2012 HMO INDIVIDUAL ENROLLMENT FORM

Please contact Tufts Health Plan Medicare Preferred
if you need information in another language or format (Braille).

To Enroll in Tufts Medicare Preferred HMO, Please Provide the Following Information:

Please check which plan you want to enroll in:

If You Live In: Hampden County			**If You Live In:** Bristol*, Middlesex, Norfolk, Plymouth* Counties		
____ HMO Basic No Rx	$0	per month	____ HMO Basic No Rx	$0	per month
____ HMO Basic Rx	$27.90	per month	____ HMO Basic Rx	$27.90	per month
____ HMO Value No Rx	$24.00	per month	____ HMO Value No Rx	$72.00	per month
____ HMO Value Rx	$51.90	per month	____ HMO Value Rx	$99.90	per month
____ HMO Prime No Rx	$54.00	per month	____ HMO Prime No Rx	$102.00	per month
____ HMO Prime Rx	$81.90	per month	____ HMO Prime Rx	$129.90	per month
____ HMO Prime Rx Plus	$112.40	per month	____ HMO Prime Rx Plus	$160.40	per month
If You Live In: Hampshire County			**If You Live In:** Essex, Suffolk, Worcester Counties		
____ HMO Basic No Rx	$0	per month	____ HMO Basic No Rx	$20.00	per month
____ HMO Basic Rx	$27.90	per month	____ HMO Basic Rx	$47.90	per month
____ HMO Value No Rx	$52.00	per month	____ HMO Value No Rx	$93.00	per month
____ HMO Value Rx	$79.90	per month	____ HMO Value Rx	$120.90	per month
____ HMO Prime No Rx	$82.00	per month	____ HMO Prime No Rx	$126.00	per month
____ HMO Prime Rx	$109.90	per month	____ HMO Prime Rx	$153.90	per month
____ HMO Prime Rx Plus	$140.40	per month	____ HMO Prime Rx Plus	$184.40	per month
If You Live In: Barnstable County			*If you live in one of the following zip codes, you live outside the service area and are not eligible to be a member: Bristol County - 02715, 02718, 02764, 02779, 02780, 02783. Plymouth County - 02344, 02346, 02347, 02348, 02349.		
____ HMO Basic No Rx	$0	per month			
____ HMO Basic Rx	$27.90	per month			
____ HMO Value No Rx	$72.00	per month			
____ HMO Value Rx	$99.90	per month			
____ HMO Prime No Rx	$112.00	per month			
____ HMO Prime Rx	$139.90	per month			
____ HMO Prime Rx Plus	$170.40	per month			

LAST Name:	**FIRST Name:**	**Middle Initial**	☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: (__ __/__ __/__ __ __ __) (MM/DD/YYYY)	Sex: ☐M ☐F	**Home Phone Number:** ( )	**Alternate Phone Number:** ( )
Email Address:			
Permanent Residence Street Address (P.O. Box is not allowed)	**City:**	**State:**	**ZIP Code:**
Mailing Address (only if different from your Permanent Residence Address):			
Street Address:	**City:**	**State:**	**ZIP Code:**
Emergency contact:	**Phone Number:** ( )	**Relationship to You:**	

Please Provide Your Medicare Insurance Information

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card

–OR–

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name: _____

Medicare Claim Number Sex _____

__ __ __ - __ __ - __ __ __ __ _____

Is Entitled To Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Paying Your Plan Premium

You can pay your monthly plan premium including any late enrollment penalty that you currently have or may owe by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or Railroad Retirement Board (RRB). DO NOT pay Tufts Health Plan Medicare Preferred the Part D-IRMAA.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

☐ **Get a Bill Each Month**

☐ **Electronic Funds Transfer (EFT) from your bank account each month**

☐ **Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check**
The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

Please Read And Answer These Important Questions:

1. Please choose a Tufts Medicare Preferred HMO Contracted Primary Care Physician (PCP):

_____

☐ Yes ☐ No **Are you a current patient?**

☐ Yes ☐ No **2. Do you have End-Stage Renal Disease (ESRD)**
If you have had a successful kidney transplant and/or you don't need regular dialysis any more, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

☐ Yes ☐ No **3. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to Tufts Medicare Preferred HMO?**

If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage:	ID # for this coverage:	Group # for this coverage
_____	_____	_____

☐ Yes ☐ No **4. Are you a resident in a long-term care facility, such as a nursing home? If "yes", please provide the following information:**

Name of Institution:	Address & Phone Number of Institution (number and street):	
_____	_____	_____

☐ Yes ☐ No **5. Are you enrolled in your State Medicaid program?**
If "yes", please provide your Medicaid number:

☐ Yes ☐ No **6. Do you or your spouse work?**

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:

☐ Spanish ☐ Large Print

Please contact Tufts Health Plan Medicare Preferred at 1-800-978-2222 (TTY: 1-888-899-8977) if you need information in another format or language than what is listed above. Our office hours are Monday - Friday 8:00 a.m. - 8:00 p.m. (From Oct. 15 - Feb. 14, representatives are available 7 days a week 8:00 a.m. - 8:00 p.m.) After hours and on holidays, please leave a message and a representative will return your call on the next business day.

Please Read This Important Information

If you currently have health coverage from an employer or union, joining Tufts Medicare Preferred HMO could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Tufts Medicare Preferred HMO. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please Read and Sign Below

By completing this enrollment application, I agree to the following:

Tufts Health Plan Medicare Preferred is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 – December 7 of every year), or under certain special circumstances.

Tufts Medicare Preferred HMO serves a specific service area. If I move out of the area that Tufts Medicare Preferred HMO serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Tufts Medicare Preferred HMO I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Tufts Health Plan Medicare Preferred when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Tufts Medicare Preferred HMO coverage begins, I must get all of my health care from Tufts Medicare Preferred HMO, except for emergency or urgently needed services or out-of-area dialysis services, and I must choose a primary care physician (PCP) and get a referral before seeing a specialist within my PCP's referral circle. If I obtain routine care from providers outside my PCP's referral circle neither Medicare nor Tufts Health Plan Medicare Preferred will be responsible for the cost. Services authorized by Tufts Medicare Preferred HMO and other services contained in my Tufts Medicare Preferred HMO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR TUFTS HEALTH PLAN MEDICARE PREFERRED WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Tufts Health Plan Medicare Preferred, he/she may be paid based on my enrollment in Tufts Medicare Preferred HMO.

Release of Information: By joining this Medicare health plan, I acknowledge that Tufts Health Plan Medicare Preferred will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Tufts Health Plan Medicare Preferred will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on 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 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 from Medicare.

Signature:	**Today's Date:**

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

Name: _____ **Address:** _____

Phone Number: (_____)_____ – _____ **Relationship to Enrollee** _____

Office Use Only: Internet

Name of staff member, agent, broker (if assisted in enrollment): _____

Plan ID #: _____

Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

Enrollment Dept. Copy - White **Member Copy - Yellow**