TUFTS Health Plan

P.O. Box 9178
Watertown, MA 02472

2022 Tufts Medicare Preferred HMO Group Retiree Election Form

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

Employer or Union name:

Group #:

Requested effective date:
(mm/dd/yyyy; must be in the future) / 0 1 /

A To enroll in Tufts Medicare Preferred HMO, please provide the following information

First name:

Middle initial:

Last name:

Title: (optional)
○ Mr. ○ Mrs. ○ Ms.

Birth date: (mm/dd/yyyy) / /

Sex:
○ M ○ F

Do you or your spouse work?
○ Yes ○ No

Primary phone number: - -

☐ This is a mobile number

Alternate phone number: (optional) - -

☐ This is a mobile number

We suggest providing your mobile number so that we can provide the most timely information and updates.

Email address:

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:

Emergency contact: (optional)

Phone number: - -

Relationship to you:

B Please provide your Medicare insurance information

Please take out your red, white, and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.
- **Or** attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name: (as it appears on your Medicare card)

Medicare number:

- -

Is entitled to:

HOSPITAL (Part A) Effective date (mm/dd/yyyy): / 01 /

MEDICAL (Part B) / 01 /

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

C Please read and answer these important questions

◯ **Yes**
◯ **No**

1. Are you the retiree?

If yes, retirement date: (mm/dd/yyyy) / /

If no, name of retiree:

◯ **Yes**
◯ **No**

2. Are you covering a spouse or dependents under this employer or union plan?

If yes, name of spouse:

Name(s) of dependent(s):

◯ **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:

Phone number: - -

Street address:

City:

State:

Zip code:

D Please choose a Tufts Medicare Preferred HMO contracted primary care physician (PCP)

If you don't have a PCP, we will automatically assign one to you. You can change your PCP at any time after you enroll.

Primary care physician:

Are you a current patient?

◯ Yes ◯ No

E Alternative languages and accessible formats

Preferred written language:

Preferred spoken language:

Select one if you want us to send you information in an accessible format:

◯ Braille ◯ Large print ◯ Audio CD

*Please contact Tufts Health Plan Medicare Preferred at **1-800-936-1902 (TTY: 711)** if you need information in an accessible format or language other than what is listed above. 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.*

F Please read the below and sign on the next page

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

1. 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 only be in 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.
2. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future.
3. **If enrolling in a Medicare Advantage plan without prescription drug coverage:** 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.
4. 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 if an enrollment period is available, or under certain special circumstances.
5. 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.
6. 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.
7. 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.
8. 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.
9. 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, and I must choose a primary care physician (PCP) and get a referral before seeing a specialist within my PCP's referral circle.

Please continue ›

10. 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.

11. 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

1. 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.

2. 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.

3. 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 (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:

Tufts Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-701-9000 (TTY: 711).

OFFICE/BROKER USE ONLY

Name of staff member/agent/broker, if assisted in enrollment: (please print)

Agent NPN:

Date application received (mm/dd/yyyy): / /

Effective date of coverage (mm/dd/yyyy): / /

Plan ID#:

Enrollment period:

☐ ICEP/IEP ☐ AEP ☐ OEP ☐ SEP (type:) ☐ Not eligible