

a Point32Health company P.O. Box 483 Canton, MA 02021-9936

2024 Tufts Medicare Preferred Supplement/PDP Group Retiree Election Form

Canton, MA 02021-9936				
Employer or Union name:		Group #:	D	
Requested effective date: (mm/dd/yyyy; must be in the future)	/ 0 1 /			
A To enroll in Tufts Medicare Preference please provide the following inf		DP,		
First name:	Middle initial:	Last name:		
Title: (optional) Birth date: ((mm/dd/yyyy)	Sex:	Do you	or your spouse work?
○ Mr. ○ Mrs. ○ Ms. /	/		Yes	○ No
Primary phone number:		e number: (optiona	mobile addres	ggest providing your e number and email ss so that we can le the most timely
This is a mobile number	This is a mo	bile number	-	nation and updates.
Email address:				
Permanent street address: (P.O. Box not	t allowed unless you d	o not have a perm	anent residen	ice)
City:			State:	Zip code:
Mailing address: (only if different from y	our permanent addres	ss)		
City:			State:	Zip code:
Emergency contact: (optional)				
Phone number:	Relationship to you	ı:		

B Please provide your Medicare insurance information						
Name: (as it appears on your Medicare card)						
Medicare number:						
Is entitled to:	Effective date (mm/dd/yyyy):					
HOSPITAL (Part A)						
MEDICAL (Part B)	/ 0 1 / I					
You must have Medicare Part A and Part B to join a Medicare Supplement plan or a Medicare prescription drug plan.						
e important questions						
coverage, VA benefits, or State pondrug coverage in addition to Tu	other private insurance, TRICARE, Federal harmaceutical assistance programs. Will lifts Medicare Preferred PDP? on (ID) number(s) for this coverage.					
	Group # for this coverage:					
n-term care facility, such as a nursin ollowing information.	ng home?					
	Phone number:					
City:	State: Zip code:					
	Medicare number:					

D Ethnicity and race, alternative languages, and a	ccessible formats					
Are you of Hispanic, Latino/a, or Spanish origin? Select all that apply.						
No, not of Hispanic, Latino/a, or Spanish origin	Yes, Cuban					
Yes, Mexican, Mexican American, Chicano/a	Yes, another Hispanic, Latino/a, or Spanish origin					
Yes, Puerto Rican	I choose not to answer.					
What's your race? Select all that apply.						
American Indian or Alaska Native Asian: Asian Indian Chinese Filipino Japanese Korean Vietnamese Other Asian	 □ Black or African American Native Hawaiian and Pacific Islander: □ Guamanian or Chamorro □ Native Hawaiian □ Samoan □ Other Pacific Islander □ White □ I choose not to answer 					
Preferred written language:	Preferred spoken language:					
Select one if you want us to send you information in an accessible						
Please Read This Important Information						
If you are a member of a Medicare Advantage plan (like drug coverage from your Medicare Advantage plan that Preferred Supplement/PDP, your membership in your Jour doctor and hospital coverage as well as your present Medicare Advantage plan sends you and if you have questions.	t will meet your needs. By joining Tufts Medicare Medicare Advantage plan may end. This will affect both cription drug coverage. Read the information that your					

Please read the below and sign on the next page

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

- Tufts Medicare Preferred PDP is a Medicare drug plan and has a contract with the Federal government. I
 understand that this prescription drug coverage is in addition to my coverage under Medicare, therefore, I will
 need to keep my Medicare Part A or Part B coverage.
- 2. It is my responsibility to inform Tufts Medicare Preferred PDP of any prescription drug coverage that I have or may get in the future.
- 3. I can only be in one Medicare Prescription Drug Plan at a time if I am currently in a Medicare Prescription Drug Plan, my enrollment in Tufts Medicare Preferred PDP will end that enrollment.
- **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. I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.
- **6.** I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Tufts Medicare Preferred PDP, he/she may be paid based on my enrollment in Tufts Medicare Preferred PDP.
- 7. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.

Release of Information

- By joining this Medicare prescription drug plan, I acknowledge that Tufts Medicare Preferred PDP 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 Medicare Preferred PDP 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:			
City.		State.	Zip code.			
			1 1 1			
Phone number:	Relationship to Enrollee:					
race, color, national origin, age, disability, ATENCIÓN: Si habla español, tiene a su di 701-9000 (TTY: 711).						
OFFICE/BROKER USE ONLY						
Name of staff member/agent/broker, if as	ssisted in enrollment: (please print)					
A ANDAL	A					
Agent NPN:	Agency Name:					
Date application received (mm/dd/yyyy):	Effective date of coverage (mm/dd/y)	/yy):				
Enrollment period:						
☐ ICEP/IEP ☐ AEP ☐ OEP ☐ SEP	(type:)] Not eligible			