

Medicare Preferred

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: Essex, Suffolk, Worcester		If You Live In: Barnstable, Bristol*, Hampden, Hampshire, Norfolk, Middlesex, Plymouth*	
___ HMO Basic No RX	\$16 per month	___ HMO Basic No RX	\$0 per month
___ HMO Basic RX	\$38 per month	___ HMO Basic RX	\$22 per month
___ HMO Basic RX Plus	\$48 per month	___ HMO Basic RX Plus	\$32 per month
___ HMO Value No RX	\$58 per month	___ HMO Value No RX	\$42 per month
___ HMO Value RX	\$80 per month	___ HMO Value RX	\$64 per month
___ HMO Value RX Plus	\$90 per month	___ HMO Value RX Plus	\$74 per month
___ HMO Prime No RX	\$96 per month	___ HMO Prime No RX	\$72 per month
___ HMO Prime RX	\$118 per month	___ HMO Prime RX	\$94 per month
___ HMO Prime RX Plus	\$128 per month	___ HMO Prime RX Plus	\$104 per month

*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.

LAST Name:	FIRST Name:	Middle Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
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Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number: (providing this information is optional)	Home Phone Number: ()
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Permanent Residence Street Address:	City:	State:	ZIP Code:
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Mailing Address (only if different from your Permanent Residence Address):			
Street Address:	City:	State:	ZIP Code:

Emergency contact: _____ **Phone Number:** () _____


Relationship to You: _____ **E-mail Address:** _____

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 the Social Security Administration or 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

We will send you a bill each month which you may pay by mail or by Electronic Funds Transfer (EFT). You also have the option to have your monthly premium withheld from your Social Security check. The SSA deduction may take two or more months to begin. In most cases, the first deduction from your SSA benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If you qualify for extra help with your Medicare prescription drug coverage costs and Medicare only pays a portion of this premium, we will bill you for the portion that Medicare does not cover. If you are interested in paying by EFT or by having your premium deducted from your Social Security check, please check one of the boxes below, otherwise you will receive a bill by mail each month.

Bill by Mail EFT Deduction Automatic Deduction from SSA

Please Read And Answer These Important Questions:

Please choose the name of a Primary Care Physician (PCP): _____ .

Yes No **1. Are you a current patient?**

Yes No **2. Do you have End Stage Renal Disease (ESRD)?**

If you answered “yes” to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant.

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 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. If you have health coverage from an employer or union, joining Tufts Medicare Preferred HMO may change how your current coverage works. 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 is no 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 Medicare Preferred HMO is a Medicare Advantage plan and I will need to keep my Parts A and B. I can only be in one Medicare Advantage plan at a time. 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 do not 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. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to Tufts Medicare Preferred HMO or by calling 1-800-Medicare. TTY users should call 1-877-486-2048 24 hours a day / 7 days a week.

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 Medicare Preferred HMO when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that Medicare beneficiaries are generally not 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, with the exception of emergency or urgently needed services or out-of-area dialysis services. 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 MEDICARE PREFERRED HMO WILL PAY FOR THE SERVICES.**

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Tufts Medicare Preferred HMO will release my information to Medicare, who may release it for research and other purposes which follow all 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 behalf of the individual under the laws of the State where the individual resides) 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 Tufts Medicare Preferred HMO or by Medicare.

Your Signature: _____	Today's Date: _____
If you are the authorized representative, you must provide the following information:	
Name: _____ Address: _____	
Phone Number: (_____) _____ - _____ Relationship to Enrollee _____	

Office Use Only:
Name of staff member (if assisted in enrollment): _____
Plan ID #: _____
Effective Date of Coverage: _____
ICEP/IEP: _____ OEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____