

Medicare Preferred

Please check which plan you want to enroll in:

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

If You Live In: Essex, Suffolk, Worcester	If You Live In: Barnstable, Bristol, Hampden, Norfolk, Middlesex, Plymouth
_____ PPO \$87 per month _____ PPO Rx \$109 per month _____ PPO Rx Plus \$119 per month	_____ PPO \$82 per month _____ PPO Rx \$104 per month _____ PPO Rx Plus \$114 per month

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: _____
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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:

Yes No **1. 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 **2. 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 PPO?
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 **3. 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 **4. Are you enrolled in your State Medicaid program?**
If “yes”, please provide your Medicaid number:

Yes No **5. 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 PPO could affect your employer or union health benefits. If you have health coverage from an employer or union, joining Tufts Medicare Preferred PPO 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 PPO 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 PPO 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 PPO serves a specific service area. If I move out of the area that Tufts Medicare Preferred PPO 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 PPO, 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 PPO 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.

With the exception of emergency and urgent care, your copays and deductibles will be higher if you use a provider who is not in our PPO network. In either case you are still covered and you don't need a referral.

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 PPO 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 PPO or by Medicare.

Your Signature: _____	Today's Date: _____
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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: _____