

**2009 HMO
INDIVIDUAL
ENROLLMENT FORM**

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 Counties | | | | If You Live In: Barnstable, Bristol*, Hampden, Hampshire, Norfolk, Middlesex, Plymouth* Counties | | | |
| ___ | HMO Basic No RX | \$0 | per month | ___ | HMO Basic No RX | \$0 | per month |
| ___ | HMO Basic RX | \$21 | per month | ___ | HMO Basic RX | \$21 | per month |
| ___ | HMO Basic RX Plus | \$37 | per month | ___ | HMO Basic RX Plus | \$37 | per month |
| ___ | HMO Value No RX | \$58 | per month | ___ | HMO Value No RX | \$42 | per month |
| ___ | HMO Value RX | \$79 | per month | ___ | HMO Value RX | \$63 | per month |
| ___ | HMO Value RX Plus | \$95 | per month | ___ | HMO Value RX Plus | \$79 | per month |
| ___ | HMO Prime No RX | \$96 | per month | ___ | HMO Prime No RX | \$72 | per month |
| ___ | HMO Prime RX | \$117 | per month | ___ | HMO Prime RX | \$93 | per month |
| ___ | HMO Prime RX Plus | \$133 | per month | ___ | HMO Prime RX Plus | \$109 | 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. |

| | | | |
|--|---|--|----------------------------------|
| 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: () |
|--|---|--|----------------------------------|

| | | | |
|--|--------------|---------------|------------------|
| Permanent Residence Street Address: | 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: _____ **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

You can pay your monthly plan premium by mail or electronic funds transfer (EFT). You can also choose to pay your premium by automatic deduction from your Social Security Check (SSA) each month. 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 does not cover. If you do not select a payment option, you will receive a bill each month. 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.

Please select a monthly premium payment option:

Bill by Mail EFT Deduction Automatic Deduction from your SS check (SSA)

Please Read And Answer These Important Questions:

Please choose the name of a Tufts Medicare Preferred Contracted 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 contact Tufts Medicare Preferred at 1-800-890-6600 (TDD: 1-888-899-8977) if you need information in another format or language. Our office hours are Monday through Friday, 8:30 a.m. - 5:00 p.m.



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 has a contract with the Federal government. I will need to keep my 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 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 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. 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: November 15 – December 31 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 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. I understand that beginning on the date Tufts Medicare Preferred HMO coverage begins, 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 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 MEDICARE PREFERRED HMO WILL PAY FOR THE SERVICES.**

I understand that if I am receiving assistance from a sales agent, broker or other individual employed by or contracted with Tufts Medicare Preferred HMO, he/she may be compensated based on my enrollment in Tufts Medicare Preferred HMO. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription drug options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

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 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 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 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: _____ OEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____ |