



**2016 Employer Group HMO Election Form**

DATE STAMP

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

PO Box 9178  
Watertown, MA 02472

Coverage Through Employer/Union name \_\_\_\_\_ Grp# \_\_\_\_\_

Last Name:		First Name:		Middle Initial:	
Birth Date: ( __ __ / __ __ / __ __ __ __ ) ( M M / D D / Y Y Y Y )		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Effective Date of Coverage:		
Email Address:					
Permanent Resident Street Address (P.O. Box is not allowed):					
Street Address:		City:	State:	ZIP Code:	
County:	Home Phone: (   )		Alternate Phone: (   )		
Mailing Address (only if different from your Permanent Residence Address):					
Street Address:		City:	State:	ZIP Code:	
Emergency contact:		Phone Number: (   )	Relationship to You:		

**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 Social Security or the Railroad Retirement Board.

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

	
<b>MEDICARE HEALTH INSURANCE</b>	
SAMPLE ONLY	
Name: _____	
Medicare Claim Number _____	Sex _____
_____ - _____ - _____	
Is Entitled To	Effective Date
HOSPITAL (Part A) _____	
MEDICAL (Part B) _____	

**Please Read And Answer The Following Questions:**

Name of Tufts Medicare Preferred HMO contracted Primary Care Physician (PCP)

Yes  No 1. Are you a current patient of this PCP?

Yes  No 2. Do you have End-Stage Renal Disease (ESRD)  
If you have had a successful kidney transplant and/or you don't need regular dialysis any more, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

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. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, 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 5. Do you or your spouse work?

Yes  No 6. Are you the retiree?  
If yes, retirement date (month/date/year): \_\_\_\_\_  
If no, name of retiree: \_\_\_\_\_

Yes  No 7. Are you covering a spouse or dependents under this employer or union plan?  
If yes, name of spouse: \_\_\_\_\_  
Name of dependents: \_\_\_\_\_

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:

Spanish  Large Print

Please contact Tufts Health Plan Medicare Preferred at 1-800-936-1902 (TTY: 1-888-899-8977) if you need information in another format or language. Representatives are available Monday - Friday, 8:00 a.m. - 8:00 p.m. (From Oct. 1 - Feb. 14, representatives are available 7 days a week, 8:00 a.m. - 8:00 p.m.) After hours and on holidays, please leave a message and a representative will return your call on the next business day.

**Please Read and Sign Below**

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

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. It is my responsibility to inform you of any prescription drug coverage that I have or may get 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 if an enrollment period is available, or under certain special circumstances.

**If enrolling in a Medicare Advantage without prescription drug coverage plan:** 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 an late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.

Tufts Medicare Preferred HMO serves a specific service area. If I move out of that 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 Health Plan Medicare Preferred when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. 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.

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 services, and I must choose a primary care physician (PCP) and get a referral before seeing a specialist within my PCPs referral circle. 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 Health Plan Medicare Preferred 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.**

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:**

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 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. 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: _____
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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**

Name of staff member, agent, broker (if assisted in enrollment): \_\_\_\_\_

Plan ID #: \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_

ICEP/IEP: \_\_\_\_\_ AEP: \_\_\_\_\_ SEP (type): \_\_\_\_\_ Not Eligible: \_\_\_\_\_