

2012 Fallon Senior Plan Premier HMO Enrollment Form

Please contact Fallon Community Health Plan if you need information in another language or format (Braille).

Please contact us at 1-866-231-3669 (TTY users, please call TRS Relay 711), Monday through Friday, 8 a.m. to 8 p.m. (From October 15 – February 14, we're available seven days a week).

To enroll, please provide the following information.

Group name: _____

Group number: _____

Authorized signature: _____

Requested effective date: _____

Last name: _____ First name: _____ Middle initial: _____ Mr. Mrs. Miss Ms.

Birth date: _____ Sex: M F Home phone number: _____ Alternate phone number: _____

Permanent residence street address: _____

City/town: _____ State: _____ ZIP code: _____ County: _____

Mailing address if different from above:

Street address: _____

City/town: _____ State: _____ ZIP code: _____

Please provide your Medicare insurance information.

Please use 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.

Name of beneficiary: _____

Sex: M F

Medicare claim number: _____ - _____ - _____

Is entitled to: **Effective date**

Hospital (Part A) _____/_____/_____

Medical (Part B) _____/_____/_____

Please read and answer these important questions.

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

If you have had a successful kidney transplant and/or you do not need regular dialysis anymore, please attach a note or records from your doctor showing you do not need dialysis or have had a successful kidney transplant. Otherwise, we may need to contact you to obtain additional information.

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 Fallon Senior Plan?** Yes No

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: _____

FCHP USE ONLY New enrollment Age-in

OEV required: _____ Sales staff initials: _____ OEV complete: _____

Name of staff member (if assisted in enrollment): _____

EGWP: _____ Not eligible: _____

Staff verification: _____ Effective date of coverage: _____

County code: _____ Previous insurance: _____

Please read and answer these important questions (continued).

3. Are you a resident in a long-term care facility, such as a nursing home? Yes No

If "yes," please provide the following information:

Name of institution: _____ Phone number: _____

Address (number and street): _____

4. Are you enrolled in your state Medicaid program? Yes No

If "yes," please provide your Medicaid number: _____

5. Are you the employee/former employee? Yes No

If yes and retired, retirement date (month/day/year) _____

If no, name of employee/former employee: _____

Former employee's retirement date: _____

6. Do you or your spouse work? Yes No

7. Have you had Medicare prescription drug coverage or other drug coverage that was at least as good as standard Medicare prescription drug coverage since you became eligible to join a Medicare drug plan? Yes No

If yes, please attach evidence that some or all of your previous prescription drug coverage was at least as good as Medicare drug coverage. If no, you may pay a penalty.

8. Name of chosen Primary Care Provider (PCP): _____

Please make sure your chosen PCP is in our network. If you are an existing patient, check here:

9. What is the name of your previous insurance carrier (optional): _____

Please check one of the boxes below if you would prefer us to send you information in another format:

Braille Audio tape Large print

Please contact Fallon Community Health Plan if you need more information in another format than what is listed above.

Please read the important information on the back and then sign below.

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 by Fallon Community Health Plan or by Medicare.

X _____ Date _____
Your signature/authorized representative

If you are the authorized representative, you must sign above and provide the following information:

Name (printed) Relationship

Address

(____) _____ - _____
Phone number

Questions? Call Fallon Senior Plan, Medicare Group Sales, at 1-866-231-3669 or Customer Service at 1-800-325-5669 (TTY users, please call TRS Relay 711), Monday through Friday, 8 a.m. to 8 p.m. (From October 15 – February 14, we're available seven days a week), or visit our Web site at www.fchp.org/medicare-choices.

Please read the important information below.

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

Fallon Senior Plan Premier 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 be in only 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 don't 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: October 15 – December 7 of every year), or under certain special circumstances.

Fallon Senior Plan Premier HMO serves a specific service area. If I move out of the area that Fallon Senior Plan Premier 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 Fallon Senior Plan Premier 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 FCHP when I get it to know which rules I must follow to receive 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 Fallon Senior Plan Premier HMO coverage begins, I must get all of my health care from Fallon Senior Plan Premier HMO, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Fallon Senior Plan Premier HMO and other services contained in my plan *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR Fallon Senior Plan Premier 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 FCHP, he/she may be paid based on my enrollment in Fallon Senior Plan Premier HMO.

Release of information:

By joining this Medicare health plan, I acknowledge that Fallon Senior Plan Premier HMO will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Fallon Senior Plan Premier HMO will release my information including my prescription drug event data (if applicable) to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this 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.

Information on premiums and prescription drug costs based on your income:

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs, including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you enroll in a plan with Medicare prescription drug coverage, and 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, you will be responsible for the amount that Medicare doesn't cover.

If you enroll in a plan with Medicare prescription drug coverage and you are assessed a Part D-Income Related Monthly Adjustment Amount (IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. **DO NOT** pay FCHP the Part D-IRMAA.