TUFTS Health Plan

Tufts Medicare Preferred Supplement/PDP 2016 Group Retiree Election Form

DATE STAMP

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: ☐ M ☐ 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.

MEDICARE HEALTH INSURANCE

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:

☐ Yes ☐ No 1. 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 2. 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 3. Some individuals may have other Medicare Supplement or drug coverage, including other private insurance, Worker's Compensation or VA benefits, or State pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to Tufts Medicare Preferred Supplement/PDP?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. Do you or your spouse work?

☐ Yes ☐ No 5. Are you the retiree?

If yes, retirement date (month/date/year): _____

If no, name of retiree: _____

☐ Yes ☐ No 6. 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

I understand and agree to the following related to the Tufts Medicare Preferred Group Retiree Supplement: I acknowledge that I must continue to be enrolled in Medicare Parts A & B and continue to pay my Part B premium, unless someone pays it for me or I will be ineligible for Tufts Medicare Preferred Supplement coverage effective as of the date I discontinue either Medicare Parts A or B

I understand and agree to the following related to the Tufts Medicare Preferred Group Retiree PDP: Tufts Health Plan Medicare Preferred is a Medicare drug plan and has a contract with the Federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. It is my responsibility to inform Tufts Medicare Preferred PDP of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time—if I am currently in a Medicare Prescription Drug Plan, my enrollment in Tufts Medicare Preferred PDP will end that enrollment.

Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, or if I qualify for certain special circumstances.

I understand that I must use network pharmacies except in an emergency when I cannot reasonably use Tufts Medicare Preferred PDP network pharmacies. Once I am a member of Tufts Medicare Preferred PDP, 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. I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

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 PDP. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.

By joining this Medicare prescription drug plan, I acknowledge that Tufts Health Plan Health Plan Medicare Preferred 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.

I understand and agree to the following related to both the Tufts Medicare Preferred Group Retiree Supplement and PDP Plans: Tufts Medicare Preferred Supplement/PDP Group retiree members can live anywhere in the US.

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 grant Tufts Health Plan any legal right that I may have to recover the cost of services for an illness or injury caused by someone else when these services have been or will be paid for by Tufts Health Plan. I agree that Tufts Health Plan and health care providers may obtain or release my medical records and medical services-related information for the following purposes: (a) administering benefits; (b) managing care, including utilization review, quality assurance and member satisfaction procedures; (c) conducting bona fide medical research; and (d) when required by law. I understand that calls to Customer Relations may be monitored for quality assurance. I understand that the benefits for which I will be eligible are those described in the Tufts Medicare Preferred Group Retiree Supplement Member Policy and Tufts Medicare Preferred PDP Evidence of Coverage.

I understand that my signature (or the signature of the person authorized to act on my behalf under State law 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 Tufts Health Plan and/or Medicare.

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

Plan ID #: _____

Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ SEP(type): _____