2020 Fallon Medicare Plus™ Premier HMO Enrollment Form

Please contact Fallon Health if you need information in another language or format (Braille).
Please contact us at 1-866-231-3669 (TRS 711), 8 a.m.–8 p.m., Monday–Friday. (Oct. 1–March 31, seven days a week.)

To enroll, please provide the following information.

Company name:	Group number:
Authorized signature:	Requested effective date:

Last name: First name: Middle initial:

Birth date: (MM/DD/YYYY)	Sex: ❑ M ❑ F	Home phone number:	Alternate phone number:
_____/_____/_____		(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___	(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Permanent residence street address (P.O. Box is not allowed):

City/town:	State:	ZIP code:	County:

Mailing address if different from above:

Street address: _____

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

Primary language (optional)	Race (optional)	Ethnicity (optional)

Please provide your Medicare insurance information.

Please use your Medicare card to complete this section.

Fill out this information as it appears on your Medicare card.

OR

Attach a copy of your Medicare card or your letter from the Social Security Administration or the Railroad Retirement Board.

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

Name (as it appears on your Medicare card):

_____

Medicare 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 Medicare Plus Premier HMO?** ❑ 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: _____

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): _____

Please read and answer these important questions (continued).

4. **Are you enrolled in the Massachusetts Medicaid (MassHealth) program?** ❑ Yes ❑ No
   If "yes," please provide your Medicaid (MassHealth) 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: _____
   Employee's/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 the box below if you would prefer us to send you information in another accessible format:

❑ Braille ❑ Audio tape ❑ Large print

Please contact Fallon Health at 1-866-231-3669 (TRS 711), if you need information in another language or accessible format other than what is listed above.

Please read the important information on the following page 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 Health or by Medicare.

X _____ _____
Your signature/authorized representative — Today's date

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

_____ _____
Name (printed) — Relationship to enrollee

_____
Address

(__ __ __) __ __ __ - __ __ __ __
Phone number

FALLON USE ONLY ❑ New enrollment ❑ Group to group
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: _____
Broker name: _____ Broker ID: _____

Please read the important information below.

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

Fallon Health is an HMO plan with a Medicare contract. Enrollment in Fallon Health depends on contract renewal. I will need to keep my Medicare Parts A and B. (This means I must continue to pay my Medicare Part B premium.) 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 Advantage Plan or Medicare 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 Medicare Plus Premier HMO serves a specific service area. If I move out of the area that Fallon Medicare Plus 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 Medicare Plus 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 Fallon Medicare Plus Premier HMO 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 Medicare Plus Premier HMO coverage begins, I must get all of my health care from Fallon Medicare Plus Premier HMO, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Fallon Medicare Plus 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 MEDICARE PLUS 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 Fallon Health, he or she may be paid based on my enrollment in Fallon Medicare Plus Premier HMO.

Release of information:

By joining this Medicare health plan, I acknowledge that Fallon Medicare Plus 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 Medicare Plus 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 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 Railroad Retirement Board. DO NOT pay Fallon Health the Part D-IRMAA.

1-866-231-3669 (TRS 711)

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