TUFTS Health Plan

PO Box 9178
Watertown, MA 02472

# 2019 Employer Group HMO Election Form

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

DATE STAMP

Coverage Through Employer/Union name Town of Needham/West Suburban Health Group Grp#_____

| Last Name: | First Name: | Middle Initial: |
|---|---|---|
| Birth Date: ( __ __ /__ __ /__ __ __ __ ) (MM/DD/YYYY) | 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 red, white and blue 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 Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

_____

Medicare Number: _____

Is Entitled To: Effective Date:

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

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

## 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 an accessible format:

☐ Spanish ☐ Large Print

Please contact Tufts Health Plan Medicare Preferred at 1-800-936-1902 (TTY: 711) if you need information in an accessible format or language other than what is listed above. Representatives are available Monday - Friday, 8 a.m. - 8 p.m. (From October 1 - March 31, representatives are available 7 days a week, 8 a.m. - 8 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: |
|---|---|

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: _____

**Tufts Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Tufts Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.**

## Tufts Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - — Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - — Qualified interpreters
  - — Information written in other languages

If you need these services, contact Tufts Health Plan at 1-800-701-9000 (TTY: 711).

If you believe that Tufts Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

**Tufts Health Plan, Attention:**

Civil Rights Coordinator, Legal Dept.
705 Mount Auburn St. Watertown, MA 02472
Phone: 1-888-880-8699 ext. 48000 (TTY: 711)
Fax: 1-617-972-9048
Email: OCRCoordinator@tufts-health.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Tufts Health Plan Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

**U.S. Department of Health and Human Services**
200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
1-800-368-1019 (TDD: 1-800-537-7697)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

**English:** ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-701-9000 (TTY: 711).

**Arabic:** ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-701-9000 (رقم هاتف الصم والبكم: 711).

**Chinese:** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-701-9000 (TTY: 711)。

**Farsi: توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. 1-800-701-9000 (TTY: 711) فراهم می باشد. با تماس بگیرید.

**French:** ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-701-9000 (TTY: 711).

**German:** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-701-9000 (TTY: 711).

**Greek:** ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-701-9000 (TTY: 711).

**Gujarati:** સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-701-9000 (TTY: 711).

**Haitian Creole:** ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-701-9000 (TTY: 711).

**Italian:** ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-701-9000 (TTY: 711).

**Japanese:** 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 1-800-701-9000 (TTY: 711）まで、お電話にてご連絡ください。

**Khmer (Cambodian):** ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-701-9000 (TTY: 711)

**Korean:** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-701-9000 (TTY: 711) 번으로 전화해 주십시오.

**Laotian:** ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-701-9000 (TTY: 711).

**Navajo:** Díí baa akó nínízin: Díí saad bee yáníltí'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, koji' hódíílnih 1-800-701-9000 (TTY: 711).

**Polish:** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-701-9000 (TTY: 711).

**Portuguese:** ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-701-9000 (TTY: 711).

**Russian:** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-701-9000 (TTY: 711).

**Spanish:** ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-701-9000 (TTY: 711).

**Tagalog:** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-701-9000 (TTY: 711).

**Vietnamese:** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-701-9000 (TTY: 711).