


Medicare Preferred

DATE STAMP

1. Personal Information

Last Name _____ First Name _____ Middle Initial _____
 Birth Date _____ Sex (M/F) _____ Primary Language _____ Social Security # _____ - _____ - _____
 Permanent Address _____ City _____ State _____ Zip Code _____
 County _____ Home phone number _____ Effective Date of Coverage _____
 Mailing Address (if different) _____ City _____ State _____ Zip Code _____
 Your (or spouse's) Former Employer's Name _____ Group # _____
 Person to contact in case of emergency _____ Phone # _____ Relationship _____

Please fill in these blanks so they look the same as what is on your Medicare card. You need to fill this out, or you can attach a copy of your Medicare card, or your Letter of Verification from the Social Security Administration or Railroad Retirement Board. We cannot call this election form "finished" until you have given us this information.

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

2. Plan information

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

YES NO Are you a current patient of this PCP?

3. Additional information

YES NO 1. Do you have End Stage Renal Disease (ESRD)?

NOTE: If you answered "yes" to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant.

Your answer to the following questions will not keep you from enrolling in Tufts Medicare Preferred HMO.

- YES NO 2. Are you a resident in an institution (e.g., skilled nursing facility, rehabilitation hospital)?
 If yes, Name of Institution _____
 Address of Institution (number and street) _____
 Phone number of Institution _____ Your Date of Admission into Institution _____
- YES NO 3. Do you receive Medicaid benefits?
 If yes, Medicaid Number _____
- YES NO 4. Do you, on your own or through your spouse, have other drug or medical coverage such as private insurance, Workers Compensation, VA benefits, or State pharmaceutical assistance?
 If yes, what do you have? _____
 Provide the name of your insurance or assistance _____
- YES NO 5. Do you, or your spouse work?
- YES NO 6. Are you currently a Tufts Health Plan member?
- YES NO 7. Are you switching from another plan with prescription drug coverage?
 If yes, what is the name of the plan you are switching from? _____
- YES NO 8. Have you previously been approved for assistance in paying your premiums, through the Federal Government?

Please Read and Sign Below:

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

Tufts Medicare Preferred HMO is a Medicare Advantage plan and I will need to keep my Parts A and B. I can only be in one Medicare Advantage plan at a time. 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 do not 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. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to Tufts Medicare Preferred HMO or by calling 1-800-Medicare. TTY users should call 1-877-486-2048. 24 hours a day/7 days a week.

Tufts Medicare Preferred HMO serves a specific service area. If I move out of the 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 Member Handbook or Evidence of Coverage document from Tufts Medicare Preferred HMO when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that Medicare beneficiaries are generally not 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, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by Tufts Medicare Preferred HMO 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 MEDICARE PREFERRED HMO WILL PAY FOR THE SERVICES.**

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 Medicare Preferred HMO will release my information to Medicare, who may release it for research and other purposes which follow all 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 behalf of the individual under the laws of the State where the individual resides) 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 Medicare Preferred HMO or by Medicare.

Your Signature: _____	Today's Date: _____
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If you are the authorized representative, you must provide the following information:

Name: _____

Address: _____

Phone Number: (_____) _____ – _____

Relationship to Enrollee _____

Office Use Only:

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

Plan ID #: _____

Effective Date of Coverage: _____

ICEP/IEP: _____ OEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____