2022 Fallon Medicare Plus™ Premier HMO Enrollment Form – Worcester County

To enroll, please provide the following information.

Company name:	Group number:
WSHG - TOWN OF WELLESLEY	4518709
Authorized signature:	Requested effective date:

Select plan to enroll in:

❑ **Fallon Medicare Plus Premier HMO** ☒ **Fallon Medicare Plus Central Premier HMO** *(limited network)*

Last name: First name: Middle initial:

Birth date: (MM/DD/YYYY) ____ / ____ / ____

Sex: ❑ M ❑ F

Home phone number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Mobile phone number: *(optional)* (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

❑ *I authorize Fallon Health to send me text messages related to my plan benefits and services.*

Email address: *(optional)* ____

❑ *I authorize Fallon Health to send me email messages related to my plan benefits and services.*

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: ____

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 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. **Are you the retiree?** ❑ Yes ❑ No

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

   If no, name of retiree: ____

2. **Are you covering a spouse or dependents under this employer or union plan?** ❑ Yes ❑ No

   If yes, name of spouse: ____

   Name(s) of dependent(s): ____

Please read and answer these important questions (continued).

3. Do you or your spouse work? ❑ 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 Fallon Health? ❑ Yes ❑ No

   If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

   _____

   Name of other coverage: _____

   ID # for coverage: _____

5. 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: _____

   Address & Phone Number of Institution (number and street):

   _____

6. Please Choose a Primary Care Physician (PCP), clinic or health center:

   _____

Please check the box below if you would prefer us to send you information in another accessible format:

❑ Braille ❑ Audio CD ❑ 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: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Please read the important information below.

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

Fallon Health is a Medicare Advantage 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 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. 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 and Fallon Medicare Plus Central Premier HMO serve a specific service area. If I move out of the area that Fallon Medicare Plus Premier HMO or Fallon Medicare Plus Central 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 or Fallon Medicare Plus Central 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 or Fallon Medicare Plus Central 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 or Fallon Medicare Plus Central Premier HMO coverage begins, I must get all of my health care from Fallon Medicare Plus Premier HMO or Fallon Medicare Plus Central Premier HMO, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Fallon Medicare Plus Premier HMO or Fallon Medicare Plus Central 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 NOR FALLON MEDICARE PLUS CENTRAL 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 or Fallon Medicare Plus Central Premier HMO.

Release of information:

By joining this Medicare health plan, I acknowledge that Fallon Medicare Plus Premier HMO or Fallon Medicare Plus Central 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 or Fallon Medicare Plus Central 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.

FALLON USE ONLY ❑ New enrollment ❑ Group to group

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

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

EGWP: _____ ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not eligible: _____

Staff verification: _____ Effective date of coverage: _____

County code: _____ Previous insurance: _____

Broker name: _____ Broker ID: _____

1-866-231-3669 (TRS 711)

8 a.m.–8 p.m., seven days a week
(Apr.–Sept., 8 a.m.–8 p.m., Mon.–Fri.)