2025 Fallon Medicare Plus™ Premier HMO Enrollment Form

SECTION 1 – All fields on this page are required *(unless marked optional)*.

To enroll, please provide the following information:

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

Last name: First name: Middle initial: *(optional)*

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

Preferred written language: *(optional)*	Preferred spoken language: *(optional)*
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 (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):

City/town:	State:	ZIP code:	County: *(optional)*

Mailing address *(only if different from your permanent address):*

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: _____

Please read and answer these important questions (continued).

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): _____

3. Do you or your spouse work? ☐ Yes ☐ No

4. Some individuals may have other drug coverage, including other private insurance, Workers' 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: *(optional)*

_____

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

☐ Braille ☐ Large print ☐ Audio CD* ☐ Data CD

** Audio messages will not be encrypted, which means they could be intercepted by others. By selecting audio, you agree to receive these audio messages without encryption.*

Please contact Fallon Health at 1-866-231-3669 (TRS 711) if you need information in an accessible format other than what is listed above. Our office hours are 8 a.m.–8 p.m., 7 days a week (April–September, Monday–Friday). TTY users should call TRS 711.

I want to get the following materials via email. Select one or more.

☐ Evidence of Coverage ☐ Formulary Email address: _____

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: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

SECTION 2 – All fields in this section are optional.

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? *Select all that apply.*

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban
- ☐ **I choose not to answer.**

What's your race? *Select all that apply.*

- ☐ American Indian or Alaska Native

Asian:

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

- ☐ Black or African American

Native Hawaiian and Pacific Islander:

- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

- ☐ White
- ☐ **I choose not to answer.**

What is your gender? Select one.

- ☐ Woman
- ☐ Man
- ☐ Non-binary
- ☐ I use a different term: _____
- ☐ **I choose not to answer.**

Which of the following best represents how you think of yourself? Select one.

- ☐ Lesbian or gay
- ☐ Straight, that is, not gay or lesbian
- ☐ Bisexual
- ☐ I use a different term: _____
- ☐ I don't know
- ☐ **I choose not to answer.**

SECTION 3 – Read this important information.

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 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's 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, they 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.

For individuals helping enrollee with completing this form only:	
Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.	
Name:	Relationship to enrollee:
Signature:	
National Producer Number (Agents/Brokers only):	

fallonhealth

1-866-231-3669 (TRS 711)

8 a.m.–8 p.m., 7 days a week
(April–September, Monday–Friday)

FALLON HEALTH 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: _____

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