

2009 Fallon Senior Plan Premier Enrollment Form

To enroll, please provide the following information.

Group name: _____

Group number: _____

Authorized signature: _____

Requested effective date: _____

Last name: _____ First name: _____ Middle initial: _____ Mr. Mrs. Miss Ms.

Birth date: _____ Sex: M F Social Security number: _____ (optional) Home phone number: _____ (_____) _____

Permanent residence street address: _____

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 use your Medicare card to complete this section.

- Medicare information: Please fill in these blanks so they match your red, white and blue Medicare card, or;
- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board

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

MEDICARE HEALTH INSURANCE
1-800-MEDICARE (1-800-633-4227)

Name of beneficiary: _____

Sex: _____

Medicare claim 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 answered "yes" to this question and you do not need regular dialysis anymore, 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.

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 Senior Plan Premier?

Yes No

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

Name of other coverage: _____

ID #: _____ Group #: _____

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 of institution: _____

Address of institution (number and street): _____

Date you were admitted to the institution: ____/____/____

Please read and answer these important questions (continued).

4. Are you enrolled in your state Medicaid program? Yes No

If "yes," please provide your Medicaid 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: _____

6. Do you or your spouse currently 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(s) of prior insurance

Medical coverage: _____

Prescription drug coverage: _____

9. Name of chosen primary care provider (PCP): _____

If you are an existing patient, check here:

If you have special needs, plan information may be available in other formats. Please contact us at 1-800-868-5200 (TDD/TTY: 1-877-608-7677), seven days a week from 8 a.m. to 8 p.m.

Please read the important information on the back and then sign below.

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 form means that I have read and understand the contents of this form. 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 Community Health Plan or by Medicare.

X _____
Your signature/authorized representative Date

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

Name (printed) Relationship

Address

(_____) _____
Phone number

Questions? Call Fallon Senior Plan, Medicare Group Sales, at 1-800-333-2535, ext. 69411 (TDD/TTY: 1-877-608-7677), Monday through Friday from 8:30 a.m. to 5:00 p.m., or visit our Web site at www.fchp.org.

Fallon Senior Plan, Medicare Group Sales, 10 Chestnut St., Worcester, MA 01608

FCHP USE ONLY New enrollment Age-in Advance directive: Sent On file Declined

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

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

Group number: _____ Staff verification: _____ Effective date of coverage: _____

white copy - fallon community health plan pink copy - member

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

Fallon Senior Plan is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my parts A and B. I can be in only one Medicare Advantage plan at a time and I understand 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 only at certain times of the year, or under certain special circumstances, by sending a request to Fallon Community Health Plan, or to the group's benefit administrator, or by calling 1-800-MEDICARE. TTY users should call 1-877-486-2048.

Fallon Senior Plan serves a specific service area. If I move out of the area that Fallon Senior Plan 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 Senior Plan Premier, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Member Handbook/Evidence of Coverage* document from Fallon Senior Plan when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan.

I understand that beginning on the date Fallon Senior Plan coverage begins, I must get all of my health care from Fallon Senior Plan network providers or arranged by network providers, with the exception of emergency or urgently needed services or out-of-area dialysis services. Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage in Canada and Mexico. Services authorized by Fallon Senior Plan and other services contained in my plan *Member Handbook/Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR FALLON SENIOR PLAN 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 Senior Plan, he/she may be compensated based on my enrollment in Fallon Senior Plan.

Counseling services may be available in my state to provide advice concerning consumer Medicare supplement insurance or other consumer Medicare Advantage or Prescription Drug plan options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

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 Fallon Senior Plan will release my information, including my prescription drug event data (if applicable), to Medicare, who may release it for research and other purposes that 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.

get started today!

Thank you for applying for membership to Fallon Senior Plan Premier or Fallon Senior Plan Premier Preferred. Please complete the entire form and sign it. If we receive an incomplete form, it may not be processed and may be returned to you for additional information. (Remember to press firmly when filling out the enrollment form.)

The following checklist is to help make sure that the enrollment form is complete. Please check that you have filled out the following:

- Your full legal name as it appears on your Medicare card
- Your date of birth
- Your gender
- Your telephone number
- Your home address
- Your mailing address (if different from your home address)
- Your Medicare information (In order for your enrollment to be complete, you must either copy information from your Medicare card or you may attach a photocopy of your Medicare card or your Letter of Verification from the Social Security Administration or Railroad Retirement Board. If you do not have your Medicare information or have not been assigned a Medicare claim number at this time, call your local Social Security office to enroll or obtain proof of enrollment.)
- Answers to the important questions on pages one and two of the form.
- If you required assistance in completing this application, please include the assisting individual's signature, his or her relationship to you, his or her address, and his or her phone number.

After reading the back of your enrollment form, please remember to sign and date your enrollment form. Pull out the pink copy of your signed and dated enrollment form for your records. Please return your enrollment form to your benefits administrator, or directly to Fallon Community Health Plan if instructed to do so by your employer. If mailing to FCHP, please use the enclosed business reply envelope. If you misplace the return envelope, please mail your enrollment form to:

Medicare Group Sales
Fallon Community Health Plan
10 Chestnut St.
Worcester, MA 01608

Or, you may fax it to us at 1-508-839-0912.

If you need further information to complete this enrollment form, please call us at 1-888-333-2535, ext. 69411 (TDD/TTY: 1-877-608-7677), Monday through Friday from 8:30 a.m. to 5:00 p.m.