

Get started today!

Thank you for applying for membership to Fallon Senior Plan. 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.)

This checklist is to help make sure you have completed the enclosed enrollment form. Have you filled out the following information?

- Your plan choice
- 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.)
- Your plan premium payment option
- Answers to the important questions on page two of the enrollment 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. Return the rest of the form in the enclosed return envelope. If you misplaced the return envelope, mail your enrollment form to:

Fallon Senior Plan
10 Chestnut St.
Worcester, MA 01608
or you may fax it to us at 1-508-757-0572.

If you need further information to complete this enrollment form, please call us at

1-888-377-1980
(TDD/TTY: 1-877-608-7677),
seven days a week from 8 a.m. to 8 p.m.

Medicare beneficiaries may enroll in Fallon Senior Plan through the Centers for Medicare & Medicaid Services Online Enrollment Center located at www.medicare.gov. For more information, call us at the number above.



fallon senior plan™

2009 Fallon Senior Plan™ HMO Individual Enrollment Request Form

To enroll in Fallon Senior Plan, please provide the following information.

Please check which plan you want to enroll in:

<input type="checkbox"/> Fallon Senior Plan Saver (no prescription drug coverage) \$0	<input type="checkbox"/> Fallon Senior Plan Standard (no prescription drug coverage) \$72	<input type="checkbox"/> Fallon Senior Plan Plus (no prescription drug coverage) \$132
<input type="checkbox"/> Fallon Senior Plan Saver Basic Rx \$28	<input type="checkbox"/> Fallon Senior Plan Standard Basic Rx \$100	<input type="checkbox"/> Fallon Senior Plan Plus Basic Rx \$160
<input type="checkbox"/> Fallon Senior Plan Saver Enhanced Rx \$28	<input type="checkbox"/> Fallon Senior Plan Standard Enhanced Rx \$100	<input type="checkbox"/> Fallon Senior Plan Plus Enhanced Rx \$160

Last name: _____ First name: _____ Middle initial: ____ Mr/Mrs/Ms

Birth date: MM/DD/YYYY Social Security number (optional): _____ Sex M F

Home phone #: _____

Permanent residence street address: _____

City/town: _____ State: _____ ZIP code: _____

Mailing address if different from above: _____

City/town: _____ State: _____ ZIP code: _____

Please provide your Medicare insurance information.

Please take out your Medicare card to complete this section.

<p>Please fill in these blanks so they match your red, white and blue Medicare card.</p> <p style="text-align: center; margin: 10px 0;">OR</p> <p>Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.</p> <p>You must have Medicare Part A and Part B to join a Medicare Advantage plan.</p>	<p>Name of beneficiary: _____</p> <p>Sex: <input type="checkbox"/> M <input type="checkbox"/> F</p> <p>Medicare claim number: ____-____-____</p> <p>Is entitled to: Effective date:</p> <p style="margin-left: 20px;"><input type="checkbox"/> Hospital (Part A) _____</p> <p style="margin-left: 20px;"><input type="checkbox"/> Medical (Part B) _____</p>
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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: _____

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

Paying your plan premium:

You can pay your monthly plan premium by mail, automated clearinghouse (ACH) account debit, or by credit card (MasterCard or VISA only) each month. You can also choose to pay your premium by automatic deduction from your Social Security (SSA) check each month.

If you enroll in a plan with Medicare prescription drug coverage, and qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, you will be responsible for the amount that Medicare does not cover.

If you don't select one of the following payment options, we will bill you monthly.

Please select a premium payment option:

- Receive a bill monthly
- Automated clearinghouse (ACH) account debit from your checking or statement savings account each month. If you choose this option, we will contact you for more information.
- Credit card (MasterCard or VISA only.) If you choose this option, we will contact you for more information.
- Automatic deduction from your monthly SSA benefit check. The SSA deduction may take two or more months to begin. In most cases, the first deduction from your SSA benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.

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 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.

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? Yes No

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: _____

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: _____

Address (number and street): _____

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

If yes, please provide your Medicaid number: _____

5. Do you or your spouse work? Yes No

6. 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 1-888-377-1980 (TTY users should call 1-877-608-7677), seven days a week from 8 a.m. to 8 p.m.

Please read this important information.

If you currently have health coverage from an employer or union, joining Fallon Senior Plan could affect your employer or union health benefits. If you have health coverage from an employer or union, joining Fallon Senior Plan may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their Web site, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 of each year. In addition, you can join a Medicare Advantage plan during the open enrollment period between January 1 and March 31 of each year, as long as you do not change your prescription drug coverage. Additionally, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- I am new to Medicare.
- I recently moved outside of the service area for my current plan.
- I recently moved and this plan is a new option for me.
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I receive extra help paying for Medicare prescription drug coverage.
- I am no longer eligible for extra help paying for my Medicare prescription drugs.
- I live in or recently moved out of a long term care facility (for example, a nursing home or long-term care facility).
- I recently left a PACE program.
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's).
- I am either losing coverage or leaving employer or union coverage.
- I belong to a pharmacy assistance program provided by my state.
- I recently returned to the United States after living permanently outside of the U.S.
- None of these statements apply to me.*

*Please contact Fallon Senior Plan at 1-888-377-1980 (TTY users should call 1-877-608-7677) to see if you are eligible to enroll. We are open seven days a week from 8 a.m. to 8 p.m.

Please read the important information on the back and 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 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 Senior Plan or by Medicare.

Signature: _____ **Date:** _____

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

Name: (Print) _____ Relationship: _____

Address: _____

Phone number: (_____) _____ - _____

Please read the important information below.

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 that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug 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 the plan I am joining does 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. 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: November 15 – December 31 of every year), or under certain special circumstances.

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, 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 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 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 Fallon Senior Plan coverage begins, I must get all of my health care from Fallon Senior Plan, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by Fallon Senior Plan and other services contained in my Fallon Senior Plan *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 Medicare supplement insurance or other 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 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.