

2010 Fallon Senior Plan Premier HMO Enrollment Form

If you have special needs, plan information may be available in other formats, such as large print.
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.

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 Home phone number: _____ Alternate 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: M F

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? 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 of institution: _____

Address of institution (number and street): _____

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: _____

Former employee's retirement date: _____

6. Do you or your spouse 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. What is the name of your previous insurance carrier (optional):

9. Name of chosen Primary Care Provider (PCP): _____

Please make sure your chosen PCP is in our network. If you are an existing patient, check here:

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 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 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 1-866-231-3669 (TDD/TTY: 1-877-608-7677), Monday through Friday from 8:30 a.m. to 5:00 p.m., Customer Service at 1-800-868-5200 (TDD/TTY: 1-877-608-7677), or visit our Web site at www.fchp.org.

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: _____

County code: _____ Previous insurance: _____

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 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: 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 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 Senior Plan coverage begins, I must get all of my health care from Fallon Senior Plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Fallon Senior Plan 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 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 FCHP, he/she may be paid based on my enrollment in Fallon Senior Plan.

Release of Information: By joining this Medicare health plan, I acknowledge that Fallon Senior 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 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.