2021 Fallon Medicare Plus™ – Worcester County

Member Change Form

Directions: Please complete and sign this form ***only*** if you want to make a change in your plan. It is important to read this entire form and the *Summary of Benefits* booklets for details on plan premiums, cost-sharing and benefits associated with each plan.

Member name and address		
Last name	First name	M.I.
Medicare number	Date of birth	
Street address		
City/town	State	ZIP
Phone number (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___		
Mailing address (only if different from your permanent street address)		
Street address		
City/town	State	ZIP
Primary language (optional)		
Race (optional)	Ethnicity (optional)	

Yes, I want to change my plan choice for 2021 from _____.
insert your current plan

The following table includes the 2021 plan choices and the corresponding monthly premiums.

Please check ☑ which Fallon Medicare Plus (FMP) plan you want to enroll in:

FMP Central Orange HMO *(limited network)*	❑ $0/month (037-00)	**FMP Central Blue HMO** *(limited network)*	❑ $129/month (035-00)
FMP Orange HMO	❑ $0/month (034-15)	**FMP Blue HMO**	❑ $254/month (031-15)
FMP Central Green HMO *(limited network)*	❑ $34/month (036-00)	**FMP Super Saver HMO**	❑ $51/month (032-15)
FMP Green HMO	❑ $120/month (030-15)	**FMP Saver No Rx HMO**	❑ $71/month (029-15)

Please mail to:
Fallon Health, Attn: Enrollment and Billing Operations, 10 Chestnut St., Worcester, MA 01608.

If you enroll in an option that does not have a monthly premium and we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we will need to know how you would prefer to pay it. Please select a payment option from below to pay a late enrollment penalty.

If you enroll in a plan with Medicare prescription drug coverage that has a monthly premium and we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), you will pay this through the payment option you select below because it will be included with your monthly premium.

For more information on premiums and prescription drug costs based on your income, please refer to the last page.

Plan premium payment options

Please check the box next to the payment option that you would like. If you do not select a method of payment, we will bill you monthly.

- ❑ **Receive a bill monthly.**
- ❑ **Electronic Funds Transfer (EFT)** from your checking or savings account each month. If you choose this option, we will contact you for more information.
- ❑ **Credit card (Discover, MasterCard or VISA)** If you choose this option, we will contact you for more information.
- ❑ **Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.** (The Social Security deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

  I get monthly benefits from: ❑ Social Security ❑ RRB

Please read the important information on the last page 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 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 from Medicare.

X _____ _____

Your signature/authorized representative **Date**

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

Name (printed) _____

Relationship to Enrollee _____

Address _____

Phone number (_____) _____

If you need help completing this form, call us at 1-800-325-5669 (TRS 711), 8 a.m.–8 p.m., Monday–Friday. (Oct. 1–March 31, seven days a week.)

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

❑ Braille ❑ Audio CD ❑ Large print

STOP Please read the important information below. STOP

Fallon Health is a plan that has a contract with the Federal government.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Fallon Health, he/she may be paid based on my enrollment in Fallon Medicare Plus.

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 Health 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. I understand that people with Medicare aren't 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 coverage begins, I must get all of my health care from Fallon Medicare Plus, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Fallon Medicare Plus and other services contained in my Fallon Medicare Plus *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR FALLON MEDICARE PLUS WILL PAY FOR THE SERVICES.**

Information on premiums and prescription drug costs based on your income:

If you enroll in a plan with Medicare prescription drug coverage and you are assessed a Part D-Income-Related Monthly Adjustment Amount (IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the Railroad Retirement Board (RRB). DO NOT pay Fallon Health the Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs, including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

BROKER/AGENT INFO: Prior insurance: _____

Requested effective date: _____

Agency name (if applicable): _____

Broker/agent name: _____ Mass. Lic#: _____

SOA form: ❑ Yes ❑ No

FALLON USE ONLY: RTS verification: ❑ Yes ❑ No QNXT attribute needed: _____

Date received: _____ Method of receipt: _____

Telephonic: ❑ No ❑ Yes If yes, confirmation number: _____

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

Sales staff initials: _____ Plan ID#: _____ Effective date of coverage: _____

ENROLLMENT DEPT USE ONLY: