TUFTS Health Plan

P.O. Box 9178
Watertown, MA 02472

2022 Tufts Medicare Preferred Supplement/PDP Group Retiree Election Form

Employer or Union name: City of Boston

Group #: 3144 S/D

Requested effective date:
(mm/dd/yyyy; must be in the future) ___ / 01 / 2022

A To enroll in Tufts Medicare Preferred Supplement/PDP, please provide the following information

First name: | Middle initial: | Last name:

Title: (optional) ○ Mr. ○ Mrs. ○ Ms.

Birth date: (mm/dd/yyyy) ___ / ___ / ____

Sex: ○ M ○ F

Do you or your spouse work? ○ Yes ○ No

Primary phone number: ___ - ___ - ____

☐ This is a mobile number

Alternate phone number: (optional) ___ - ___ - ____

☐ This is a mobile number

We suggest providing your mobile number so that we can provide the most timely information and updates.

Email address:

Permanent street address: (P.O. box is not allowed)

City: | State: | Zip code:

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

City: | State: | Zip code:

Emergency contact: (optional)

Phone number: ___ - ___ - ____

Relationship to you:

B 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 Social Security or the Railroad Retirement Board.

Name: (as it appears on your Medicare card)

Medicare number:

Is entitled to:

Effective date (mm/dd/yyyy):

HOSPITAL (Part A) / 0 1 /

MEDICAL (Part B) / 0 1 /

You must have Medicare Part A and Part B to join a Medicare Supplement plan or a Medicare prescription drug plan.

C Please read and answer these important questions

◯ Yes
◯ No

1. 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 Tufts Medicare Preferred PDP?
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:

◯ Yes
◯ No

2. Are you a resident in a long-term care facility, such as a nursing home?
If yes, please provide the following information.

Name of institution:

Phone number:

Street address:

City:

State:

Zip code:

D Alternative languages and accessible formats

Preferred written language:

Preferred spoken language:

Select one if you want us to send you information in an accessible format:

◯ Braille ◯ Large print ◯ Audio CD

*Please contact Tufts Medicare Preferred Supplement/PDP at **1-800-936-1902 (TTY: 711)** if you need information in an accessible format or language other than what is listed above. Representatives are available 8:00 a.m.–8:00 p.m., 7 days a week from October 1 to March 31 and Monday–Friday from April 1 to September 30.*

Please Read This Important Information

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage Plan that will meet your needs. By joining Tufts Medicare Preferred PDP, your membership in your Medicare Advantage Plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. Read the information that your Medicare Advantage Plan sends you and if you have questions, contact your Medicare Advantage Plan.

E Please read the below and sign on the next page

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

1. Tufts Medicare Preferred PDP is a Medicare Drug plan and has a contract with the Federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare, therefore, I will need to keep my Medicare Part A or Part B coverage.
2. It is my responsibility to inform Tufts Medicare Preferred PDP of any prescription drug coverage that I have or may get in the future.
3. I can only be in one Medicare prescription drug plan at a time - if I am currently in a Medicare Prescription Drug Plan, my enrollment in Tufts Medicare Preferred PDP will end that enrollment.
4. 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 if an enrollment period is available, or under certain special circumstances.
5. I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.
6. I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Tufts Medicare Preferred PDP, he/she may be paid based on my enrollment in Tufts Medicare Preferred PDP.
7. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.

Release of Information

1. By joining this Medicare prescription drug plan, I acknowledge that Tufts Medicare Preferred PDP will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations.
2. I also acknowledge that Tufts Medicare Preferred PDP will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.
3. 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 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 from Medicare.

Signature:

Today's date (mm/dd/yyyy):

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

Full name:

Street address:

City:

State:

Zip code:

Phone number:

Relationship to Enrollee:

Tufts Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-701-9000 (TTY: 711).

OFFICE/BROKER USE ONLY

Name of staff member/agent/broker, if assisted in enrollment: (please print)

Agent NPN:

Date application received (mm/dd/yyyy):

Effective date of coverage (mm/dd/yyyy):

Plan ID#:

Enrollment period:

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