TUFTS Health Plan

a Point32Health company

Tufts Medicare Preferred Supplement 2024 Enrollment Application

Send your completed and signed form to:

Tufts Medicare Preferred Supplement
P.O. Box 483
Canton, MA 02021-9936

Please read the "Important Information" **section, fill out the application on pages 2–3, answer questions 1 through 5 on pages 4–5, then sign the application on page 6.**

Important Information

(a) You do not need more than one Medicare Supplement Insurance Policy.

(b) If you newly enroll in a Medicare Supplement 1 plan, you are not permitted to switch within the same company into a Medicare Supplement 1A plan until you have been covered by the company's Medicare Supplement 1 plan for at least 12 months.

(c) If you purchase this Policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(d) You may be eligible for Medicaid benefits and may not need a Medicare Supplement Insurance Policy.

(e) The benefits and premiums under your Medicare Supplement Insurance Policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your Policy will be reinstituted if requested within 90 days of losing Medicaid eligibility.

If the Medicare Supplemental Insurance Policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your Policy was suspended, the reinstituted Policy will not have outpatient prescription drug coverage, as you will be enrolled in the most comparable plan without outpatient prescription drug coverage.

(f) If you are eligible for, and have enrolled in a Medicare Supplement Insurance Policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement Insurance Policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement Insurance Policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement Insurance Policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan.

If the Medicare Supplement Insurance Policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your Policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, as you will be enrolled in the most comparable plan without outpatient prescription drug coverage.

(g) Counseling services are available in Massachusetts to provide advice concerning your purchase of a Medicare Supplement Insurance Policy and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). You may call the Massachusetts Executive Office of Elder Affairs insurance counseling program at **1-800-243-4636 (TTY: 1-800-439-2370)** or write to that office at the following address for more information: One Ashburton Place, 5th Floor, Boston, MA 02108.

Please answer all questions

Requested effective date:
(date must be in the future and the 1st of the month)

Check the Plan of your choice:
(You may be eligible for a 15% discount. Please see the Outline of Coverage for more information.)

◯ Tufts Medicare Preferred Supplement Core	**$139.00/month**
◯ Tufts Medicare Preferred Supplement 1*	**$245.50/month**
◯ Tufts Medicare Preferred Supplement 1A	**$210.00/month**
Optional supplemental dental benefit	
☐ Tufts Medicare Supplement Dental Option	**$33.00/month**

*Tufts Medicare Preferred Supplement 1 is only available to members who became Medicare eligible prior to 1/1/20.

Please select a premium payment option:

◯ Get a bill each month.

◯ Electronic Funds Transfer (EFT) from your bank account each month.
(If this option is selected, an EFT Authorization Form will be mailed to you. Please continue to pay your monthly premium until we notify you of your enrollment in the EFT program.)

Social Security Number:

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:

HOSPITAL (Part A) Effective date: (mm/dd/yyyy)

MEDICAL (Part B)

You must have Medicare Part A and Part B to join a Medicare Supplement Plan.

First name: Middle initial: Last name:

Title: (optional) Birth date: (mm/dd/yyyy) Sex:

◯ Mr. ◯ Mrs. ◯ Ms. ◯ M ◯ F

Home phone number:

☐ This is a mobile number

Alternate phone number: (optional)

☐ This is a mobile number

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

Email address: (optional)

Permanent street address: (P.O. Box not allowed unless you do not have a permanent residence)

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:

If you are under age 65, are you eligible for Medicare coverage due solely to End Stage Renal disease?

◯ Yes ◯ No

Are you currently a Tufts Health Plan member? **If yes,** please provide your Tufts Health Plan identification number:

◯ Yes ◯ No

Are you of Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ I choose not to answer.

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native

Asian:

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

- ☐ Black or African American

Native Hawaiian and Pacific Islander:

- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

- ☐ White
- ☐ I choose not to answer

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 at 1-800-701-9000 (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.

Questions

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement Insurance Policy, or that you had certain rights to buy such a Policy, you may be guaranteed acceptance in one or more of our Medicare Supplement Plans. Please include a copy of the notice from your prior insurer with your application.

PLEASE ANSWER ALL QUESTIONS. (Please mark Yes or No below with an **"X"**)

To the best of your knowledge:

1. ◯ **Yes** ◯ **No** **(a)** Did you turn age 65 in the last six months?

◯ **Yes** ◯ **No** **(b)** Did you enroll in Medicare Part B in the last six months?

(c) If yes, what was the effective date? (mm/dd/yyyy)

2. ◯ **Yes** ◯ **No** Are you covered for medical assistance through the state Medicaid program?
Note to Applicant: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer **"No"** to this question.

If yes, continue. **If no,** proceed to question 3.

◯ **Yes** ◯ **No** **(a)** Will Medicaid pay your premiums for this Medicare Supplement Insurance Policy?

◯ **Yes** ◯ **No** **(b)** Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

3. **(a)** If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave **"End"** blank.

Start: (mm/dd/yyyy) End: (mm/dd/yyyy)

◯ **Yes** ◯ **No** **(b)** If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement Insurance Policy?

◯ **Yes** ◯ **No** **(c)** Was this your first time in this type of Medicare plan?

◯ **Yes** ◯ **No** **(d)** Did you drop a Medicare Supplement Insurance Policy to enroll in the Medicare plan?

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4. ◯ **Yes** ◯ **No** **(a)** Do you have another Medicare Supplement Insurance Policy in force?

(b) **If yes,** with what company, and what plan do you have?

◯ **Yes** ◯ **No** **(c)** **If yes,** do you intend to replace your current Medicare Supplement Insurance Policy with this policy?

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5. ◯ **Yes** ◯ **No** Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)

(a) **If yes,** with what company, and what kind of policy?

(b) What are your dates of coverage under the other policy? If you are still covered under the other policy, leave **"End"** blank.

Start: (mm/dd/yyyy) End: (mm/dd/yyyy)

◯ **Yes** ◯ **No** **(c)** If you answered "yes" to question **5(a)**, are you replacing the other health insurance you indicated?

Please read and sign below

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

(a) The information supplied on this form is true and complete.

(b) I acknowledge that I must continue to be enrolled in Medicare Parts A & B, and continue to pay my Part B premium unless someone pays it for me, or I will be ineligible for Tufts Medicare Preferred Supplement coverage effective as of the date I discontinue either Medicare Parts A or B.

(c) I grant Tufts Health Plan any legal right that I may have to recover the cost of services for an illness or injury caused by someone else when these services have been or will be paid for by Tufts Health Plan.

(d) I agree that Tufts Health Plan and health care providers may obtain or release my medical records and medical services-related information for the following purposes: (a) administering benefits; (b) managing care, including utilization review, quality assurance and member satisfaction procedures; (c) conducting bona fide medical research; and (d) when required by law.

(e) I understand that calls to Member Services may be monitored for quality assurance.

(f) I understand that the benefits for which I will be eligible are those described in the Tufts Medicare Preferred Supplement Member Policy.

Dental benefits for members of Tufts Health Plan Medicare Supplement are administered by Dominion Dental Services, Inc., which operates under the trade name Dominion National. For questions regarding your benefits, please contact Member Services at **1-800-701-9000 (TTY: 711)**.

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 Massachusetts law 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 Massachusetts law to complete this enrollment and **2)** documentation of this authority is available upon request by Tufts Health Plan.

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: