

Medicare Preferred Please contact Tufts Medicare Preferred PDP if you need information in another language or format.

To Enroll in Tufts Medicare Preferred PDP, Please Provide the Following Information:

Please check which plan you want to enroll in:
 PDP Standard \$63.80 per month PDP Enhanced \$50.60 per month PDP Premier \$89.60 per month

LAST name: _____ **FIRST name:** _____ **Middle initial** _____
 Mr. Mrs. Ms.

Birth Date: (___ / ___ / ___) Sex: M F
 (MM / DD / YYYY) **Home Phone Number:** () **Alternate Phone Number:** ()

Permanent Residence Street Address (P.O. Box is not allowed):

City: _____ **State:** _____ **ZIP Code:** _____

Mailing Address (only if different from your Permanent Residence Address):
Street Address: _____ **City:** _____ **State:** _____ **ZIP Code:** _____

Emergency contact: _____
Phone Number: () _____ **Relationship to You:** _____


E-mail Address: _____

Please Provide Your Medicare Insurance Information

Please take out your Medicare card to complete this section.

- 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 Social Security or the Railroad Retirement Board.

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

MEDICARE			HEALTH INSURANCE	
SAMPLE ONLY				
Name: _____				
Medicare Claim Number _____			Sex _____	
_____ - _____ - _____				
Is Entitled To		Effective Date		
HOSPITAL (Part A)		_____		
MEDICAL (Part B)		_____		

Paying Your Plan Premium

You can pay your monthly plan premium by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month. People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible 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. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover. If you don't select a payment option, you will get a bill each month. *The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.

Please select a monthly premium payment option:

Bill by Mail EFT Deduction Automatic Deduction from your monthly Social Security Benefit Check*

Please Answer The Following 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: Address & Phone Number of Institution (number and street):

Please contact Tufts Medicare Preferred PDP at 1-800-978-2222 (TTY: 1-888-899-8977) if you need information in another format or language. Representatives are available Monday - Friday, 8:00 a.m. - 8:00 p.m. (Representatives are available 7 days a week, 8:00 a.m. - 8:00 p.m. from Nov 15- Mar 1.) After hours and on holidays, please leave a message and a representative will return your call the next business day.



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.

If you currently have health coverage from an employer or union, joining Tufts Medicare Preferred PDP could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Tufts Medicare Preferred PDP. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please Read and Sign Below

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

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. It is my responsibility to inform Tufts Medicare Preferred PDP of any prescription drug coverage that I have or may get in the future. 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. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (November 15 – December 31), unless I qualify for certain special circumstances.

Tufts Medicare Preferred PDP serves a specific service area. If I move out of the area that Tufts Medicare Preferred PDP serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies except in an emergency when I cannot reasonably use Tufts Medicare Preferred PDP network pharmacies. Once I am a member of Tufts Medicare Preferred PDP, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Tufts Medicare Preferred PDP when I get it to know which rules I must follow to get coverage.

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.

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. 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:

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. 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. 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 State 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 State law to complete this enrollment and 2) documentation of this authority is available upon request by Tufts Medicare Preferred PDP or by Medicare.

Signature:

Today's Date:

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

Name: _____ **Address:** _____

Phone Number: _____ **Relationship to Enrollee:** _____

Medicare Prescription Drug Plan Use Only:

Plan ID #: _____

Effective Date of Coverage: _____ IEP: _____ AEP: _____ SEP (type): _____

Plan Representative/agent/broker Signature: _____