2027 Tufts Medicare Preferred HMO Short Enrollment Request Form

Send your completed and signed form to:

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

A Personal information

First name:

Middle initial:

Last name:

Member ID number:

Email address:

Primary phone number:

Alternate phone number: (optional)

☐ This is a mobile number (optional)

☐ This is a mobile number (optional)

Email address: (optional)

By providing an SMS-enabled phone number you are giving Tufts Health Plan permission to send you text messages about your plan and benefits. You may unsubscribe from text messages at any time. For texting terms of use, please visit https://tuftshealthplan.com/text-terms-of-use.

☐ Opt out of SMS text messages

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:

Select a primary care provider (PCP)

A PCP is a doctor, nurse practitioner, clinical nurse specialist or physician assistant who provides, coordinates and helps you access a range of health care services.

First name of your PCP:

Last name of your PCP:

PCP address and/or medical group:

Your PCP's NPI number*:

Are you a current patient?

◯ Yes ◯ No

HELPFUL INFORMATION

Please choose a Tufts Medicare Preferred HMO-contracted PCP and enter your PCP's information in the fields to the left. If you don't list a PCP here, we will automatically assign one to you. You can change your PCP at any time after you enroll.

These questions are optional.

* To find a PCP in your area or to find your PCP's NPI number, use the search tool at **thpmp.org/doctor**.

B Please provide your plan information

The chart below shows available plans for each service area and standard monthly plan premiums (**in bold**). The chart also shows plan premiums with the Tufts Medicare Preferred Dental Option included (*in italics*). To enroll in the Tufts Medicare Preferred Dental Option, complete the *Optional Supplemental Benefit* section below.

Barnstable, Bristol, Middlesex, Norfolk and Plymouth Counties	Plan Premium	*With Dental Option*
HMO Basic Rx	**$82/month**	*$123.50*
HMO Value No Rx	**$133/month**	*$174.50*
HMO Value Rx	**$185/month**	*$226.50*
HMO Prime No Rx	**$163/month**	*$201.50*
HMO Prime Rx	**$214/month**	*$252.50*
HMO Prime Rx Plus	**$252/month**	*$290.50*

Hampden and Hampshire Counties	Plan Premium	*With Dental Option*
HMO Basic Rx	**$65/month**	*$106.50*
HMO Value Rx	**$108/month**	*$149.50*
HMO Prime Rx	**$138/month**	*$176.50*
HMO Prime Rx Plus	**$158/month**	*$196.50*

Essex and Suffolk Counties	Plan Premium	*With Dental Option*
HMO Basic No Rx	**$58/month**	*$99.50*
HMO Basic Rx	**$88/month**	*$129.50*
HMO Value No Rx	**$153/month**	*$194.50*
HMO Value Rx	**$207/month**	*$248.50*
HMO Prime No Rx	**$186/month**	*$224.50*
HMO Prime Rx	**$244/month**	*$282.50*
HMO Prime Rx Plus	**$280/month**	*$318.50*

Worcester County	Plan Premium	*With Dental Option*
HMO Basic No Rx	**$50/month**	*$91.50*
HMO Basic Rx	**$85/month**	*$126.50*
HMO Value No Rx	**$142/month**	*$183.50*
HMO Value Rx	**$190/month**	*$231.50*
HMO Prime No Rx	**$182/month**	*$220.50*
HMO Prime Rx	**$224/month**	*$262.50*

	Counties	Plan Premium
HMO Smart Saver Rx	Hampden, Hampshire, Middlesex and Worcester Counties	**$0/month**
HMO Smart Saver Rx	Bristol, Essex, Norfolk, Plymouth and Suffolk Counties	**$0/month**
HMO Smart Saver Rx	Barnstable County	**$0/month**

Name of the plan you are currently a member of:

Tufts Medicare Preferred HMO _____

Current monthly premium:

$ _____

Name of the plan you would like to change to:

Tufts Medicare Preferred HMO _____

New monthly premium:

$ _____

Requested effective date:
(mm/dd/yyyy; must be in the future) ____ / **0 1** / ____

☐ **I understand that this plan has different health benefits and a different monthly premium. I have reviewed my new plan premium in the chart above.**

OPTIONAL SUPPLEMENTAL BENEFIT: Tufts Medicare Preferred Dental Option

The Tufts Medicare Preferred Dental Option can only be elected along with a medical plan. The following is the additional cost to the premiums in the chart above for the Tufts Medicare Preferred Dental Option:

- *HMO Basic Rx, HMO Basic No Rx, HMO Value Rx and HMO Value No Rx:* **$41.50 per month.**
- *HMO Prime Rx, HMO Prime Rx Plus* and *HMO Prime No Rx:* **$38.50 per month.**
- *HMO Smart Saver Rx:* **NOT available.**

☐ **Yes, I would like to add the Tufts Medicare Preferred Dental Option.**

C Paying your plan premium

You can pay your monthly plan premium (including any late enrollment penalty* that you currently have or may owe) by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. DON'T pay Tufts Health Plan Medicare Preferred the Part D-IRMAA.

If you don't select a payment option, you will get a bill each month.

For plans with a $0 premium: If you currently owe a late enrollment penalty* or have selected the optional supplemental dental benefit, we need to know how you prefer to pay it. You can pay by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month. **If you do not owe a late enrollment penalty* or have not selected the optional supplemental dental benefit, a payment option is not required**.

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 your drug costs including monthly prescription drug premiums, annual deductibles and coinsurance. Additionally, those who qualify will not be subject to 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 **ssa.gov/medicare/part-d-extra-help**.

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.

*For more information on the late enrollment penalty, visit **thpmp.org/LEP.**

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.)

◯ Automatic deduction from your monthly Social Security benefit check.

◯ Automatic deduction from your monthly Railroad Retirement Board (RRB) benefit check.

The Social Security/RRB deduction may take two or more months to begin. There may be a delay in withholding your premium due to the Social Security Administration's monthly processing schedule, as the start date of premium withholding cannot be retroactive. If there is a delay, you will be billed directly for the first 1–2 months until your premium is deducted from your Social Security or RRB benefit check. You are responsible for paying all premiums due until premium withholding begins. If you do not pay your premium for the month(s) before premium withholding begins, you may be disenrolled from Tufts Health Plan Medicare Preferred. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

D Please select eligibility for enrollment period

Typically, you may enroll in a Medicare Advantage plan only during the Annual Enrollment Period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period. Please read the following statements carefully and check the box if the statement applies to you (check all that apply). By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

☐ Annual Enrollment Period (AEP). Your plan effective date will be January 1.

☐ I recently moved outside of the service area for my current plan or I recently moved and have new options avaialble to me.

I moved on: (mm/dd/yyyy)
/ /

☐ I am moving into, live in, or recently moved out of a long-term care facility (for example, a nursing home or long-term care facility).

I moved on: (mm/dd/yyyy)
/ /

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid).

I had this change on: (mm/dd/yyyy)
/ /

☐ Other reason: (please describe Special Election Period)

E 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 ☐ Data CD

*Please contact Tufts Health Plan Medicare Preferred 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 a.m.–8 p.m., 7 days a week (Mon.–Fri. from Apr. 1–Sept. 30).*

☐ I would like to sign up for eDelivery and get my Annual Notice of Change (ANOC), Evidence of Coverage (EOC), Formulary, Provider Directory and Pharmacy Directory electronically instead of by mail.

☐ I would like to get my medical Explanation of Benefits (EOB) electronically instead of by mail.

F Please read and sign below.

1. Tufts Health Plan Medicare Preferred is a plan that has a contract with the Federal government.
2. I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Tufts Health Plan Medicare Preferred, he/she may be paid based on my enrollment in Tufts Medicare Preferred HMO.
3. I understand that beginning on the date Tufts Medicare Preferred HMO coverage begins, I must get all of my health care from Tufts Medicare Preferred HMO, except for emergency or urgently needed services or out-of-area dialysis, and I must choose a primary care provider (PCP) and get a referral before seeing a specialist within my PCP's referral circle.
4. If I obtain routine care from providers outside my PCP's referral circle, neither Medicare nor Tufts Health Plan Medicare Preferred will be responsible for the cost. Services authorized by Tufts Medicare Preferred HMO and other services contained in my Tufts Medicare Preferred HMO *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR TUFTS HEALTH PLAN MEDICARE PREFERRED WILL PAY FOR THE SERVICES.
5. Dental benefits for members of Tufts Health Plan Medicare Preferred are administered by Dominion Dental Services, Inc. For questions regarding your benefits or provider network, please contact Member Services.

Release of Information

1. By joining this Medicare health plan, I acknowledge that Tufts Health Plan Medicare Preferred 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 Health Plan Medicare Preferred 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.
4. 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 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:

FOR INDIVIDUALS HELPING ENROLLEE WITH COMPLETING THIS FORM ONLY

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members or other third parties) helping an enrollee fill out this form.

Name: (please print)

Signature:

Relationship to enrollee:

OFFICE/BROKER USE ONLY

Agent NPN:

Agency name:

FMO name:

Date application received: (mm/dd/yyyy)

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

Plan ID#:

Tufts Medicare Preferred HMO (H2256)

Barnstable, Bristol, Middlesex, Norfolk and Plymouth Counties		Hampden and Hampshire Counties		Essex and Suffolk Counties		Worcester County	
◯ Basic Rx	**026/002**	◯ Basic Rx	**026/003**	◯ Basic No Rx	**042/000**	◯ Basic No Rx	**041/000**
◯ Value No Rx	**019/007**	◯ Value Rx	**018/008**	◯ Basic Rx	**026/001**	◯ Basic Rx	**036/000**
◯ Value Rx	**018/007**	◯ Prime Rx	**015/006**	◯ Value No Rx	**019/001**	◯ Value No Rx	**040/000**
◯ Prime No Rx	**016/002**	◯ Prime Rx Plus	**001/006**	◯ Value Rx	**018/001**	◯ Value Rx	**034/000**
◯ Prime Rx	**015/002**			◯ Prime No Rx	**016/001**	◯ Prime No Rx	**039/000**
◯ Prime Rx Plus	**001/002**			◯ Prime Rx	**015/001**	◯ Prime Rx	**033/000**
				◯ Prime Rx Plus	**001/001**		

Hampden, Hampshire, Middlesex and Worcester Counties		Bristol, Essex, Norfolk, Plymouth and Suffolk Counties		Barnstable County	
◯ Smart Saver Rx	**047/001**	◯ Smart Saver Rx	**047/002**	◯ Smart Saver Rx	**047/003**

Enrollment period:

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

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

TUFTS Health Plan

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Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) or speak to your provider.

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) o hable con su proveedor.

Português (Portuguese) ATENÇÃO: Se fala Português, estão disponíveis para si serviços gratuitos de assistência linguística. Estão também disponíveis gratuitamente ajudas e serviços auxiliares adequados para fornecer informações em formatos acessíveis. Ligue para 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY - Dispositivo das telecomunicações para surdos: 711) ou fale com o seu prestador.

中文 (**Simplified Chinese**) 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-800-701-9000 (HMO)/1-866-623-0172 (PPO)（文本电话：711）或咨询您的服务提供商。

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) oswa pale avèk founisè w la.

Việt (Vietnamese) LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

РУССКИЙ (Russian) ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) или обратитесь к своему поставщику услуг.

(Arabic)العربية تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 711 (1-800-701-9000 (PPO) 1-866-623-0172 (HMO)) أو تحدث إلى مقدم الخدمة.

ភាសាខ្មែរ (**Khmer**) សូមយកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយ ភាសាខ្មែរ សេវាកម្មជំនួយភាសាឥតគិតថ្លៃគឺមានសម្រាប់អ្នក។ ជំនួយ និងសេវាកម្មដែលជាការជួយដ៏សមរម្យ ក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ដែលអាចចូលប្រើប្រាស់បាន ក៏អាចរកបានដោយឥតគិតថ្លៃផងដែរ។ ហៅទូរសព្ទទៅ 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។

Français (French) ATTENTION: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) ou parlez à votre fournisseur.

Italiano (Italian) ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (tty: 711) o parla con il tuo fornitore.

한국어 **(Korean)** 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-701-9000 (HMO)/1-866-623-0172 (PPO)(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

Ελληνικά (Greek) ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες υποστήριξης στη συγκεκριμένη γλώσσα. Διατίθενται δωρεάν κατάλληλα βοηθήματα και υπηρεσίες για παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε το 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) ή απευθυνθείτε στον πάροχό σας.

POLSKI (Polish) UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) lub porozmawiaj ze swoim dostawcą.

हिंदी **(Hindi)**न दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

ગુજરાતી **(Gujarati)** ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.