Fallon Medicare Plus™
Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Fallon Health representative at 1-800-325-5669 (TRS 711), 8 a.m.–8 p.m., Monday–Friday (Oct. 1–March 31, seven days a week).

Understanding the benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit fallonhealth.org/medicare or call 1-800-325-5669 (TRS 711) to view or request a copy of the EOC.
- ☐ Review the Provider Directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the Pharmacy Directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding important rules

- ☐ Benefits, premiums, and/or copayments/coinsurance may change on January 1, 2025.
- ☐ In addition to any monthly premium for your plan, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the Provider Directory).
- ☐ **Effect on current coverage.** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

fallon health

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fallonhealth

2024 Fallon Medicare Plus™

Individual Enrollment Request Form

Who can use this form?

People with Medicare who want to join a Fallon Medicare Plus Medicare Advantage Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important:
To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional—you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join Fallon Health during fall open enrollment (October 15–December 7), we must get your completed form by December 7.
- Fallon Health will send you a bill for your plan premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:

{Fallon Health
Attn: Medicare Sales
10 Chestnut St.
Worcester, MA 01608} or
Fax to: {1-508-757-0572} or
Email it to: {MedicareSalesOperations@fallonhealth.org}

Once we process your request to join, we'll contact you.

How do I get help with this form?

Call Fallon Health at {1-888-377-1980 (TRS 711).}

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Fallon Health al {1-888-377-1980 (TRS 711).}

O a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

SECTION 1 – All fields on this page are required *(unless marked optional)*.

Please select the plan you want to join.

Fallon Medicare Plus (FMP) options	If you live in one of the following counties:		
	Worcester	**Franklin, Hampden, Hampshire**	**Barnstable, Berkshire, Bristol, Essex, Middlesex, Norfolk, Plymouth, Suffolk**
FMP Orange HMO	❑ $0/month (038-00)	❑ $0/month (038-00)	❑ $0/month (038-00)
FMP Green HMO	❑ $99/month (030-15)	❑ $66/month (030-16)	❑ $78/month (030-18)
FMP Central Green HMO	❑ $33/month (036-00)	—	—
FMP Blue HMO	❑ $207/month (031-15)	❑ $110/month (031-16)	❑ $174/month (031-18)
FMP Central Blue HMO	❑ $123/month (035-00)	—	—

FIRST name:	LAST name:	Middle initial: *(optional)*
Birth date: __ __ / __ __ / __ __ __ __ M M D D Y Y Y Y	Sex: ❑ Male ❑ Female	Home phone number: (__ __ __) __ __ __ - __ __ __ __
Preferred written language: *(optional)*	Preferred spoken language: *(optional)*	
Mobile phone number: *(optional)* (__ __ __) __ __ __ - __ __ __ __ ❑ *I authorize Fallon Health to send me text messages related to my plan benefits and services.*	Email address: *(optional)* _____ ❑ *I authorize Fallon Health to send me email messages related to my plan benefits and services.*	
Permanent residence street address *(Don't enter a P.O. Box)*:		
City/town:	County: *(optional)*	State: ZIP code:
Mailing address *(if different from your permanent address (P.O. Box allowed))*: Street address:		
City/town:	County: *(optional)*	State: ZIP code:

Your Medicare information:

Medicare Number: __ __ __ __ - __ __ __ - __ __ __ __

Answer these important questions.

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Fallon Medicare Plus? ❑ Yes ❑ No	Name of other coverage:
Member number for this coverage:	Group number for this coverage:

IMPORTANT: Read and sign below.

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Fallon Medicare Plus.
- By joining this Medicare Advantage Plan, I acknowledge that Fallon Health will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one Medicare Advantage plan at a time–and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for Medicare Advantage Private Fee-for-Service and Medicare Medical Savings Account plans).
- I understand that when my Fallon Health coverage begins, I must get all of my medical and prescription drug benefits from Fallon Health. Benefits and services provided by Fallon Health and contained in my Fallon Health "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Fallon Health will pay for benefits or services that are not covered.
- 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 legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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 Medicare.

Signature:	**Today's date:**

If you're the authorized representative, sign above and fill out these fields:

Name:	
Address:	
Primary phone number:	Relationship to enrollee:

SECTION 2 – All fields in this section are optional.

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

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

- ❑ No, not of Hispanic, Latino/a, or Spanish origin
- ❑ Yes, Puerto Rican
- ❑ Yes, another Hispanic, Latino/a, or Spanish origin
- ❑ Yes, Mexican, Mexican American, Chicano/a
- ❑ Yes, Cuban
- ❑ **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.**

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

❑ Braille ❑ Large print ❑ Audio CD

Please contact Fallon Health at {1-888-377-1980} if you need information in an accessible format other than what's listed above. Our office hours are {8 a.m.–8 p.m., seven days a week (Apr.–Sept., 8 a.m.–8 p.m., Mon.–Fri.) TTY users can call TRS 711.}

Do you work? ❑ Yes ❑ No	Does your spouse work? ❑ Yes ❑ No

List your primary care provider (PCP), clinic, or health center:

I want to get the following materials via email. Select one or more.

❑ Evidence of Coverage ❑ Formulary

Email address: _____

SECTION 3 – Paying your plan premium.

You can pay any monthly plan premium you may have (including any late enrollment penalty that you currently have or may owe) by mail, Electronic Funds Transfer, or credit card 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 any monthly plan premium you may have. DON'T pay Fallon Health the Part D-IRMAA.

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

SECTION 4 – Read this important information.

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. 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.

- ❑ I am new to Medicare.
- ❑ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ❑ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date): _____
- ❑ I recently was released from incarceration. I was released on (insert date): _____
- ❑ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date): _____

- ❑ I recently obtained lawful presence status in the United States. I got this status on (insert date): _____
- ❑ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date): _____
- ❑ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date): _____
- ❑ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ❑ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home). I moved/will move into/out of the facility on (insert date): _____
- ❑ I recently left a PACE program on (insert date): _____
- ❑ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date): _____
- ❑ I am leaving employer or union coverage on (insert date): _____
- ❑ I belong to a pharmacy assistance program provided by my state.
- ❑ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ❑ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date): _____
- ❑ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date): _____
- ❑ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity). One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

If none of these statements apply to you or you're not sure, please contact Fallon Health at {1-888-377-1980 (TRS 711)} to see if you are eligible to enroll. We are open {8 a.m.–8 p.m., seven days a week (Apr.–Sept., we are available 8 a.m.–8 p.m., Mon.–Fri.)}

BROKER/AGENT INFO: Agency name: _____

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

Prior insurance: _____

Requested effective date: _____

SOA form: ❑ Yes ❑ No

FALLON HEALTH 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: