TUFTS Health Plan

TUFTS MEDICARE PREFERRED SUPPLEMENT 2018 ENROLLMENT APPLICATION

PO Box 9178
Watertown, MA 02472

IMPORTANT INFORMATION

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

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

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

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

(d) 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.

(e) 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.

(f) Counseling services are available in Massachusetts to provide advice concerning your purchase of 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.

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Please answer all questions.

Check the Plan of your choice: (You may be eligible for a 15% discount. Please see page 3 of the enclosed Outline of Coverage.)

☐ Tufts Medicare Preferred Supplement Core Premium $114.00

☐ Tufts Medicare Preferred Supplement One Premium $212.00

Optional Supplemental Benefit:

☐ Delta Dental® Option $60.00 per month*

Please select a premium payment option

☐ Get a bill each month ☐ Electronic Funds Transfer (EFT) from your bank account each month

Social Security Number – –

Last Name First Name Middle Initial

Gender

☐ Male ☐ Female

Birth Date

_____
(MM / DD / YYYY)

Home Phone Number

( ) –

Permanent Home Address:
Number and Street City State Zip

Preferred Written Language:

Preferred Spoken Language:

If you want your Tufts Medicare Preferred Supplement bill sent to an address other than your home address, complete the following section.

Billing Address Only:
Number and Street City State Zip

Medicare Number Information

Please copy information from your red, white, and blue Medicare card in the spaces below.

Medicare Number:

Medicare Part A (Hospital Insurance) Effective Date: _____
(MM / DD / YYYY)

Medicare Part B (Medical Insurance) Effective Date: _____
(MM / DD / YYYY)

If you are under age 65, what is your disability that qualifies you for Medicare coverage?

☐ Yes ☐ No Are you currently a Tufts Health Plan member?
If yes, give your Tufts Health Plan identification number:

*®A Registered Mark of Delta Dental Plans Association. Delta Dental of Massachusetts is an Independent Licensee of the Delta Dental Plans Association

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 is the effective date? _____

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 _____/_____/_____ END _____/_____/_____

   ☐ 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?

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?

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?
   START _____/_____/_____ END _____/_____/_____
   (If you are still covered under the other policy, leave "END" blank.)

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

PLEASE READ & SIGN BELOW

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

The information supplied on this form is true and complete. 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. 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. 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. I understand that calls to Customer Relations may be monitored for quality assurance. I understand that the benefits for which I will be eligible are those described in the Tufts Medicare Preferred Supplement Member Policy.

Important: Your dental benefit and coverage plan is called the "Delta Dental Option," which requires members to seek services from providers in the Delta Dental PPO network only. Your dental benefit under this plan **does not cover** dental services from Delta Dental providers who are outside of the PPO network or any out-of-network providers. For additional questions regarding this benefit or provider network, please contact customer service using the number listed on your card.

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:

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

Name: _____ Address: _____

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, or sex. Tufts Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Tufts Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - — Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - — Qualified interpreters
  - — Information written in other languages

If you need these services, contact Tufts Health Plan at 1-800-701-9000 (TTY: 711).

If you believe that Tufts Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Tufts Health Plan, Attention:

Civil Rights Coordinator, Legal Dept.
705 Mount Auburn St. Watertown, MA 02472
Phone: 1-888-880-8699 ext. 48000, (TTY number—711 or 1-800-439-2370. Español: 866-930-9252)
Fax: 617-972-9048
Email: OCRCoordinator@tufts-health.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Tufts Health Plan Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-701-9000 (TTY: 711).

Arabic: ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-701-9000 (رقم هاتف الصم والبكم: 711).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-701-9000 (TTY 711)。

Farsi: توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. 1-800-701-9000 (TTY: 711) فراهم می باشد. با تماس بگیرید.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-701-9000 (ATS : 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-701-9000 (TTY: 711).

Greek: ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-701-9000 (TTY: 711).

Gujarati: સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-701-9000 (TTY: 711).

Haitian Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-701-9000 (TTY: 711).

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-701-9000 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 1-800-701-9000 (TTY: 711）まで、お電話にてご連絡ください。

Khmer (Cambodian): ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-701-9000 (TTY: 711)

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-701-9000 (TTY: 711) 번으로 전화해 주십시오.

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັ່ງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-701-9000 (TTY: 711).

Navajo: Díí baa akó nínízin: Díí saad bee yáníltí'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, koji' hódíílnih 1800-701-9000 (TTY: 711.)

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-701-9000 (TTY: 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-701-9000 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-701-9000 (телетайп: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-701-9000 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-701-9000 (TTY: 711).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-701-9000 (TTY: 711).