TUFTS MEDICARE COMPLEMENT

You must have Medicare Parts A and B to enroll.

New Members—Register at tuftshealthplan.com for Fast Access to Your Personal Benefit Information.

Please complete the member section of this application in full. Failure to do so could delay enrollment. You will receive your ID card and member benefit document soon. Need a temporary ID? Use the yellow copy of this completed form.

Member Sections

- **Personal Information:** Complete all enrollment information, including the selection of a primary care provider (PCP).
- **Primary Care Provider:** It is important that you choose a PCP immediately. Without a PCP assignment, your in-network benefits may be limited to emergency services only. To find a PCP, visit tuftshealthplan.com, and use the doctor search feature. If you are selecting a new PCP, contact the doctor right away. Introduce yourself as a new member and find out if your doctor would like to schedule a physical exam. Transfer your medical records to your new PCP right away.
- **Other Health Coverage:** If you have other insurance (including Medicare), please check the correct box and fill in the additional information about your other insurance. If you do not have other insurance, be sure to check the No box.

Employer Section

Your employer must fill out this section.

When the Application is Complete

- Employee keeps the yellow copy (also your temporary ID)
- Employer keeps the pink copy
- Tufts Health Plan receives the original white copy

Tufts Health Plan
P.O. Box 9186
Watertown, MA 02471-9186

If You Need Emergency Care

In an emergency, go to the nearest medical facility or call 911. An emergency is a serious injury or the onset of a serious condition that prevents you from taking the time to call your PCP, if your plan requires one.

Please Note

By enrolling, you agree to and understand that if you obtain a health care benefit or payment that you know you are not entitled to receive or be paid; or knowingly present or cause to be presented with fraudulent intent a claim that contains a false statement, you can be liable for the full amount of the health care benefit or payment made and for reasonable attorney's fees and costs, including cost of investigation. Tufts Health Plan arranges for the provision of health care services, but does not provide health care services. Tufts Health Plan arranges for the provision of health care through agreements with independent community-based health care professionals working in private offices and with hospitals throughout the Tufts Health Plan service area. These providers are independent contractors and not employees, agents, or representatives of Tufts Health Plan for any purposes.

Need Help?

If you need assistance selecting a PCP, visit tuftshealthplan.com and use the doctor search feature. If you need help filling out this form, call 800.936.1902.

We speak 140 languages.
Call for translation services:

Nous parlons français
Hablamos Español
Nós falamos português
Мы говорим по-русски
Parliamo Italiano
Wir sprechen Deutsch
我們會講普通話
我們會講廣東話
Chúng tôi nói được tiếng Việt
Nou pale Kreyòl
យើង និយាយ ភាសាខ្មែរ

TUFTS Health Plan

TUFTS MEDICARE COMPLEMENT MEMBER ENROLLMENT FORM

TUFTS Health Plan

Please print or type. Please be sure application is completed in full to ensure enrollment. **Enrollment/Eligibility • PO Box 9186 • Watertown, Massachusetts 02471-9186**

Employer Section

FAILURE TO COMPLETE AREAS MARKED IN BLUE MAY CAUSE A DELAY IN ENROLLMENT.

1. Name of Employer or Group	2. Group Number	3. Effective Date of Coverage

Member Section

4. Subscriber's Medicare #_____

5. Have you or anyone in your family used tobacco products e.g., cigarettes, chewing tobacco, etc. in the last 12 months? ❑ Yes ❑ No

6. Last Name	7. First Name	8. Middle Initial
9. Member's Social Security Number (SSN)	10. Date of Birth (MM/DD/YYYY) / /	11. Gender ❑ M ❑ F
12. Mailing Address (Home address)		13. Apt#
14. City	15. State	16. ZIP
17. Primary Care Provider	18. PCP ID#	19. Check if currently used for primary care ❑
20. Home Telephone ( )	21. Fitness Center	22. Primary Language

IMPORTANT: TO ENROLL, PLEASE ATTACH A COPY OF YOUR MEDICARE CARD.

23. Do you currently have Tufts Health Plan through a group plan? ❑ Yes ❑ No — If yes, what is your membership number?_____

24. Are you or your spouse actively working for the sponsoring employer? ❑ Yes ❑ No (YOU) ❑ Yes ❑ No (SPOUSE)

25. Has end stage renal disease qualified you for Medicare parts A & B? ❑ Yes ❑ No — If yes, please indicate your certification dates: Part A _____ / _____ / _____ Part B _____ / _____ / _____

26. Do you have other health care coverage (including Medicare)? ❑ Yes ❑ No — If yes, please indicate the plan: _____

The information supplied on this form is true and complete. I acknowledge that I must continue to be enrolled in Medicare Parts A & B or I will be ineligible forTufts Medicare Complement coverage effective as of the date I discontinue either Medicare Part A or B. I authorize my employer (sponsor) to remit my share of Tufts Medicare Complement (TMC) premium together with any contributions by my employer (sponsor). I assign benefits to Tufts Health Plan providers, which means that Tufts Health Plan is authorized to make payments directly to Tufts Health Plan providers for services rendered to me. 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, except in an emergency, all health services must be provided or authorized by the Tufts Health Plan primary care physician that I have designated. I understand that calls to the Member Services Department may be monitored for quality assurance. I understand that the benefits for which I will be eligible are those described in the Tufts Medicare Complement (TMC) Evidence of Coverage.

Signature (required): _____ Date: _____

WHITE - TUFTS HEALTH PLAN COPY **PINK** - EMPLOYER COPY **YELLOW** - SUBSCRIBER COPY. Please keep yellow copy as your temporary Tufts Health Plan ID.