TUFTS Health Plan

a Point32Health company

2025 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:

Primary phone number:

- -

Alternate phone number: (optional)

- -

We suggest providing your mobile number and email address so that we can provide the most timely information and updates.

☐ This is a mobile number

☐

Email address:

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:

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 Saver Rx (HMO)	**$0/month**	*$37*
HMO Smart Saver Rx (HMO)	**$0/month**	*N/A*
HMO Basic Rx (HMO)	**$48/month**	*$85*
HMO Value No Rx (HMO)	**$113/month**	*$150*
HMO Value Rx (HMO)	**$156/month**	*$193*
HMO Prime No Rx (HMO)	**$143/month**	*$179.50*
HMO Prime Rx (HMO)	**$283/month**	*$219.50*
HMO Prime Rx Plus (HMO)	**$217/month**	*$253.50*

Hampden and Hampshire Counties	Plan Premium	*With Dental Option*
HMO Saver Rx (HMO)	**$0/month**	*$37*
HMO Smart Saver Rx (HMO)	**$0/month**	*N/A*
HMO Basic Rx (HMO)	**$37/month**	*$74*
HMO Value Rx (HMO)	**$83/month**	*$120*
HMO Prime Rx (HMO)	**$106/month**	*$142.50*
HMO Prime Rx Plus (HMO)	**$122/month**	*$158.50*

Essex and Suffolk Counties	Plan Premium	*With Dental Option*
HMO Saver Rx (HMO)	**$0/month**	*$37*
HMO Smart Saver Rx (HMO)	**$0/month**	*N/A*
HMO Basic No Rx (HMO)	**$38/month**	*$75*
HMO Basic Rx (HMO)	**$58/month**	*$95*
HMO Value No Rx (HMO)	**$133/month**	*$170*
HMO Value Rx (HMO)	**$178/month**	*$215*
HMO Prime No Rx (HMO)	**$166/month**	*$202.50*
HMO Prime Rx (HMO)	**$213/month**	*$249.50*
HMO Prime Rx Plus (HMO)	**$245/month**	*$281.50*

Worcester County	Plan Premium	*With Dental Option*
HMO Saver Rx (HMO)	**$0/month**	*$37*
HMO Smart Saver Rx (HMO)	**$0/month**	*N/A*
HMO Basic No Rx (HMO)	**$30/month**	*$67*
HMO Basic Rx (HMO)	**$45/month**	*$82*
HMO Value No Rx (HMO)	**$122/month**	*$159*
HMO Value Rx (HMO)	**$163/month**	*$200*
HMO Prime No Rx (HMO)	**$162/month**	*$198.50*
HMO Prime Rx (HMO)	**$193/month**	*$229.50*

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 Tufts Medicare Preferred Dental Option is **$37 per month** for *HMO Saver Rx*, *HMO Basic Rx*, *HMO Basic No Rx, HMO Value Rx, and HMO Value No Rx* plans. The Tufts Medicare Preferred Dental Option is **$36.50 per month** for *HMO Prime Rx, HMO Prime Rx Plus,* and *HMO Prime No Rx* plans. The Tufts Medicare Preferred Dental Option is **NOT available for the *HMO Smart Saver Rx*** plan. The chart above shows plan premiums with the Tufts Medicare Preferred Dental Option included (*in italics*).

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

C Please choose a Tufts Medicare Preferred HMO contracted primary care physician (PCP) (If you currently have a PCP the following is optional)

If you don't have a PCP, we will automatically assign one to you. You can change your PCP at any time after you enroll.

Primary care physician:

Are you a current patient?

◯ Yes ◯ No

D 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 your premium 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 **www.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.

Please continue ›

E 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.

☐ 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: (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)
__ / __ / ____

☐ 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.

☐ Other reason: (please describe Special Election Period)

_____

F Ethnicity and race, alternative languages, and accessible formats

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

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

What is your gender? Select one.

- ☐ Woman
- ☐ Man
- ☐ Non-binary
- ☐ I use a different term: _____
- ☐ I choose not to answer

Which of the following best represents how you think of yourself? Select one.

- ☐ Lesbian or gay
- ☐ Straight, that is, not gay or lesbian
- ☐ Bisexual
- ☐ I use a different term: _____
- ☐ I don't know
- ☐ I choose not to answer

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).*

G 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 physician (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/FMO Name:

Date application received: (mm/dd/yyyy)

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

Barnstable, Bristol, Middlesex, Norfolk, and Plymouth Counties		Hampden and Hampshire Counties		Essex and Suffolk Counties		Worcester County	
○ Saver Rx	**028/000**	○ Saver Rx	**028/000**	○ Saver Rx	**028/000**	○ Saver Rx	**028/000**
○ 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**	○ Smart Saver Rx	**046/000**	○ Prime No Rx	**016/001**	○ Prime No Rx	**039/000**
○ Prime Rx Plus	**001/002**			○ Prime Rx	**015/001**	○ Prime Rx	**033/000**
○ Smart Saver Rx	**046/000**			○ Prime Rx Plus	**001/001**	○ Smart Saver Rx	**046/000**
				○ Smart Saver Rx	**046/000**		

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).

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Form Approved
OMB# 0938-1421

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-701-9000 (HMO)/1-866-623-0172 (PPO)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-701-9000 (HMO)/1-866-623-0172 (PPO)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-701-9000 (HMO)/1-866-623-0172 (PPO)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على **1-800-701-9000 (HMO)/1-866-623-0172 (PPO)** . سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-701-9000 (HMO)/1-866-623-0172 (PPO)にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。