Fallon Medicare Plus™ Supplement Individual Enrollment Request Form

fallonhealth & life assurance company, inc.

Fallon Health & Life Assurance Company, Inc., a wholly owned subsidiary of Fallon Community Health Plan.

To enroll in a Fallon Medicare Plus Supplement option, please provide the following information:

Check the Medicare Supplement plan of your choice:

❒ **Fallon Medicare Plus Supplement Core** $165 per month	❒ **Fallon Medicare Plus Supplement 1*** $275 per month	❒ **Fallon Medicare Plus Supplement 1A** $199 per month

You could qualify for a 15% discount. See the Outline of Coverage for details.

Last name	First name	M.I.	❒ Mr. ❒ Mrs. ❒ Ms.
Birth date MM / DD / YYYY	Sex ❒ M ❒ F	Social Security Number __ __ __ - __ __ - __ __ __ __	
Permanent residence street address (P.O. Box not allowed)			
City/town	State	ZIP	
Home phone number (__ __ __) __ __ __ - __ __ __ __			
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.*		
Mailing address if different from above			
City/town	State	ZIP	
Written language preferred *(optional)*	Race *(optional)*		
Spoken language preferred *(optional)*	Ethnicity *(optional)*		

Please provide your Medicare information. Use your red, white and blue Medicare card to complete this section.

Medicare Number	
Medicare Part A (Hospital Insurance) effective date	Medicare Part B (Medical Insurance) effective date

Are you under 65 and eligible for Medicare coverage due solely to end-stage renal disease (ESRD)? ❒ Yes ❒ No

Note: *If you are under age 65, you may only enroll in this plan if the disability that made you eligible for Medicare is a condition other than end-stage renal disease.*

Are you currently a Fallon Health member? ❒ Yes ❒ No	If yes, please provide your Fallon Health member ID number
Do you or your spouse work? ❒ Yes ❒ No	

***If you became Medicare Eligible on or after January 1, 2020,**
you may enroll in the Fallon Medicare Supplement Core or 1A plans only.

If you newly enroll in a Medicare Supplement 1 plan and you became Medicare eligible before January 1, 2020,
you will not be able to switch into the same company's Medicare Supplement 1A plan until you have been covered under the Medicare Supplement 1 plan for a period of at least 12 months.

Important Information

Please read the "Important Information" section. Then answer questions 1–5 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 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.

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 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: 1-800-872-0166) or write to that office at the following address for more information: One Ashburton Place, 5th Floor, Boston, MA 02108.

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 to the best of your knowledge. (Please mark Yes or No below with an "X".)

Question 1:

(a) Did you turn age 65 in the last 6 months? ❒ Yes ❒ No

(b) Did you enroll in Medicare Part B in the last 6 months?
❒ Yes ❒ No

(c) If yes, what is the effective date?
_____ /_____ /_____
MM DD YYYY

Question 2:

Are you covered for medical assistance through the state Medicaid program? ❒ Yes ❒ No

[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,

(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?
❒ Yes ❒ No

Question 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 to the right. If you are still covered under this plan, leave "END" blank.

Start: _____ /_____ /_____
MM DD YYYY

End: _____ /_____ /_____
MM DD YYYY

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplemental 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? ❒ Yes ❒ No

Question 4:

(a) Do you have another Medicare Supplement Insurance Policy in force? ❒ Yes ❒ No

(b) If so, with what company, and what plan do you have?

(c) If so, do you intend to replace your current Medicare Supplement Insurance Policy with this policy?
❒ Yes ❒ No If yes, please complete the Medicare Supplement Replacement form.

Question 5:

Have you had coverage under any other health insurance within the past 63 days?
(For example, an employer, union, or individual plan) ❒ Yes ❒ No

(a) If so, with what company, and what plan do you have?

(b) What are your dates of coverage under the other policy?

Start: _____ /_____ /_____ End: _____ /_____ /_____
MM DD YYYY MM DD YYYY

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

Please read the following, and sign below:

I certify that the statements made and answers given are complete and true. If I am under age 65, I may only enroll in this plan if the disability that made me eligible for Medicare is a condition other than ESRD. I have read and carefully considered all of the "Important Information" on this form. I also certify that I received the "Outline of Medicare Supplement Coverage." I understand that no employer, former employer, health care provider, or private agency may sponsor, purchase, or contribute to the cost of this plan.

For the purpose of processing this application, for 30 months from the date this authorization is signed, and if I enroll in coverage, for as long as I am covered, I understand that all of my health care providers, other insurance companies, or my employer are authorized to release all of my medical records and other information to Fallon Health representatives for the purpose of determining my coverage and administering my benefits. I am, or my authorized representative is, entitled to receive a copy of this authorization form. I understand that the benefits for which I am eligible are those described in the applicable plan Subscriber Certificate. I understand that plan benefits and premium rates are subject to change as allowed by state law. I understand that enrollment in this plan is contingent upon payment of premium.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of Massachusetts) on this application means that I have read and understand the contents of this application. If signed by an authorized individual, 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 Fallon Health & Life Assurance Company, Inc.

Signature: _____ Date: _____

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

Name: (print) _____

Relationship: _____

Address: _____

Phone #: _____ Alternate phone #: _____

fallonhealth
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BROKER/AGENT INFO: Agency name: _____ Broker/agent name: _____ Mass. Lic#: _____ Election type: _____ Requested effective date: _____ MSR form: Yes No N/A	**ENROLLMENT DEPT. USE ONLY**
FALLON HEALTH USE ONLY: RTS Verification: Yes No QNXT sponsor needed: Yes No Date received: _____ Method of receipt: _____ Telephonic: No Yes If yes, confirmation number: _____ Name: _____ MA ID# _____	