Health New England
One Monarch Place, Suite 1500
Springfield, MA 01144-1500
(413) 787-0010 | (877) 443-3314 | TTY 711
healthnewengland.org/medicare

EMPLOYER GROUP WAIVER PLAN ENROLLMENT REQUEST FORM

Secure Freedom (HMO-POS)

Please contact Health New England Medicare Advantage Employer Group Waiver Plan if you need information in another language or format (Braille).

To enroll in an Health New England Medicare Advantage Employer Group Waiver Plan, please provide the following information:

Employer or Union Name:	Group #:

Please check which plan you want to enroll in:

❒ Health New England Medicare
Secure Freedom HMO-POS

LAST Name:	FIRST Name:	Middle Initial:	❒ Mr. ❒ Mrs. ❒ Ms.

Birth Date: (_____/ _____/_____) (MM/ DD/ YYYY	Sex: ❒ M ❒ F	Home Phone Number: ( )	Alternate Phone Number: ( )

Permanent Residence Street Address (P.O. Box is not allowed):

Street Address:	City:	State:	ZIP Code:

Mailing Address (only if different from your Permanent Residence Address):

Street Address:	City:	State:	ZIP Code:

E-mail Address:

Please provide your Medicare Insurance information.

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

  - OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Name (as it appears on your Medicare card):
_____

Medicare Number: _____

Is Entitled To: Effective Date:

HOSPITAL (Part A): _____

MEDICAL (Part B): _____

Please read and answer these important questions:		
1.	Are you the retiree? ❒ Yes ❒ No If yes, retirement date: (month/date/year): _____ If no, name of retiree: _____	
2.	Are you covering a spouse or dependents under this employer? ❒ Yes ❒ No If yes, name of spouse: _____ Name(s) of dependent(s): _____	
3.	Do you or your spouse work? ❒ Yes ❒ No	
4.	Some individuals may have other drug coverage, including other private insurance, Workers' Compensation, VA benefits or State pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to a Health New England Medicare Employer Group Waiver Plan? ❒ Yes ❒ No	
	If yes, please list your other coverage and your identification (ID) number(s) for this coverage:	
	Name of other coverage:	ID # for this coverage:
5.	Are you a resident in a long-term care facility, such as a nursing home? ❒ Yes ❒ No	
	If yes, please provide the following information:	
	Name of Institution:	
	Address of Institution (number and street):	
	Phone Number of Institution: ( )	
Please choose the name of a Primary Care Provider (PCP):		
PCP Provider ID # (Found in the Provider Directory):		

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format.

❒ Large Format

❒ Other Format (Braille or audio tape) _____

Please contact Health New England Medicare Advantage at **(413) 787-0010** or **(877) 443-3314** (TTY users should call 711) if you need information in an accessible format or language other than what is listed above. Our office hours are: 8 a.m.–8 p.m., Monday–Friday (October 1–March 31: 8 a.m.–8 p.m., seven days a week).

Please read and sign below.

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

Health New England Medicare Advantage is an HMO, HMO-POS, and PPO plan with a Medicare contract. Enrollment in Health New England Medicare Advantage depends on contract renewal. I will need to keep my Medicare Part A and Part B coverage. I can be in only one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year or under certain special circumstances. Please contact your employer's benefit administrator for more information on times you can enroll.

Health New England Medicare Advantage Employer Group Waiver Plan serves a specific service area. If I move out of the area that Health New England Medicare Advantage Employer Group Waiver Plan serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of a Health New England Medicare Advantage Employer Group Waiver Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Health New England Medicare Advantage Employer Group Waiver Plan when I get it to know which rules I must follow in order to get coverage with this Medicare Advantage Employer Group Waiver Plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

Additional Information on next page

I understand that beginning on the date the Health New England Medicare Advantage Employer Group Waiver Plan coverage begins, I must get all of my health care from the Health New England Medicare Advantage Employer Group Waiver Plan, except for emergency or urgently needed services or out-of-area dialysis services. Members enrolled in our Health New England Medicare Secure Freedom (HMO-POS) Point of Service Employer Group Waiver Plan can choose to get routine medical care from network providers or use their Point of Service benefit to get care from non-network providers. Our network providers know what we cover under your benefit plan. They also know what requires prior authorization and will request approval from Health New England on your behalf. Members of the Health New England Medicare Secure Freedom (HMO-POS) Employer Group Waiver Plan who choose to get these services out-of-network are responsible for getting prior authorization from Health New England. Please tell your out-of-network provider that prior authorization is required. The provider may be willing to contact Health New England Member Services for you to get prior authorization. Call Member Services to confirm prior authorization. For a complete list of services that require prior authorization, refer to the Summary of Benefits. Services authorized by Health New England Medicare Advantage Employer Group Waiver Plan and other services contained in my Health New England Medicare Advantage Employer Group Waiver Plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR THE HEALTH NEW ENGLAND MEDICARE ADVANTAGE EMPLOYER GROUP WAIVER PLAN WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with Health New England Medicare Advantage Employer Group Waiver Plans, he/she may be paid based on my enrollment in Health New England Medicare Advantage Employer Group Waiver Plan.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Health New England Medicare Advantage Employer Group Waiver Plan will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes that follow all applicable Federal statutes and regulations. 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 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.

X Signature:	Today's Date:

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

FIRST Name:	LAST Name:	
Street Address:		
City:	State:	ZIP Code:
Phone Number:	Relationship to Enrollee:	
E-mail Address:		

This section to be completed by employer.

Group Name:	
Group/DIV #:	Effective Date:

New enrollment reason:
❒ Annual open enrollment ❒ Retirement ❒ Moved into service area ❒ Other _____

X Employer Signature:	Date:

Office Use Only (Broker/Agent, please complete below):

Name of staff member/agent/broker (if assisted in enrollment):				
Broker NPN #:		Plan ID #:		
Effective Date of Coverage: / /	ICEP/IEP:	AEP:	SEP (type):	Not Eligible: