Now We Are One

NBT Northeast Business Trust | HSA | MBA

New Case Submission Checklist

Tufts Health Plan
Tufts Medicare Complement (TMC)
For Retirees

	To ensure that your applications are processed as quickly as possible, just follow this checklis	Check if Complete
1	**Employer** *completes and signs* the **New Group Application For Retirees.**	☐
2	**Employer** checks off choice of plan and Rx option	
3	**Employer** *encloses* the first monthly premium **(Payable to MBA).**	☐
4	**Employer** provides copy of most recent **Schedule C** or **WR-1.**	☐
5	Enclose Annual Membership Fee of **$125 (Payable to NBT/ MBA)** **-or-** If enrolling through an **Association or Chamber of Commerce, please indicate name of Association or Chamber** _____ * If not already a member of a participating Association or Chamber of Commerce, additional requirements may apply such as completing a membership application and paying dues.	☐
6	Eligible **enrollee** *completes* a **Tufts Medicare Complement Member Enrollment Form.**	☐
7	Eligible **enrollee** *writes* in their Medicare number and effective dates of Part A and B on **Election Form** and includes a copy of their **Medicare card** or letter from the Social Security Administration.	☐
8	Eligible **enrollee** *selects* a ***Primary Care Physician*** on **Election Form.**	☐
9	Eligible **enrollee** *signs and dates* the **Election Form.**	☐

Send all required documents (<u>including this checklist</u>) to:

☐ **MBA Main Office**
135 Wood Road
Braintree, MA 02184
Tel 800-696-8167
Fax 781-843-5001

☐ **MBA Sales Office**
574 Boston Road
Billerica, MA 01821
Tel 800-464-0039
Fax 978-663-5431

Special instructions:

All coverage will be effective on the 1st day of the month. Enrollment materials should be received by the 25th of the preceding month. Keep a copy of your application as your temporary ID. Once your enrollment have been approved and processed, you will receive a member confirmation by mail with your group number. Your permanent ID cards will be issued to you directly from the carrier. Permanent ID cards generally take 7-10 business days from date your enrollment was approved and processed.

<u>www.hsainsurance.com</u>
781-848-4950
877-777-4414

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2011 V1

Tufts Medicare Complement

Thank you for your inquiry into the **MBA** sponsored Medicare Wrap Plan by *Tufts Health Plan*. This plan offers more benefits at lower cost than most other options available to Medicare eligible recipients in Massachusetts by utilizing the Tufts HMO network of doctors in conjunction with original Medicare. Foremost among the benefits is **unlimited prescription drug coverage.** The plan is also available without prescription drug coverage. The monthly premium for this Medicare plan is **$410** with Rx and **$191** without Rx coverage. Premiums are guaranteed through December 31, 2011.

Eligibility Guidelines

Eligible Companies	Eligible Enrollee	Effective Dates
An Eligible company is one that: • Employs less than 20 total employees (includes full and part time) • Is actively in business. • Is located in the Tufts Medicare Complement service area. • Is a member in good standing of **MBA**	**An eligible enrollee is one that:** • Is enrolled in Medicare **Part A and Part B** • Lives in the Tufts Medicare Complement service area **Working Aged:** Is a full-time employee. Part-time employees are not eligible. **Retired:** Is no longer working for this employer.	• All coverage will be effective on the **1st day of the month** • Applications must be received by MBA by the 25th of the month.

NEW GROUP APPLICATION FOR RETIREES

TUFTS Health Plan

PLEASE ANSWER EVERY QUESTION COMPLETELY

Effective date:_____ (Will renew in January)

PLEASE CHECK THE BOX FOR YOUR CHOSEN PLAN BELOW:

❒ **Tufts Medicare Preferred HMO Prime**
❒ Group Rx ❒ Group Rx Plus

❒ **Tufts Medicare Complement (TMC)**
❒ With prescription drug coverage
❒ No prescription drug coverage

GROUP INFORMATION

Full legal name of group: _____ (the "Group")

Corporate headquarters address: _____

City: _____ **State:** _____ **Zip:** _____

Contact name: _____ **Title:** _____

Mailing address (if different): _____

Billing address (if different): _____

Billing contact name (if different): _____ **Title:** _____

Phone #: ( ) _____ Fax #: ( ) _____

Email address: _____ **Web site:** _____

SIC code: _____

Organization type: _____

Date business established: _____ **Tax I.D. number:** _____

Number of full time employees: _____ **Number of part time employees:** _____

Number of seasonal employees: _____ **How many were employed 12 months ago?** _____

How many employees are eligible for health insurance? _____

INFORMATION REQUIRED FOR MEDICARE SECONDARY PAYOR (MSP) REPORTING

The total number of current employees who receive wages, tips, or other compensation (refer to line 1 of your most recent federal tax return form 941 or 944 _____ (Included FT, PT, seasonal, new hire): as of this date _____ (mm/dd/yy).

IMPORTANT

Group represents and warrants that Group is actively engaged in business, and coverage will become effective only upon Tufts Health Plan's acceptance of this application and payment of the required premium or fee at rates Tufts Health Plan determines. If approved, the effective date of coverage will be the effective date mutually agreed upon between Tufts Health Plan and the employer, however coverage will renew on January 1 every calendar year. Group further acknowledges that Group is providing coverage to retirees only. Group acknowledges that if Group commits fraud or misrepresents matters related to this application, Tufts Health Plan has the authority to retroactively terminate coverage back to the date of the fraud or misrepresentation. Group represents and warrants that, to the best of its knowledge, the information contained in this application is complete and true.

I have read and understand this information.

Signed at (City & state) _____

Name of Applicant/Employer _____

Date Signed _____

By (Signature/Title)_____

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 physician (PCP).
- **Primary Care Physician:** 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 www.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 www.tuftshealthplan.com and use the doctor search feature. If you need help filling out this form, call 1-800-936-1902. If you receive your retiree health coverage through the Commonwealth of Mass. Group Insurance Commission, call 1-888-833-0880.

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
No one does more to keep you healthy.

16148-10/07

TUFTS MEDICARE COMPLEMENT MEMBER ENROLLMENT FORM

You must have Medicare Parts A and B to enroll.

TUFTS Health Plan
No one does more to keep you healthy.

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. Employee 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 Physician	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: _____ Benefits Dept. Signature: _____ Telephone: _____Date: _____

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

Now We Are One

2009 V1

AUTHORIZATION AGREEMENT FOR ELECTRONIC PAYMENTS

Save time with the NBT/MBA/HSA Electronic Payment (EP) Program. We now offer the convenience of electronic payments to their members. This means the end of writing checks. With the EP Program, you authorize NBT, MBA or HSA to deduct your monthly payments directly from your checking account. It's that easy! Simply fill out this form and include a copy of a voided check. Please note, once Electronic Payment has been established, your billing statement will reflect the message "Please Do Not Pay This Bill" towards the middle/top section of your statement. This program could take 2 – 4 weeks to begin due to timing and processing factors.

Electronic payments can be deducted from your account on either the 15th or 24th day of each month. For example, July premium payments will be processed on June 15th or June 24th. All outstanding balances owed, including fees, will be transferred at that time.

AUTHORIZATION AGREEMENT FOR ELECTRONIC PAYMENTS

Client Name _____ Account # _____

I (we) herby authorize NBT, MBA or HSA, hereinafter called COMPANY, to initiate debit entries for my (our) Checking account indicated below and the depository named below, hereinafter called DEPOSITORY, to debit the same to such account.

Please indicate which date you prefer by circling one date: ◉15th or ○24th

Please indicate the date you would like us to start the Electronic Payment _____

Depository Name _____ Branch _____

City _____ State _____ Zip _____

Bank Transit / ABA # _____ Bank Account # _____

This authorization is to remain in full force and effect until COMPANY has received written notification from me (us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Authorized Signer _____ _____
Sign Name Print Name and Title

Authorized Signer _____ _____
(if more than one required) Sign Name Print Name and Title

Date _____ Client Telephone # _____

NOTE: ALL WRITTEN DEBIT AUTHORIZATIONS MUST PROVIDE THAT THE RECEIVER MAY REVOKE THE AUTHORIZATION ONLY BY NOTIFYING THE ORIGINATOR IN THE MANNER SPECIFIED IN THE AUTHORIZATION.

Attach voided check here

Please fax, email or mail the completed form to:
MBA/NBT/HSA • 135 Wood Road • Braintree, MA 02184
Phone 781-848-4950 • 877-777-4414 Fax 781-848-7020 Email billing@hsamembership.com