Mass General Brigham
Health Plan

OMB No. 0938-1378
Expires:7/31/2024

**Who can use this form?**

People with Medicare who want to join a Medicare Advantage Plan

**To join a plan, you must:**

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

**Important:** To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

**When do I use this form?**

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit **Medicare.gov** to learn more about when you can sign up for a plan.

**What do I need to complete this form?**

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

**Note:** You must complete all items in Section 1.

The items in Section 2 are optional—you can't be denied coverage because you don't fill them out.

**Reminders:**

- If you want to join a plan during fall open enrollment (October 15 – December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

**What happens next?**

Send your completed and signed form to:

Mass General Brigham Health Plan
Medicare Advantage
399 Revolution Drive, Suite 850
Somerville, MA 02145

Once they process your request to join, they'll contact you.

**How do I get help with this form?**

Call Mass General Brigham Health Plan at **(855)486-3097** (TTY: 711).

Or, call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users can call **1-877-486-2048**.

**En español:** Llame a Mass General Brigham Health Plan al **855-833-3668** (TTY: 711) o a Medicare gratis al **1-800-633-4227** y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

**Individuals experiencing homelessness**

If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

**Section 1 – All fields on this page are required (unless marked optional)**

Select the plan you want to join.

☐ Mass General Brigham Advantage Secure (HMO-POS) $52 per month

☐ Mass General Brigham Advantage (PPO) $0 per month

☐ Mass General Brigham Advantage Premier (PPO) $140 per month

First name: Last name: Middle Initial (Optional):

Birthdate (MM/DD/YYYY) ( __ __ /__ __ / __ __ __ __)

Sex: ☐ Male ☐ Female

Phone number: ( )

Permanent Residence street address (Don't enter a PO Box):

City: State: ZIP Code:

Mailing address, if different from your permanent address (PO Box allowed):
Street Address:

City: State: ZIP Code:

**Your Medicare Information**

Medicare Number: __ __ __ __- __ __ __- __ __ __ __

Effective date: Part A ___/___/____ Part B ___/___/____

**Answer these important questions:**

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Mass General Brigham Health Plan? Yes No

Name of other coverage: _____ Member number for this coverage: _____ Group number for this coverage: _____

**IMPORTANT—Read and sign below:**

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Mass General Brigham Health Plan.
- By joining this Medicare Advantage, I acknowledge that Mass General Brigham Health Plan will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time—and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Mass General Brigham Health Plan coverage begins, I must get all of my medical and prescription drug benefits from Mass General Brigham Health Plan. Benefits and services provided by Mass General Brigham Health Plan and contained in my Mass General Brigham Health Plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Mass General Brigham Health Plan will pay for benefits or services that are not covered.
- 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 legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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 by Medicare.

| **Please sign below:** | |
|---|---|
| Signature: | Today's date: |
| **If you're the authorized representative, sign above and fill out these fields:** | |
| Name: | Address: |
| Phone number: | Relationship to enrollee: |

| **Section 2 – All fields on this page are optional** | |
|---|---|
| **Answering these questions is your choice. You can't be denied coverage because you don't fill them out.** | |
| Are you Hispanic, Latnino/a, or Spanish origin? Select all that apply. | |
| ☐ No, not of Hispanic, Latino/a, or Spanish origin<br>☐ Yes, Puerto Rican<br>☐ Yes, another Hispanic, Latino/a, or Spanish origin<br>☐ ***I choose not to answer.*** | ☐ Yes, Mexican, Mexican American, Chicano/a<br>☐ Yes, Cuban |
| What's your race? Select all that apply. | |
| ☐ American Indian or Alaska Native<br>☐ Chinese<br>☐ Japanese<br>☐ Other Asian<br>☐ Vietnamese<br>☐ Asian Indian<br>☐ Filipino<br>☐ **I choose not to answer.** | ☐ Korean<br>☐ Other Pacific Islander<br>☐ White<br>☐ Black or African American<br>☐ Guamanian or Chamorro<br>☐ Native Hawaiian<br>☐ Samoan |
| Select one if you want us to send you information in a language other than English.<br>☐ Spanish | |
| Select one if you want us to send you information in an accessible format.<br>☐ Braille ☐ Large print ☐ Audio CD<br>Please contact Mass General Health Plan at **(855)486-3097** (TTY: 711) if you need information in an accessible format other than what's listed above. Our office hours are October 1 – March 31, 8:00 AM to 8:00 PM EST, Monday through Sunday and April 1 – September 30, 8:00 AM to 8:00 PM EST, Monday through Friday. | |
| Do you work? ☐ Yes ☐ No | Does your spouse work? ☐ Yes ☐ No |
| List your Primary Care Physician (PCP), clinic, or health center: | |
| I want to get the following materials via email. Select one or more.<br>☐ Evidence of Coverage (EOC) ☐ Summary of Benefits (SB) ☐ Provider directory ☐ Pharmacy directory<br>E-mail address: | |

**Paying your plan premiums:**

You have a choice in how to pay your monthly plan premium (including any Part D late enrollment penalty that you currently have or may owe). Please select a premium payment option below:

☐ Get a bill monthly.

☐ Set up automatic withdrawal from your checking or savings account or automatic charge to your credit card.

☐ You can also choose to pay your premium by having it automatically taken out of your Social Security benefit or Railroad Retirement Board (RRB) benefit each month. The Social Security deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

**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 *Mass General Brigham Health Plan* the Part D-IRMAA.

**Section 3**

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. 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 am new to Medicare.

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

☐ 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 (insert date) _____.

☐ I recently was released from incarceration. I was released on (insert date) _____.

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.

☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____.

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.

☐ 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.

☐ 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/will move into/out of the facility on (insert date) _____.

☐ I recently left a PACE program on (insert date) _____.

**Section 3 (continued)**

☐ I recently involuntarily lost my creditable prescription drug coverage on (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.

☐ I am leaving employer or union coverage on (insert date) _____.

☐ I belong to a pharmacy assistance program provided by my state.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.

☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.

☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

If none of these statements applies to you or you're not sure, please contact Mass General Brigham Health Plan at **(855)486-3097 (TTY: 711)** to see if you are eligible to enroll.

**Hours of operation:**

**October 1 – March 31**, 8:00 AM to 8:00 PM EST, Monday through Sunday.
**April 1 – September 30**, 8:00 AM to 8:00 PM EST, Monday through Friday.

| 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: |

**PRIVACY ACT STATEMENT**

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.