HSAinsurance

Corporate Office
135 Wood Road
Braintree, MA 02184
781.848.4950

Fallon Health
Fallon Medicare Plus Premier HMO
Rx

Check if Complete	To ensure that your applications are processed as quickly as possible, just follow this checklist
☐	**Employer** *completes and signs* the **Master Application.**
☐	**Employer** provides copy of most recent **Schedule C** or **WR-1.**
☐	Pay your first premium, $5 monthly service fee and $125 annual membership fee: •Pay over the phone: (781) 228-2222. Payment Confirmation #:_____ -or- •Complete Electronic Payment Request Form -or- •Enclose check payable to HSA *(Receipt of payment does not guarantee coverage. HSA must receive completed enrollment materials by the carrier deadline)*
☐	Enclose Annual Membership Fee of **$125 (Payable to HSA)** **-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.
☐	Eligible **enrollee** *completes and signs a* **Fallon Medicare Plus Premier HMO Enrollment Form.**
☐	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.
☐	Eligible **enrollee** *selects* a ***Primary Care Physician*** on **Election Form.**

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

☐ **HSA Main Office**
135 Wood Rd,
Braintree MA 02184

Sales Rep:_____

Contact Info:

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.

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Fallon Health
2023 Medicare Plus Premier HMO Rx

The Medicare Plus Premier HMO, *a Medicare Advantage Plan* from Fallon Health offers more benefits at lower cost than most other options available to Medicare eligible recipients in Massachusetts. Foremost among the added benefits is **unlimited prescription drug coverage.**

The monthly premium for this Medicare plan is $467.00 and is guaranteed through December 31, 2022.

Eligibility Guidelines

Eligible Companies

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 Fallon Medicare Plus Premier HMO service area.
- Is a member in good standing of HSA

Eligible Enrollee

An eligible enrollee is one that:

- Is enrolled in Medicare Part A and Part B
- Lives in the Fallon Medicare Plus Premier HMO service area

Effective Dates

- All coverage will be effective on the 1st day of the month
- Applications must be received by HSA by the 25th of the preceding month.

HSAinsurance

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Fallon Health
Medicare Plus Premier
HMO Rx Member
Application

2022

Company Name		**Desired Effective Date**
Business Address (street, city, state, zip)	**Billing Address** (if different)	
Principal Contact	**Telephone**	**Fax**
Type of Business ☐ Corporation ☐ Proprietorship ☐ Partnership ☐ Other	**Email**	
Nature of Business	**SIC code**	
Date Established	**Tax ID Number**	

Number of Full Time Employees_____ **Number of Part Time Employees**_____

Number of Seasonal Employees_____ **How many were employed 12 months ago?**_____

Information Related to Medicare Secondary Payer (MSP)

Group attests that group has fewer than 20 employees as defined in the Medicare Secondary Payer regulations at 42 CFR § 411.170:

An employer is considered to employ 20 or more employees if the employer has 20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.

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):

Previous Year	Current Year
Q1_____	Q1_____
Q2_____	Q2_____
Q3_____	Q3_____
Q4_____	Q4_____

(includes FT, PT, seasonal, new hire) as of this date_____**(mm/dd/yyyy).**

Are you offering this Medicare plan for retirees, active employees aged 65 or older or both?_____

Do you offer group Commercial insurance for your under age 65 employees? _____

If yes, current carrier(s) _____

Plan Selection

Choose plan:		**Monthly Premium**
☐	**Medicare Plus Premier HMO With Rx**	**$467.00**

Certification

1. I understand that all premiums for health/dental insurance are due on or before the 1st day of the month of coverage
2. I understand if premiums are not received by the 1st day of the month of coverage, HSA has the option of assessing a $25 late fee on the balance due.
3. I understand that if premiums are not received by the 1st day of the month, HSA has the option of terminating coverage effective that date.
4. I certify that I have not misrepresented eligibility of an employee or misrepresented information needed to determine group size, group participation rate, or group premium rate.
5. I acknowledge that HSA is a sales and billing agent and is not responsible for payment of claims on our behalf.
6. I acknowledge that this company has fewer than 20 employees as defined in the Medicare Secondary Payer statute 42 U.S.C. § 1395y. Group will immediately notify HSA if group's employee count according to Medicare Secondary Payer statute were to change so that it is no longer eligible for Medicare to be the primary payer. In the event of this change, group acknowledges that the group's Medicare eligible employees would no longer be eligible for this product.
7. HSA Insurance charges a monthly service fee per account.

Signature (Authorized Employer Representative)	**Title**	**Date**

Broker name (if applicable) _____

Address _____

City _____ State _____ ZIP _____

2023 Fallon Medicare Plus™ Premier HMO Enrollment Form

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

To enroll, please provide the following information.

Company name:	Group number:
Authorized signature:	Requested effective date:

Last name: First name: Middle initial: *(optional)*

Birth date: (MM/DD/YYYY) _____ / _____ / _____

Sex: ❑ M ❑ F

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.*

Permanent residence street address (P.O. Box is not allowed):

City/town:	State:	ZIP code:	County: *(optional)*

Mailing address if different from above:

Street address: _____

City/town: _____ State: _____ ZIP code: _____

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 the Social Security Administration 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 or union plan?** ❑ Yes ❑ No

   If yes, name of spouse: _____

   Name(s) of dependent(s): _____

Please read and answer these important questions (continued).

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 Fallon Health? ❑ Yes ❑ No

If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: _____

ID # for 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 & Phone Number of Institution (number and street):

_____

6. Please choose a primary care physician (PCP), clinic or health center:

_____

Please check the box below if you would prefer us to send you information in another accessible format:

❑ Braille ❑ Audio CD ❑ Large print

Please contact Fallon Health at 1-866-231-3669 (TRS 711) if you need information in an accessible format other than what is listed above.

I want to get the following materials via email. Select one or more.

❑ Evidence of Coverage ❑ Formulary Email address: _____

Please read the important information on the following page and then sign below.

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 by Fallon Health or by Medicare.

X _____ _____

Your signature/authorized representative — Today's date

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

_____ _____

Name (printed) — Relationship to enrollee

_____

Address

Phone number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

SECTION 2 – All fields in this section are optional.

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

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

- ❑ No, not of Hispanic, Latino/a, or Spanish origin
- ❑ Yes, Puerto Rican
- ❑ Yes, another Hispanic, Latino/a, or Spanish origin
- ❑ Yes, Mexican, Mexican American, Chicano/a
- ❑ Yes, Cuban
- ❑ I choose not to answer.

What's your race? *Select all that apply.*

- ❑ American Indian or Alaska Native
- ❑ Asian Indian
- ❑ Black or African American
- ❑ Chinese
- ❑ Filipino
- ❑ Guamanian or Chamorro
- ❑ Japanese
- ❑ Korean
- ❑ Native Hawaiian
- ❑ Other Asian
- ❑ Other Pacific Islander
- ❑ Samoan
- ❑ Vietnamese
- ❑ White
- ❑ I choose not to answer.

SECTION 3 – Read this important information.

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

Fallon Health is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in Fallon Health depends on contract renewal. I will need to keep my Medicare Parts A and B. (This means I must continue to pay my Medicare Part B premium.) I can only be in 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. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage 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 when an enrollment period is available (Example: October 15–December 7 of every year), or under certain special circumstances.

Fallon Medicare Plus Premier HMO serve a specific service area. If I move out of the area that Fallon Medicare Plus Premier HMO 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 Fallon Medicare Plus Premier HMO, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Fallon Medicare Plus Premier HMO when I get it to know which rules I must follow to receive coverage with this Medicare Advantage 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.

I understand that beginning on the date Fallon Medicare Plus Premier HMO coverage begins, I must get all of my health care from Fallon Medicare Plus Premier HMO, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Fallon Medicare Plus Premier HMO and other services contained in my plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR FALLON MEDICARE PLUS PREMIER HMO WILL PAY FOR THE SERVICES.**

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Fallon Health, they may be paid based on my enrollment in Fallon Medicare Plus Premier HMO.

Release of information:
By joining this Medicare health plan, I acknowledge that Fallon Medicare Plus Premier HMO will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Fallon Medicare Plus Premier HMO will release my information including my prescription drug event data (if applicable) to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this 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.

1-866-231-3669 (TRS 711)

8 a.m.–8 p.m., seven days a week
(Apr.–Sept., 8 a.m.–8 p.m., Mon.–Fri.)

FALLON USE ONLY ❑ New enrollment ❑ Group to group
OEV required: _____ Sales staff initials: _____ OEV complete: _____
Name of staff member (if assisted in enrollment): _____
EGWP: _____ ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not eligible: _____
Staff verification: _____ Effective date of coverage: _____
County code: _____ Previous insurance: _____
Broker name: _____ Broker ID: _____

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Electronic Payment Request Form

New Client? Pressed for time? Call (781) 228-2222 (8:30am-5:00pm, M-F) to quickly set up electronic payments. Just have your bank account and routing numbers ready. Or, complete this form:

Client Information:

Client Name: _____ Client Email: _____

New Client: Quote number and/or Application ID: _____

Current Client: 6 Digit HSA Account number: _____

Select payment type:

- ☐ **Recommended for new clients:** Withdraw both first month payment and recurring monthly payments
- ☐ First month payment only

If requesting recurring monthly payments, select date for withdrawal.

☐ 15th of the month ☐ 24th of the month

All outstanding balances owed, including fees, will be transferred at that time.

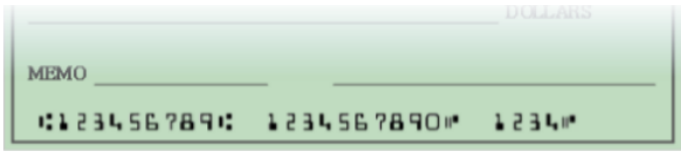
Bank Information:

Bank Name: _____ City: _____ State ____ Zip: _____

Name on Account: _____

Routing Number: _____ Bank Account Number: _____

Account Type: ☐ Checking ☐ Savings



Authorization:

I (we) hereby authorize HSA Insurance to initiate debit entries for my (our) checking account and the depository named above, hereinafter called DEPOSITORY, to debit the same to such account. This authorization is to remain in full force and effect until HSA Insurance has received written notification from me (us) of its termination in such time and in such manner as to afford HSA and DEPOSITORY a reasonable opportunity to act on it. 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.

Authorized Signer _____ _____

Sign Name Print Name and Title

Date: _____ Client Telephone: _____

Return Form

Please fax or secure email the completed form to: (781) 848-7020 or enrollment@hsainsurance.com
For changes to existing bank information, please contact Customer Service: (781) 228-2222.