OMB No. 0938-1378
Expires: 06/30/2026

fallonhealth

2025 Fallon Medicare Plus™

Member Change Form

Directions: Please complete and sign this form ***only*** if you want to change your current Fallon Health plan. It's important to read the entire form and the Summary of Benefits booklets for details on plan premiums, cost-sharing, and benefits associated with each plan.

Member name and address		
Last name:	First name:	M.I.:
Medicare number:		
Permanent street address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):		
City/Town:	State:	ZIP:
Mailing address ***(only if different from your permanent street address)***		
Street address:		
City/Town:	State:	ZIP:
Date of birth:	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.*	
Preferred spoken language *(optional)*:	Preferred written language *(optional)*:	

Yes, I want to change my plan choice for 2025 from *(insert your current plan)* _____, with a monthly premium of $_____. I understand that the plan I choose may have different health benefits and monthly premium.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT: ***Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See page 3 for the mailing address to send your completed form to the plan.***

The following table includes the 2025 plan choices and the corresponding monthly premiums.

Please check ☑ which Fallon Medicare Plus plan you want to enroll in:

Fallon Medicare Plus (FMP) options	If you live in one of the following counties:		
	Worcester	**Franklin, Hampden, Hampshire**	**Barnstable, Berkshire, Bristol, Essex, Middlesex, Norfolk, Plymouth, Suffolk**
FMP Orange HMO	❑ $0/month (038-00)		
FMP Green HMO	❑ $90/month (030-15)	❑ $57/month (030-16)	❑ $68/month (030-18)
FMP Blue HMO	❑ $197/month (031-15)	❑ $101/month (031-16)	❑ $164/month (031-18)
FMP Saver No Rx HMO	❑ $35/month (039-00)		

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:

- ❑ Asian Indian
- ❑ Chinese
- ❑ Filipino
- ❑ Japanese
- ❑ Korean
- ❑ Vietnamese
- ❑ Other Asian

- ❑ Black or African American

Native Hawaiian and Pacific Islander:

- ❑ Guamanian or Chamorro
- ❑ Native Hawaiian
- ❑ Samoan
- ❑ Other Pacific Islander

- ❑ White
- ❑ **I choose not to answer.**

What is your gender? Select one.

- ❑ Woman
- ❑ Man
- ❑ Non-binary
- ❑ I use a different term: _____
- ❑ **I choose not to answer.**

Which of the following best represents how you think of yourself? Select one.

- ❑ Lesbian or gay
- ❑ Straight, that is, not gay or lesbian
- ❑ Bisexual
- ❑ I use a different term: _____
- ❑ I don't know
- ❑ **I choose not to answer.**

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

❑ Braille ❑ Audio CD* ❑ Data CD ❑ Large print

**Audio messages will not be encrypted, which means they could be intercepted by others. By selecting audio, you agree to receive these audio messages without encryption.*

Please contact Fallon Health at 1-800-325-5669 if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m.–8 p.m., Monday–Friday (7 days a week, Oct. 1–March 31). TTY users can call TRS 711.

Your plan premium

If you enroll in an option that does not have a monthly premium and we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. Please select a payment option from below to pay a late enrollment penalty.

If you enroll in a plan with Medicare prescription drug coverage that has a monthly premium and we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), you will pay this through the payment option you select below because it will be included with your monthly premium.

For more information on premiums and prescription drug costs based on your income, please refer to the last page.

Plan premium payment options

Please check the box next to the payment option that you would like. If you don't select a payment option, you will get a bill each month.

- ❑ **Receive a bill monthly.**
- ❑ **Electronic Funds Transfer (EFT)** from your checking or savings account each month. If you choose this option, we will contact you for more information.
- ❑ **Credit card (Discover, MasterCard, or VISA)** If you choose this option, we will contact you for more information.
- ❑ **Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.** (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.)

  I get monthly benefits from: ❑ Social Security ❑ RRB

Please read the important information on the last page and 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 from Medicare.

X _____ _____

Your signature/authorized representative **Date**

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

Name (printed) _____

Relationship to Enrollee _____

Address _____

Primary phone number (_____) _____

Please mail to:

Fallon Health, Attn: Enrollment and Billing Operations, 1 Mercantile St., Ste. 400, Worcester, MA 01608

STOP Please read the important information below. STOP

Fallon Health is a plan that has a contract with the Federal government.

I understand that if I am getting 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.

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 Fallon Medicare Plus 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 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 people with Medicare aren't 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 coverage begins, I must get all of my health care from Fallon Medicare Plus, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Fallon Medicare Plus and other services contained in my Fallon Medicare Plus Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR FALLON MEDICARE PLUS WILL PAY FOR THE SERVICES.**

Information on premiums and prescription drug costs based on your income:

If you enroll in a plan with Medicare prescription drug coverage and you are assessed a Part D Income-Related Monthly Adjustment Amount (IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the Railroad Retirement Board (RRB). DO NOT pay Fallon Health the Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for your drug costs, including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name: _____ Relationship to enrollee: _____

Signature: _____ National Producer Number *(Agents/Brokers only)*: _____

BROKER/AGENT INFO: Agency name: _____

Broker/agent name: _____ Mass. Lic#: _____

Prior insurance: _____

Requested effective date: _____

SOA form: ❑ Yes ❑ No

FALLON HEALTH USE ONLY: RTS verification: ❑ Yes ❑ No

QNXT attribute needed: _____

Date received: _____ Method of receipt: _____

Telephonic: ❑ No ❑ Yes If yes, confirmation number: _____

❑ ICEP/IEP: _____ ❑ AEP: _____ ❑ SEP (type): _____ ❑ Not eligible: _____

Sales staff initials: _____ Plan ID#: _____ Effective date of coverage: _____

ENROLLMENT DEPT USE ONLY: