2024 Medicare PPO Blue (PPO) FreedomRx Enrollment Form

Employer Group Received Date

Employer Use Only:

Group Name: City of Woburn Group Number: Requested Eff Date:

Section 1 - Member Use - All fields are required (unless marked optional)

FIRST name: LAST name: Middle Name (optional):

Birth date: (MM/DD/YYYY) (__ __ __ __ __ __ __ __) Sex: ☐ Male ☐ Female Phone number: ( ) - County (Optional):

Permanent Residence (Don't enter a P. O. Box):

Street Address: City: State: ZIP Code:

Mailing address, if different from your permanent address (P. O. Box allowed):

Street Address: City: State: ZIP Code:

Your Medicare information:

Medicare Number: ____ ____ ____ ____ - ____ ____ ____ -____ ____ ____ ____

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Medicare PPO Blue (the Plan).
- By joining this Medicare Advantage Plan, I acknowledge that the 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).
- 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 are generally not covered under Medicare while out of the country, except for limited coverage near the United States border.
- I understand that when the Plan coverage begins, I must get all my medical and prescription drug benefits from the Plan. Benefits and services provided by the Plan and contained in the Plan (Evidence of Coverage) document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor the Plan will pay for benefits or services that are not covered.
- 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.

Signature: Today's date:

If you're the authorized representative, sign above and fill out these fields:

Name: Address:

Phone number: Relationship to enrollee: