2025 Employer/Retiree Group Enrollment Application

PSHB Medicare Advantage PPO Plan

Please contact Medical Mutual toll free at **1-800-801-4823** (TTY: 711 for hearing impaired) if you need information in another language or format (Braille, large print and more). We are open 8 a.m. to 8 p.m. EST, seven days a week from October 1 through March 31 (except Thanksgiving and Christmas), and 8 a.m. to 8 p.m. EST, Monday through Friday from April 1 through September 30 (except holidays).

Submitting your application:

1. If you and your Medicare-eligible spouse and/or dependent are applying, you will each need to complete a separate application. If you need another enrollment application, call Medical Mutual toll free at **1-800-801-4823** (TTY: 711 for hearing impaired).
2. Read and complete all pages of the application.
3. Mail the application(s) to the address listed below.

Enrollment Department
Medical Mutual
PO Box 94563
Cleveland, OH 44144-9815

After we receive your application:

- We will notify Medicare you applied to join our plan.
- After Medicare confirms you are eligible to enroll, we will confirm the effective date of your coverage. We will send you a Medical Mutual Medicare Advantage member ID card and information for new members.

X11558-MCA 10.24
Y0121_P_S3287_2025_C

MEDICAL MUTUAL®
Medicare Advantage

Employer/Retiree Group Enrollment Application

MEDICAL MUTUAL® Medicare Advantage

To enroll in a Medicare Advantage plan, you must have Medicare Part A and Part B and provide the following information:

1. Medicare Information (please use your Medicare card to complete this section)

Please fill in the blanks OR include a copy of your Medicare card OR include a copy of your Social Security Administration or Railroad Retirement Board Letter. **You must have Medicare Part A and Part B to join a Medicare Advantage Plan.**	Medicare Number

2. Plan Selection Information

Please check the plan that you would like to enroll in:

☑ PSHB Medicare Advantage PPO

3. Employer Information

Employer/Union Name

The Postal Service Health Benefits Program

Group Number

A27313

4. Applicant Information

First Name		MI	Last Name
Birthdate (MM/DD/YYYY)	Gender ☐ Male ☐ Female	Email Address	
Home Phone Number ( ) –		Cell Phone Number ( ) –	
Permanent Residence Street Address (P. O. Box is not allowed)			
City	State	ZIP	County
Mailing Address (only if different from your Permanent Residence Address)			
City		State	ZIP

Note: By providing your email address, you are giving Medical Mutual permission to send you an email message (e.g., confirming we received your application and/or information about how to opt in to receive additional plan-related email communications).

Employer/Retiree Group Enrollment Application

5. Primary Care Physician Information (optional)

Physician's Name	Physician's Phone Number ( ) –	Physician's NPI Number

6. Race and Ethnicity Information (optional)

These questions are optional and will not impact your application.

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

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

What is your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamo
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ 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:

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

7. Language and Accessibility Options

Please fill in if you prefer a language other than English.

☐ _____

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large Print ☐ Audio CD ☐ Data CD

If you need information in an accessible format other than what is listed above, please contact Medical Mutual toll free at **1-800-801-4823** (TTY: 711 for hearing impaired) seven days a week, 8 a.m. to 8 .m. from October 1 through March 31 (except Thanksgiving and Christmas) and Monday through Friday, 8 a.m. to 8 p.m. from April 1 through September 30 (except holidays).

8. Please read and answer all questions that apply to you (check all that apply)

1. Are you the: ☐ **Retiree** ☐ **Medicare-eligible spouse** ☐ **Medicare-eligible dependent**

If retiree, please provide your retirement date: / /

2. Are you or your spouse currently employed? ☐ **Yes** ☐ **No**

3. Will you have prescription drug coverage in addition to the PSHB Medicare Advantage PPO Plan you have selected? For example, through TRICARE, other private insurance, state pharmaceutical assistance programs, VA benefits or federal employee health benefits

☐ **Yes** ☐ **No** **If yes**, please list the name, your identification (ID) and group number for this coverage:

Name of Coverage

1607

Employer/Retiree Group Enrollment Application

9. Terms and Conditions (please read and sign below)

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

MedMutual Advantage PPO plans are Medicare Advantage plans offered by Medical Mutual through a contract with the federal government. Enrollment in a MedMutual Advantage plan depends on contract renewal. I will need to keep my Medicare Parts A and B. I can be in only 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 or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage I have or may get 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 through December 7 of every year), or under certain special circumstances.

Each MedMutual Advantage plan serves a specific service area. If I move out of the area that MedMutual Advantage 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 Medical Mutual, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Medical Mutual when I get it to know which rules I must follow to get coverage with this 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 MedMutual Advantage PPO coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Medical Mutual provides refunds for all covered benefits, even if I get services out of network. Services authorized by Medical Mutual and other services contained in my MedMutual Advantage Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR MEDICAL MUTUAL WILL PAY FOR THE SERVICES.**

I understand if I am getting assistance from a sales agent, broker or other individual employed by or contracted with Medical Mutual, they may be paid based on my enrollment in MedMutual Advantage.

Proxy: I appoint the Secretary of Medical Mutual of Ohio as my proxy to act for me at any annual or special meeting of the members of Medical Mutual of Ohio. The Secretary will act as fully and to the same extent that I could act if personally present at the meeting. This proxy will be in effect for 10 years from the date of my signature below or the effective date of my coverage, whichever date is later. This proxy may be taken back at any time by mailing a letter to the Secretary.

Email Address: I understand if I have included my email address in this application, I am authorizing Medical Mutual to send me an email confirming they received my application.

Release of Information: By joining this Medicare health plan, I acknowledge that Medical Mutual will release my information to Medicare and other plans as is necessary for treatment, payment and healthcare operations. I also acknowledge that Medical Mutual will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes that 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.

Medical Mutual will use and disclose my information as permitted by law and consistent with Medical Mutual's Notice of Privacy Practices (available at MedMutual.com or by calling toll free **1-800-801-4823** (TTY: 711 for hearing impaired).

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 I have read and understand the contents of this application.

Signature	Today's Date

Employer/Retiree Group Enrollment Application

10. Authorized Representative Information (if applicable)		
Note: If signed by an authorized individual (as described in Section 9), this signature certifies that this person is authorized under state law to complete this enrollment and that documentation of this authority is available upon request from Medicare. If you are the authorized representative, you must sign page 3 and provide the following information:		
Authorized Representative's Name		
Street Address		
City	State	ZIP
Relationship to Enrollee	Home Phone Number ( ) –	
Note: All mail will be sent to the permanent address or mailing address provided in Section 4 of this application.		

MEDICAL MUTUAL®
100 American Road
Cleveland, OH 44144-2322

MedMutual.com/Medicare