

You may choose to enroll on-line using our website: aetnamedicare.com. Otherwise, follow these instructions to complete this enrollment form.

Applicant Enrollment Instructions

Follow these steps to enroll:

SECTION 1:	Choose the Aetna Medicare Advantage plan in which you wish to enroll; include the premium amount of the chosen plan (refer to the Summary of Benefits for detailed benefit information, premium amounts, and to determine if a Primary Care Physician (PCP) selection is required). <u>Please be aware:</u> You can change plans only at certain times during the year*. The general timeframes are: – Annual Enrollment Period: This year, the Annual Enrollment Period is November 15 through December 31, 2010. During the Annual Enrollment Period anyone with Medicare can select a new Medicare health and/or Medicare prescription drug plan for the following year. (Starting next year, the Annual Enrollment Period will be from October 15 through December 7.) <u>Please be aware:</u> Optional Dental plans require payment of an additional monthly premium and may not be available with all plan options (refer to the Summary of Benefits for detailed benefit information and premium amounts). If you elect to enroll, your monthly premium will be the combined total of the monthly health plan premium <u>and</u> the Optional Dental plan premium. * There are exceptions that may allow you to enroll at other times. Refer to Section 6. Contact Aetna at the number listed below for more information on these special enrollment periods.
SECTION 2:	Complete the personal information section (Name, Address, Phone number, etc.). <u>Print clearly.</u>
SECTION 3:	Using your red, white and blue <i>Medicare Card</i> , provide us with your Medicare Insurance information.
SECTION 4:	Check a box for your preferred premium payment method. Do not submit your premium payment with this enrollment form.
SECTION 5:	Please read and answer the questions in this section to help Aetna coordinate your benefits.
SECTION 6:	Complete this section if you are enrolling during a special enrollment period. Check the box(es) that apply to you. A Customer Service Representative may contact you if additional information is required.
SECTION 7:	Read the Important Information in SECTION 7.
SECTION 8:	Sign and date the enrollment form in the space provided. <u>If you are a legally authorized representative</u> and assisting the enrollee in completing this enrollment form, sign this form and provide your information under the signature area.
SECTION 9:	Broker/Agent section (if applicable) – your broker or agent signs and dates the application.

Be sure to complete the entire enrollment form. Missing or inaccurate data will delay enrollment processing.

Mail your completed form to the address below using the enclosed, postage-paid envelope.

**Aetna Medicare
PO Box 14088
Lexington, KY 40512-4088**

If you have questions, call **1-800-832-2640** (TTY/TDD **1-888-760-4748**), 8:00 a.m. – 8:00 p.m. 7 days a week
You may also enroll in an Aetna Medicare plan through the Centers for Medicare and Medicaid Services Online Enrollment Center at www.medicare.gov.

A Medicare Advantage organization with a Medical contract.

Applicant's Name: _____ **Effective Date:** _____

Please contact the Aetna Medicare Advantage Plan if you need information in another language or format (Braille).

Section 1 – To Enroll in the Aetna Medicare Advantage Plan, Please Provide the Following Information:

Please check which plan you want to enroll in:

Aetna MedicareSM Plans (HMO) <input type="checkbox"/> Basic SM (HMO) \$ _____ per month <input type="checkbox"/> Value SM (HMO) \$ _____ per month <input type="checkbox"/> Standard SM (HMO) \$ _____ per month <input type="checkbox"/> Select SM (HMO) \$ _____ per month <input type="checkbox"/> Premier SM (HMO) \$ _____ per month		Aetna MedicareSM Plans (PPO) <input type="checkbox"/> Value SM (PPO) \$ _____ per month <input type="checkbox"/> Standard SM (PPO) \$ _____ per month <input type="checkbox"/> Select SM (PPO) \$ _____ per month <input type="checkbox"/> Premier SM (PPO) \$ _____ per month	
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Primary Care Doctor Name & Address (required for HMO; recommended for PPO & Open Access HMO (for lowest PCP copay)) _____	Aetna Primary Office ID _____	Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Optional Dental Plan:** Available in select areas for an additional monthly premium.

Aetna Preventive Dental Plan Aetna Advantage Dental Plan

** Primary Care Dentist Name (both dental choices require selection) _____	Dental Office Code _____
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Section 2 – Personal Information

LAST NAME _____	FIRST NAME _____	MIDDLE INITIAL _____	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
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Birth Date ____/____/____ M M D D Y Y Y Y	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number () _____
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Permanent Residence Street Address (PO Box is not allowed) _____	Apt./ Suite/Unit _____
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City _____	County _____	State _____	Zip Code _____
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Mailing Address (only if different from your Permanent Residence Address)

Street Address _____	City _____	State _____	Zip Code _____
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Emergency Contact (Optional) Name _____	Phone Number () _____	Relationship to You _____
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Email Address (Optional) _____

Section 3 – Please Provide Your Medicare Insurance Information

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card
- OR -
- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

	
MEDICARE HEALTH INSURANCE	
SAMPLE ONLY	
Name _____	
Medicare Claim Number _____	Sex ___M ___F

Is Entitled To	Effective Date
HOSPITAL (Part A)	_____
MEDICAL (Part B)	_____

Applicant's Name:	Effective Date:
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Section 4 – Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail each month. You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible 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.socialsecurity.gov/prescriptionhelp.

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

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

- Get a bill monthly
- Automatic deduction from your monthly Social Security benefit check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

Section 5 – Please Read and Answer These Important Questions

<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Do you have End-Stage Renal Disease (ESRD)? If you answered "Yes" to this question and you don't need regular dialysis any more, or if you have had a successful kidney transplant, please attach a note or records from your doctor showing you don't need dialysis or have had a successful kidney transplant.
<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or state pharmaceutical assistance programs. Will you have other <u>prescription drug coverage</u> in addition to the Aetna Medicare Advantage plan? If "Yes," list your other coverage and your identification (ID) number(s) for this coverage: Name of other coverage: _____ ID # for this coverage: _____ Group # for this coverage: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Are you a resident in a long-term care facility, such as a nursing home? If "Yes," please provide the following information: Name of Institution: _____ Phone number: (____) _____ Address (number & street): _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Are you enrolled in your State Medicaid program? If "Yes," please provide your Medicaid number: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	5. Do you or your spouse work?

Please check the box if you would prefer us to send you information in a language other than English. Spanish
Please contact the Aetna Medicare Advantage plan at **1-800-832-2640** if you need information in another format or language than what is listed above. Our office hours are 8:00 a.m. – 8:00 p.m., 7 days a week. TTY/TDD users should call **1-888-760-4748**.

Section 6 – Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between October 15 and 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.

<input type="checkbox"/> I am new to Medicare.	<input type="checkbox"/> I am moving in to, 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 ___/___/___ (date)
<input type="checkbox"/> I recently moved and this plan is a new option for me. I moved on ___/___/___ (date)	<input type="checkbox"/> I recently left a PACE program on ___/___/___ (date)
<input type="checkbox"/> I recently moved outside of the service area for my current plan. I moved on ___/___/___ (date)	<input type="checkbox"/> I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on ___/___/___ (date)
<input type="checkbox"/> I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.	<input type="checkbox"/> I am leaving employer or union coverage on ___/___/___ (date)
<input type="checkbox"/> I get extra help paying for Medicare prescription drug coverage.	<input type="checkbox"/> I belong to a pharmacy assistance program provided by my state.
<input type="checkbox"/> I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on ___/___/___ (date)	<input type="checkbox"/> I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on ___/___/___ (date)
<input type="checkbox"/> My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.	

None of these statements apply to me. Please contact the Aetna Medicare Advantage plan at **1-800-832-2640** (TTY/TDD users should call **1-888-760-4748**, to see if you are eligible to enroll. We are open 8:00 a.m. – 8:00 p.m., 7 days a week.

Applicant's Name:	Effective Date:
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Section 7 – Please Read This Important Information

If you currently have health coverage from an employer or union, joining the Aetna Medicare Advantage plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join the Aetna Medicare Advantage plan. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Section 8 – Please Read and Sign Below

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

The Aetna MedicareSM Plan (HMO) and the Aetna MedicareSM Plan (PPO) are Medicare Advantage plans and have a contract with the Federal government. I will need to keep my Medicare Parts A and B. 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 or prescription drug 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 a Medicare prescription drug plan 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.

The Aetna Medicare Advantage plan serves a specific service area. If I move out of the area that the Aetna Medicare Advantage plan 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 the Aetna Medicare Advantage plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from the Aetna Medicare Advantage plan when I get it to know which rules I must follow to get 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.

(For HMO/PPO plans) I understand that beginning on the date the Aetna Medicare Advantage plan coverage begins, I must get all of my health care from the Aetna Medicare Advantage plan, except for emergency or urgently-needed services or out-of-area dialysis services;

(For PPO plans) I understand that using services in-network can cost less than using services out-of-network. If medically necessary, the Aetna Medicare Advantage plan provides refunds for all covered benefits, even if I get services out-of-network. Services authorized by the Aetna Medicare Advantage plan and other services contained in my Aetna Medicare Advantage plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR THE AETNA MEDICARE ADVANTAGE PLAN WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with the Aetna Medicare Advantage plan, he/she may be paid based on my enrollment in the Aetna Medicare Advantage Plan.

Release of Information: By joining this Medicare health plan, I acknowledge that the Aetna Medicare Advantage Plan or its affiliates will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that the Aetna Medicare Advantage Plan will release my information, including prescription drug event data, 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 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 the Aetna Medicare Advantage Plan or by Medicare.

Signature	Today's Date
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If you are the authorized representative, you must sign above and provide the following information.

Name	Address
Phone Number	Relationship to Enrollee

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies (Aetna).

Applicant's Name: _____ Effective Date: _____



Section 9 – These Sections Are To Be Completed By A Broker, Agent or Aetna



Is applicant a current Aetna Member? Yes No If "Yes," provide Aetna Member ID #: _____

Check one election type below:

Requested Effective Date of Coverage: _____

ELECTION PERIOD CODES**			ELECTION PERIOD CODES**		
<input type="checkbox"/>	E	(IEP) – Initial Election Period when 1 st elig for Part D	<input type="checkbox"/>	S	(SEP) – Provide explanation:
<input type="checkbox"/>	I	(IEP) – Initial Election Period when 1 st elig not choosing Part D	<input type="checkbox"/>	W	(SEP) – U/EGHP (Union or Employer Group Health Plan) ____/____/____ (date)
<input type="checkbox"/>	U	(SEP) – Dual Eligible	<input type="checkbox"/>	A	(AEP) – Annual Election Period
<input type="checkbox"/>	V	(SEP) – Change of Residence ____/____/____ (date)	<input type="checkbox"/>	T	(OEPI) – Open Enroll for newly eligible institutionalized individuals

Name of Agency or organization receiving commissions * (if different than selling agent)

Date: ____/____/____ (must be submitted to Aetna within 48 hours of this date)

TIN # _____ Organization Name _____

Phone Number _____ Email _____

Selling Agent/Broker Use *

Date: ____/____/____ (Selling agent/broker who completed member application. Must be submitted to Aetna within 48 hours of this date.)

Selling Agent # (SSN/TIN #) _____ Name _____

Phone Number _____ Email _____

Aetna General Agent (GA) Use – (holds a current Aetna-approved General Agency contract)

Date: ____/____/____ (must be submitted to Aetna within 48 hours of this date)

Tax ID # _____ Organization Name _____

Phone Number _____ Email _____

Field Marketing Organization (FMO) or Affinity Partner Use – (holds a current Aetna-approved FMO/Affinity contract)

Date: ____/____/____ (must be submitted to Aetna within 48 hours of this date)

Tax ID # _____ Organization Name _____

Phone Number _____ Email _____

*** This information must match your approved Aetna Medicare licensing AND commission records**

Aetna Field Sales Representative Use

Date: ____/____/____ (must be submitted to Aetna within 48 hours of this date)

FSR Name _____ Agent ID: _____

Phone Number _____

** Attach required documentation to determine if eligible for an SEP (i.e., Proof of LIS, Loss of LIS, Change of Residence, etc.)

IF YOU WORK THROUGH A GA, FMO, OR AFFINITY PARTNER, SUBMIT THE COMPLETED ENROLLMENT FORM TO THEIR OFFICE TO AVOID DELAYS IN APPLICATION AND COMMISSION PROCESSING.

IF YOU DO NOT WORK THROUGH A GA, FMO OR AFFINITY PARTNER, send this completed enrollment form directly to:

Aetna Medicare

PO Box 14088, Lexington, KY 40512-4088 Call: 1-800-832-2640 or fax to: 1-866-441-2341

Failure to complete this form accurately may result in non-payment of commission.