Aetna Medicare

Aetna Medicare Advantage Plan
2012 Individual Enrollment Form
Health Maintenance Organization (HMO)
Preferred Provider Organization (PPO)

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:	Please select 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 and premium amounts). **Please be aware**: You can change plans only at certain times during the year*. The general timeframes are: – Annual Enrollment Period: The Annual Enrollment Period is from October 15 through December 7, 2011. During the Annual Enrollment Period anyone with Medicare can select a new Medicare health and/or Medicare prescription drug plan for the following year. **Optional Supplemental Benefits Plans –** Optional Supplemental Benefits Plans are offered with many of our Aetna Medicare HMO plans. **Please be aware**: These optional plans require payment of an additional monthly premium and may not be available with all HMO plan options (refer to the HMO Summary of Benefits for detailed benefit information). If you elect to enroll in an optional supplemental benefits plan, your monthly premium will be the combined total of the monthly health plan premium *and* the Optional Supplemental Benefits 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.). ***Print clearly.***
SECTION 3:	Using your red, white and blue *Medicare Card*, 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. For HMO plans, you must choose the name of a Primary Care Physician. If you have chosen to enroll in a Supplemental Benefits Plan, please select a Primary Care Dentist. For a list of Aetna Medicare physicians and dentists, go to **www.aetnamedicaredocfind.com** or call **1-800-832-2640 (TTY/TDD 1-888-760-4748 or 711)**, 8:00 am - 8:00 pm 7 days a week.
SECTION 6:	Complete this section if you are applying outside of the Annual Enrollment Period (October 15 through December 7). 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 at the end of Section 8.** If you are a legally authorized representative 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 must sign and date the application.

Be sure to complete the entire enrollment form. Missing or inaccurate data will delay enrollment processing.
After you have completed the form, tear out pages marked "Applicant Copy" and keep them for your records.
Mail your completed form (pages marked "Aetna Copy") 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 or 711**), 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 or call 1-800-Medicare 1-800-633-4227 (TTY/TDD 1-877-486-2048).
Plans are offered by Aetna Health Inc., Aetna Health of California Inc., and/or Aetna Life Insurance Company (Aetna).
A Medicare Advantage organization with a Medicare 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 Medicare℠ Plans (HMO)	**Aetna Medicare℠ Plans (PPO)**
☐ Basic℠ (HMO) $__________ per month	
☐ Value℠ (HMO) $__________ per month	☐ Value℠ (PPO) $__________ per month
☐ Standard℠ (HMO) $__________ per month	☐ Standard℠ (PPO) $__________ per month
☐ Select℠ (HMO) $__________ per month	☐ Select℠ (PPO) $__________ per month
☐ Premier℠ (HMO) $__________ per month	☐ Premier℠ (PPO) $__________ per month

Optional Supplemental Benefits Plans: *Available with many Aetna Medicare HMO plans in select areas for an additional monthly premium.*

- ☐ Aetna Preventive Dental Plan
- ☐ Aetna Advantage Dental Plan
- ☐ Aetna Advantage Dental+Eyewear+Hearing Aid Plan
- ☐ Aetna Preventive Dental+Eyewear+Hearing Aid Plan
- ☐ Aetna Advantage Dental+Eyewear Plan

Section 2 – Personal Information

LAST NAME	**FIRST NAME**	**MIDDLE INITIAL**	☐ Mr. ☐ Mrs. ☐ Ms.

Birth Date ___ ___ /___ ___ /___ ___ ___ ___ M M D D Y Y Y Y	**Sex** ☐ M ☐ F	**Home Phone Number** ( ) —

Permanent Residence Street Address (PO Box is not allowed)	**Apt./ Suite/Unit**

City	**County**	**State**	**Zip Code**

Mailing Address (only if different from your Permanent Residence Address)

Street Address	**City**	**State**	**Zip Code**

Emergency Contact (Optional)

Name	**Phone Number** ( )	**Relationship to You**

Email Address (Optional)

Section 3 – Please Provide Your Medicare Insurance Information

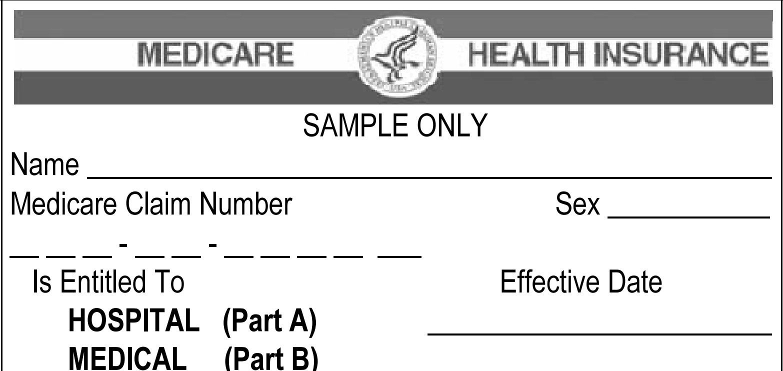
Please take out your Medicare card to complete this section.

- 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.



SAMPLE ONLY

Name ______________________________

Medicare Claim Number   Sex __________

___ ___ ___ - ___ ___ - ___ ___ ___ ___ ___

Is Entitled To   Effective Date

HOSPITAL (Part A) ____________________

MEDICAL (Part B) ____________________

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

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 or Railroad Retirement Board (RRB) benefit check each month.
If you are assessed a Part D-Income Related Monthly Adjustment Amount, 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 RRB. DO NOT pay the Aetna Medicare Advantage Plan the Part D-IRMAA.
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 your 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 or Railroad Retirement Board (RRB) benefit check. (The Social Security/RRB 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.)

Section 5 – Please Read and Answer These Important Questions:

☐ Yes ☐ No	1. Do you have End-Stage Renal Disease (ESRD)? If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.
☐ Yes ☐ 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 prescription drug coverage in addition to the Aetna Medicare Advantage plan? If "Yes," please 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: ____________
☐ Yes ☐ 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): ________________
☐ Yes ☐ No	4. Are you enrolled in your State Medicaid program? If "Yes," please provide your Medicaid number: ______________
☐ Yes ☐ No	5. Do you or your spouse work?

Please choose the name of a Primary Care Physician (PCP)	**Please choose the name of a Primary Care Dentist Name**

Please check the box if you would prefer us to send you information in a language other than English or in another format.
☐ 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 users should call **1-888-760-4748 or 711**.

Section 6 – Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through 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.

- ☐ I am new to Medicare.
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on __ __/__ __/__ __ (date)
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on __ __/__ __/__ __ (date)
- ☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- ☐ I get extra help paying for Medicare prescription drug coverage.
- ☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on __ __/__ __/__ __ (date)
- ☐ I am moving into, 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)
- ☐ I recently left a PACE program on __ __/__ __/__ __ (date)
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on __ __/__ __/__ __ (date)
- ☐ I am leaving employer or union coverage on __ __/__ __/__ __(date)
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on __ __/__ __/__ __ (date)

If none of these statements applies to you or you're not sure, please contact the Aetna Medicare Advantage plan at **1-800-832-2640** (TTY users should call **1-888-760-4748 or 711**) 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:

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 Medicare[SM] Plan (HMO) and the Aetna Medicare[SM] 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 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.

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.

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 beginning on the date the Aetna Medicare Advantage plan 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, 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 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 my 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 from Medicare.

Signature	**Today's Date**

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

Name	Address
Phone Number	Relationship to Enrollee

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****
☐	**E**	(IEP) – Initial Election Period when 1st elig for Part D	☐	**S**	(SEP) – Provide explanation:
☐	**F**	(IEP2) – Second Initial Election Period for Medicare members who are turning 65	☐	**W**	(SEP) – U/EGHP (Union or Employer Group Health Plan) __ __/__ __/__ __ (date, include termination date if applicable)
☐	**I**	(IEP) – Initial Election Period when 1st elig not choosing Part D	☐	**A**	(AEP) – Annual Election Period
☐	**U**	(SEP) – Dual Eligible	☐	**T**	(OEPI) – Open Enroll for newly eligible institutionalized individuals
☐	**V**	(SEP) – Change of Residence __ __/__ __/__ __ (date circumstance occurred, if applicable)			

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)
TIN # ____________________ Organization Name ____________________
Phone Number ____________________ Email ____________________

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)
TIN # ____________________ 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 documentation if available, (not required) 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.