Enrollment & Compensation for Aetna Medicare Advantage Products is as easy as 1-2-3

FOLLOW THE STEPS OUTLINED BELOW:
Incomplete, inaccurate, or illegible enrollment information will cause delays in enrollment and compensation.

Questions?
Please call our Broker Support team at
1-888-247-1050
or email brokerservice-medicareteam@aetna.com

STEP 1

The Enrollment Application

- Be sure all fields are complete, concise, and written legibly.
- The following fields are required for the document to be deemed complete. If these fields are not complete, the application will be considered "missing information" and will therefore delay enrollment processing. Missing information can also result in a denial if the information is not successfully collected.
  - — Plan Selection
  - — Beneficiary Date of Birth
  - — Permanent Residence Address
  - — Beneficiary signature or Authorized representative signature
  - — Heath Insurance Claim Number (HICN)
  - — Beneficiary Name
  - — Beneficiary Sex
  - — Response to the ESRD Question
  - — Special Election Period Effective date (when applicable)
- Use blue or black ink.
- Print versus using script

STEP 2

Timely and accurate submission

- Make sure every application has a valid requested effective date that corresponds with a permissible CMS election period.
- Be sure the application is received by Aetna within 48 hours of completing it with the beneficiary.
- **Submit the application only once – either by fax or mail.**
  - — By fax: 866-441-2341
  - — By mail: Aetna Medicare Broker Enrollment Team
    P.O. Box 14088
    Lexington, KY 40512-4088
- If you work with a FMO/GA or Affinity partner, please follow their instructions for submitting **completed applications to them** to ensure timely processing and accurate commission payments.

STEP 3

Broker / FMO / General Agent Information

- Complete section 9 entirely.
- Be sure to use your Broker SSN/TIN; please do not use your NPN — you will not be paid commission.
- If you work with a FMO/GA or Affinity partner, be sure to forward the completed application to them. FMO/GA/Affinity must complete their section as appropriate.

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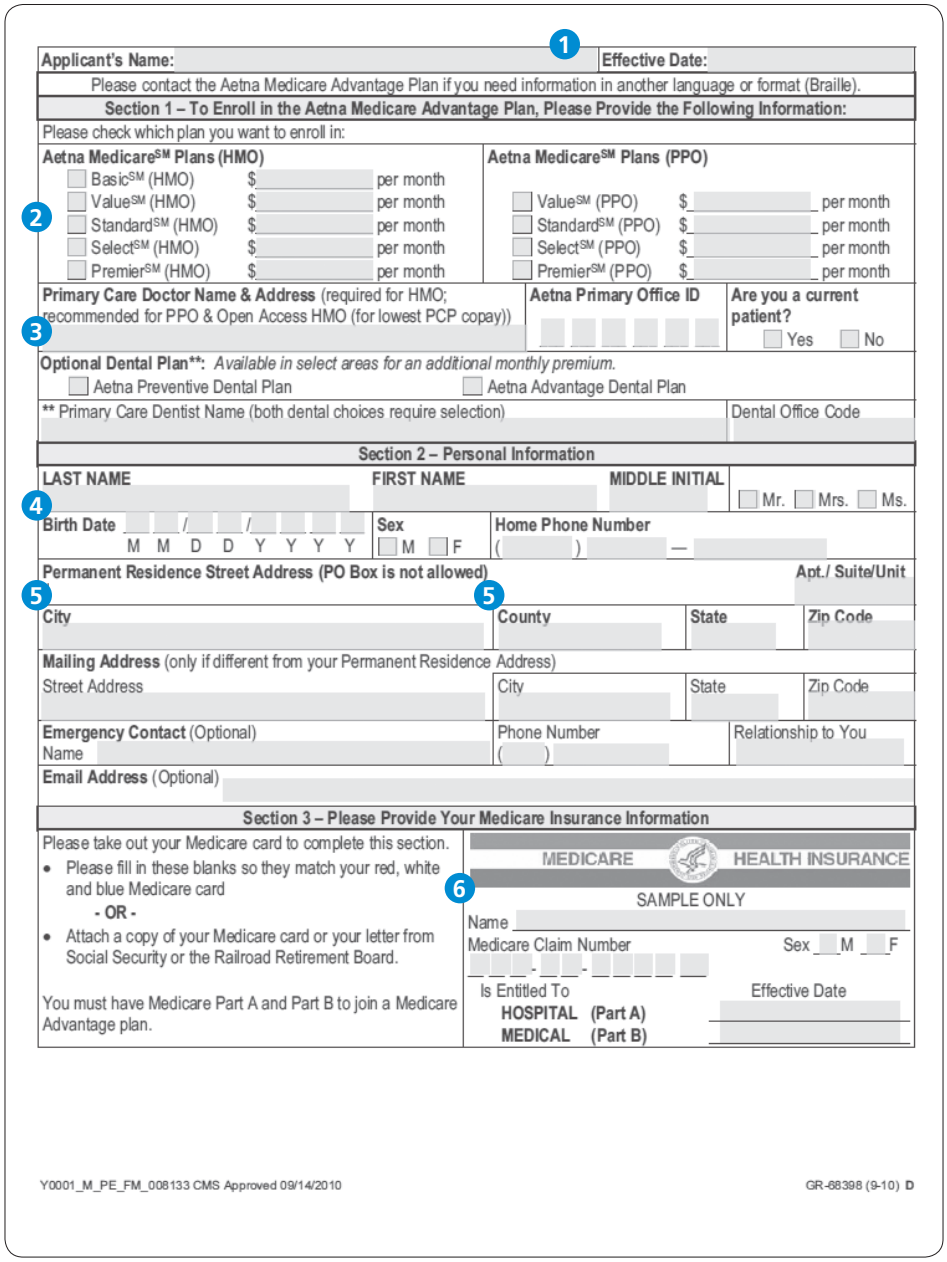
Enrollment & Compensation for Aetna Medicare Advantage Products

PAGE 1

1. Choose a valid effective date on every application.
2. Choose a plan (include the optional dental plan, if applicable).
3. Choose Primary Care Physician (and Primary Dentist if member requests a dental plan). *This information is required for HMO plans.*
4. Enter all applicant's personal data.
5. Don't forget to list complete address information. The county is used to assign the member's monthly premium payment.
6. Include the Medicare Claim number (also called HICN number), exactly as it appears on the red, white, and blue Medicare Card. Include **all** letters and numbers as they appear.

Double check each page – make sure all fields are legible and complete. Incomplete, inaccurate, or illegible enrollment information will cause delays in enrollment and compensation.



Applicant's Name: (1) **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: (2)

Aetna Medicare℠ Plans (HMO)

- ☐ Basic℠ (HMO) $ _____ per month
- ☐ Value℠ (HMO) $ _____ per month
- ☐ Standard℠ (HMO) $ _____ per month
- ☐ Select℠ (HMO) $ _____ per month
- ☐ Premier℠ (HMO) $ _____ per month

Aetna Medicare℠ Plans (PPO)

- ☐ Value℠ (PPO) $ _____ per month
- ☐ Standard℠ (PPO) $ _____ per month
- ☐ Select℠ (PPO) $ _____ per month
- ☐ Premier℠ (PPO) $ _____ per month

(3) **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?** ☐ Yes ☐ No

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

Section 2 – Personal Information

(4) **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** ( ) —

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

(5) **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.

(6) MEDICARE HEALTH INSURANCE
SAMPLE ONLY
Name
Medicare Claim Number | Sex ☐ M ☐ F
Is Entitled To | Effective Date
HOSPITAL (Part A)
MEDICAL (Part B)

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Questions?

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PAGE 2

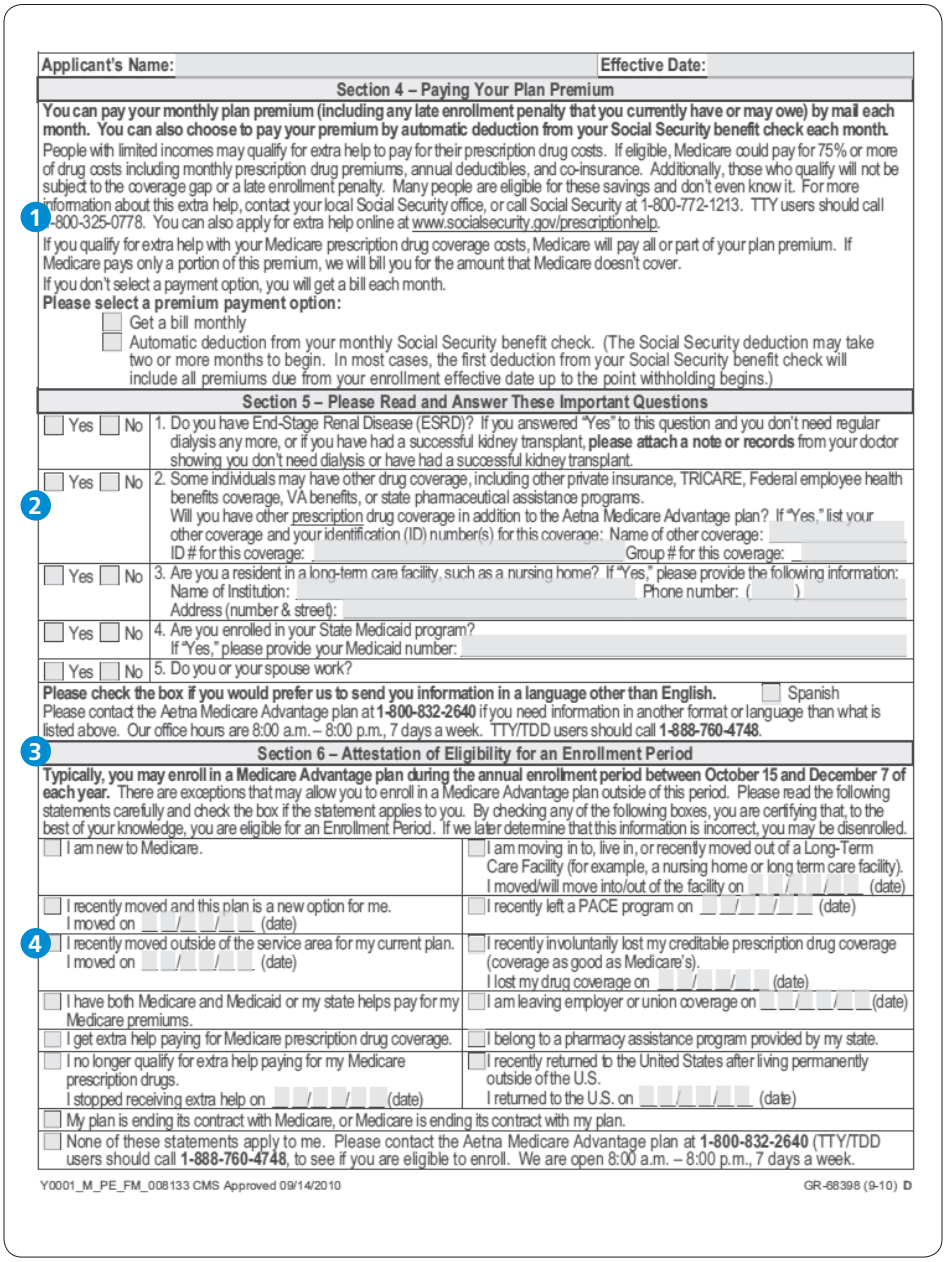
1. Select a Premium Payment Option. Leaving this field blank results in monthly premium statements.

2. Be sure to completely fill out Section 5 (either Yes or No). Do not leave blank, otherwise processing delays will occur.

3. Determine and select the correct enrollment period. Attach supporting documentation, used to determine members eligibility for special enrollment periods or exceptions.

4. Provide the effective date for a specific special enrollment period, if applicable.

Double check each page – make sure all fields are legible and complete. Incomplete, inaccurate, or illegible enrollment information will cause delays in enrollment and compensation.



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 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

☐ Yes ☐ 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.
☐ 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," 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 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.

☐ I am new to Medicare.	☐ 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)
☐ I recently moved and this plan is a new option for me. I moved on __/__/____ (date)	☐ I recently left a PACE program on __/__/____ (date)
☐ I recently moved outside of the service area for my current plan. I moved 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 have both Medicare and Medicaid or my state helps pay for my Medicare premiums.	☐ I am leaving employer or union coverage on __/__/____(date)
☐ I get extra help paying for Medicare prescription drug coverage.	☐ I belong to a pharmacy assistance program provided by my state.
☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help 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)
☐ 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.	

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Questions?

Please call our Broker Support team at **1-888-247-1050**
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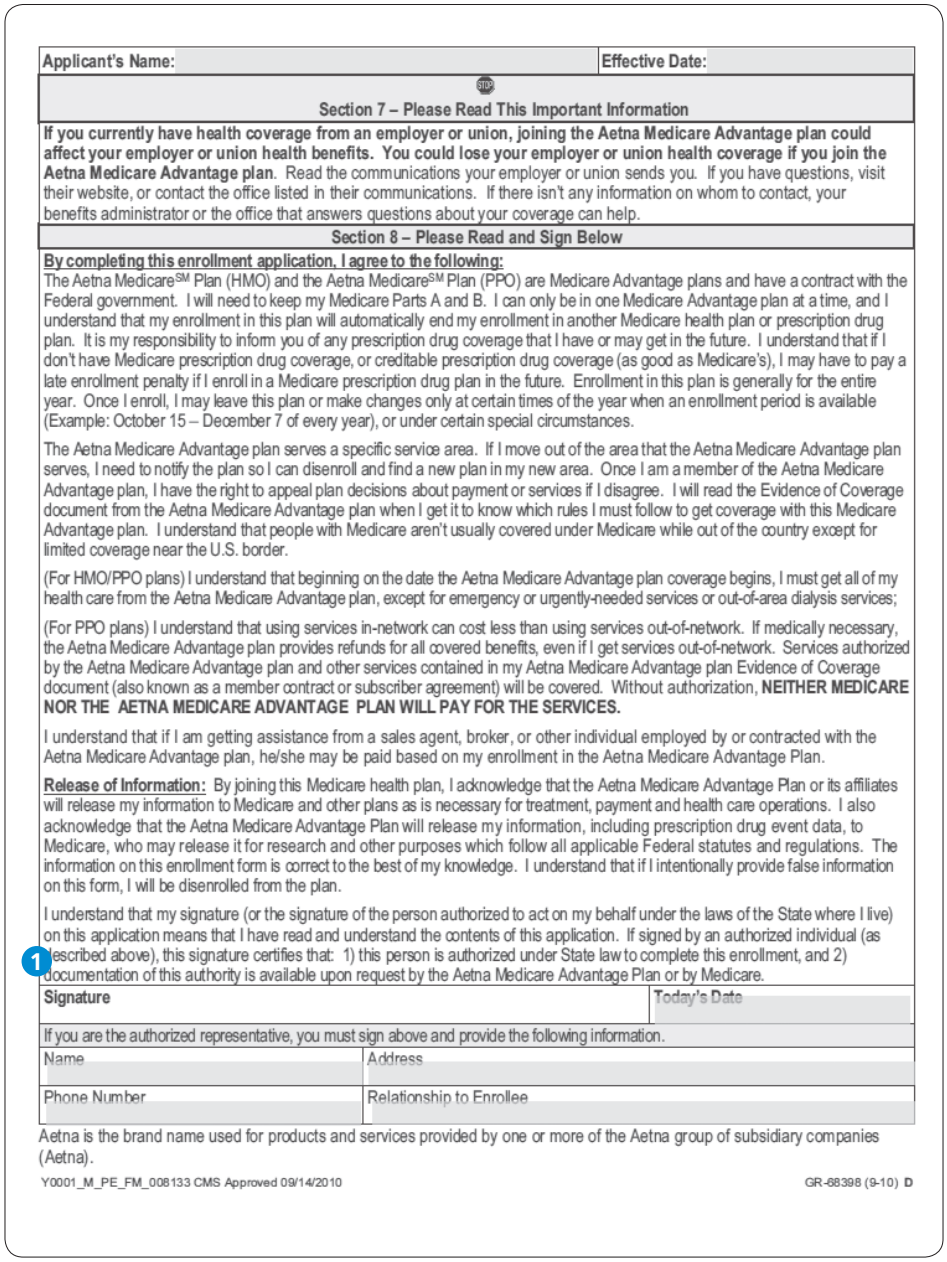
PAGE 3

1. Make sure the form is signed and dated by the applicant or by any person acting as a Power of Attorney or Legal Representative. *Be sure the application is received by Aetna within 48 hours of completing it with the beneficiary.*

Double check each page – make sure all fields are legible and complete. Incomplete, inaccurate, or illegible enrollment information will cause delays in enrollment and compensation.



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℠ Plan (HMO) and the Aetna Medicare℠ 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.

1

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

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

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Questions?

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PAGE 4

1. Complete with full agency or firm name.

2. **These are mandatory fields on all applications submitted.** Must be completed with individual writing agent name and social security number.

   Incomplete or inaccurate information may result in non-payment of commissions.

   Information not reflecting the actual writing agent may result in disciplinary action.

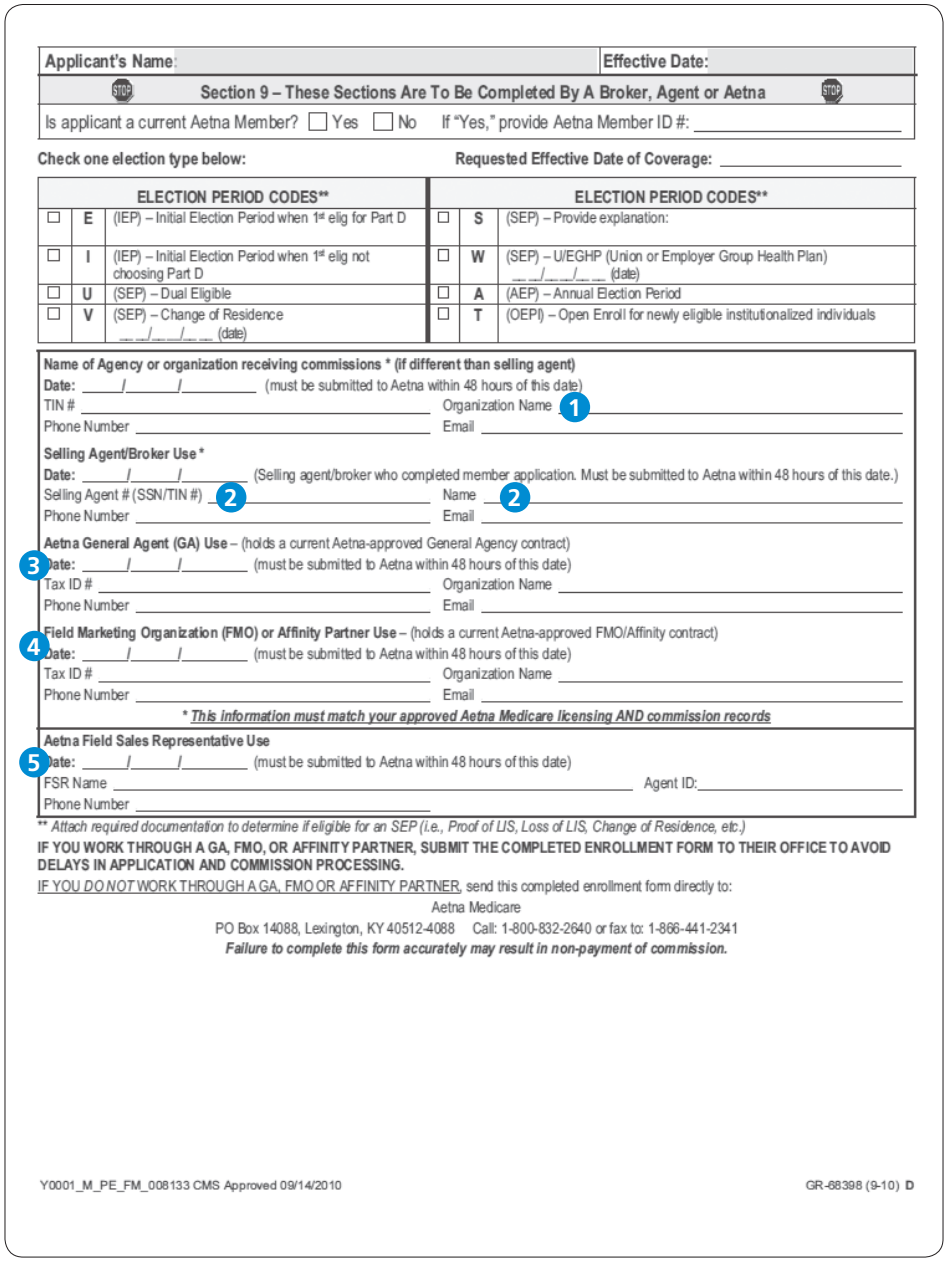
   This information must match the approved broker information on our files. Remember: the producer must be licensed and registered with Aetna to sell in the state where the beneficiary resides.

   Provide broker SSN/TIN, not the NPN.

3. Complete when there is a general agency (GA) with an active executed Medicare GA contract only (this is not the same as the producer agreement found on Producer World).

4. Complete when there is a Field Marketing Organization (FMO) with an active executed Medicare FMO contract only (this is not the same as the producer agreement found on Producer World).

5. Complete if you are an AETNA EMPLOYEE ONLY.



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:
☐	I	(IEP) – Initial Election Period when 1st elig not choosing Part D	☐	W	(SEP) – U/EGHP (Union or Employer Group Health Plan) __/__/__/__ (date)
☐	U	(SEP) – Dual Eligible	☐	A	(AEP) – Annual Election Period
☐	V	(SEP) – Change of Residence __/__/__/__ (date)	☐	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 1 _____
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 #) 2 _____ Name 2 _____
Phone Number _____ Email _____

Aetna General Agent (GA) Use – (holds a current Aetna-approved General Agency contract)
3 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)
4 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
5 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.

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Frequently Asked Questions and Useful Information:

Who can I contact if I need assistance?

Contact our Broker Support team!
By phone: 888-247-1050
By email:
brokerservice-medicareteam@aetna.com
Hours of operation:
Monday-Friday 8:30am-5pm local time

How can I order enrollment kits?

Complete the online order form.
Visit the Medicare Sales Support page on Producer World.

Where do I submit completed applications?

Send to our Medicare Broker Enrollment Team!
By fax: 866-441-2341
By mail:
Aetna Medicare Broker Enrollment Team
P.O. Box 14088
Lexington, KY 40512-4088

Who can I contact if I need assistance with commissions?

By phone: 888-622-3435
Monday-Friday 8:00am-4:30pm EST
By email: BrokerComm@aetna.com

When can I expect to see my commission from this application?

Once the application is completed by Aetna and approved by CMS, the client's information will be included in our compensation file.

The member application will then be reviewed for commission eligibility in the next scheduled Commission processing run. Upon validation of all licensing, appointment, registration and training requirements related to the parties involved in the sales process, the member enrollment will be eligible for commission payment.

Commission checks are printed/issued **bi-weekly** with an approximate 10-day lag from when the enrollment was submitted (ie: enrollments in active membership and approved by CMS by 1/2/11 will be paid on 1/12/11).

Are there web pages where I can find information about Aetna's plans or Medicare Advantage plans in general?

Producer World
AetnaMedicare.com
Centers for Medicare and Medicaid Services (CMS) cms.gov

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This information is intended for brokers only. Aetna Medicare Advantage Plans: Offered by Aetna Health Inc., Aetna Health of California Inc., and/or Aetna Life Insurance (Aetna). Coverage is provided through a Medicare Advantage organization or a Medicare prescription drug plan sponsor with a Medicare contract. Benefits, limitations, service areas, and premiums are subject to change on January 1 of each year. Plans contain exclusions and limitation Plans availability varies by county and state. Producers must be licensed in the applicable state and registered and/or appointed by Aetna prior to engaging in the sale of Aetna products.

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