

**Applicant Enrollment Instructions**

**Fill out this form completely by answering all the questions. Incomplete or inaccurate information may delay the start date of your coverage.** Below are the instructions for each section of the enrollment form.

<b>Effective Date:</b>	Generally, the effective date will be on the first day of the month following the date you sign this enrollment form or on the effective date of your group health plan. The effective date cannot be earlier than the signature date.
<b>Former Employer Information:</b>	Provide the name of your former employer that is offering this health plan (the company from which you are a retiree). Also list the Group number if you know what it is. Group number is not a required field. (This information may be pre-filled.)
<b>Personal Information:</b>	Complete the personal information section (Name, Address, Phone number, etc.). <b><u>Print clearly.</u></b>
<b>Medicare Information:</b>	Using your red, white and blue <i>Medicare Card</i> , provide us with your Medicare Insurance information. Failure to provide this information accurately may delay your enrollment.
<b>Health Plan Selection:</b>	Check the Aetna Medicare Advantage plan box [and provide the plan name] in which you wish to enroll. Refer to the Benefit Summary for detailed plan information.
<b>Selected Providers:</b>	Provide your Primary Care Physician (PCP) name and Office ID number (if applicable; required for HMO; recommended for PPO in some plans, your cost share will be the lower PCP cost share amount if you select a PCP). When applicable, list your Dentist name and Office ID number.
<b>Medicare-related Questions:</b>	Please read and answer the questions in this section to help Aetna coordinate your benefits.
<b>Read the following important information carefully:</b>	DISCLOSURES ACKNOWLEDGMENTS CREDITABLE COVERAGE
<b>Signature Required:</b>	Sign and date the application <b>in the space provided</b> on this form. <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.
<b>Make a copy for your records and mail original:</b>	Make a copy of the entire application for your records. Then mail the ORIGINAL form (completed and signed) to the address listed below ("Mail to"). A separate enrollment form must be completed for Medicare eligible dependents. Two forms may have been included for your convenience.

If you have any questions about this application, contact your former employer or call Aetna Medicare at:

Customer Service Phone Number:	<b>1-800-307-4830 (TTY/TDD: 1-888-760-4748)</b>
Hours of Service:	Monday through Friday – 8:00 a.m. to 6:00 p.m.
Mail To:	Aetna, PO Box 14088, Lexington, KY 40512-4088
Visit Website:	<a href="http://www.aetnamedicare.com">www.aetnamedicare.com</a>

Effective Date: / 01 /

**Former Employer Information** – Provide the company name of your former employer who is offering your retiree health plan options (unless this information is pre-filled).

**Former Employer Company Name** \_\_\_\_\_ **Group Number** \_\_\_\_\_

**PERSONAL INFORMATION**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
 Mr.  Mrs.  Ms.

Birth Date (    /    /    ) Sex  M  F Home Phone Number (    )

Permanent Residence Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_ County \_\_\_\_\_

P.O. Box (Mailing Address) \_\_\_\_\_ Email Address \_\_\_\_\_

**Medicare Information**

Use your Medicare card to complete this section.  
• 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 \_\_\_\_\_ Sex \_\_\_\_\_  
Medicare Claim Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Is Entitled To \_\_\_\_\_ Effective Date \_\_\_\_\_  
**HOSPITAL (Part A)** \_\_\_\_\_  
**MEDICAL (Part B)** \_\_\_\_\_

**Health Plan Selection** – Select one health plan. Read important health plan DISCLOSURES and ACKNOWLEDGMENTS.

**Aetna Medicare HMO** (write plan name below) \_\_\_\_\_  
 **Aetna Medicare PPO** (write plan name below) \_\_\_\_\_  
 **Aetna Medicare HMO with Rx** (write plan name below) \_\_\_\_\_  
 **Aetna Medicare PPO with Rx** (write plan name below) \_\_\_\_\_

**Selected Providers:** Required for HMO; recommended for PPO (may provide a lower PCP copay). (Refer to the Aetna Medicare Provider Directory or call the number listed on the Instruction page to select a Primary Care Physician/Dentist and their office ID numbers.)

PCP Office ID: \_\_\_\_\_ PCP Name: \_\_\_\_\_

Dentist Name (if applicable): \_\_\_\_\_ Dentist Office ID: \_\_\_\_\_

**Answer the Following Questions to Help Coordinate Your Benefits**

Yes  No **Are you the retiree?** If Yes, retirement date (mm/dd/yyyy): \_\_\_ / \_\_\_ / \_\_\_\_  
If No, name of retiree: \_\_\_\_\_

Yes  No **Are you covering a spouse or dependents under this employer or union plan?**  
If Yes, name of spouse: \_\_\_\_\_ Name of dependents: \_\_\_\_\_

Yes  No **Do you or your spouse work?**

Yes  No **Do you have End-Stage Renal Disease (ESRD)?** If you answered Yes to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, **attach a note or records from your doctor** showing you do not need dialysis or have had a successful kidney transplant.

Yes  No **Are you a resident in a long-term care facility, such as a nursing home?** If Yes, provide the following information:  
Name of Institution: \_\_\_\_\_ Phone number: (    ) \_\_\_\_\_  
Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Yes  No **Are you an Aetna member?** If Yes, provide your member ID number \_\_\_\_\_

Yes  No **Are you enrolled in your state Medicaid program?** If Yes, provide your Medicaid number \_\_\_\_\_

Check the box if you would prefer us to send you information in a language other than English or other format.  Spanish

**Other Rx Coverage** – Complete only if you have other prescription drug coverage.

Yes  No Some individuals may have other drug coverage, including other private insurance, Workers' Compensation, VA benefits, or state pharmaceutical assistance programs.

**Will you have other prescription drug coverage in addition to the Aetna Medicare Advantage drug plan?** If Yes, list your other coverage and identification (ID) number(s) for this coverage:  
Name of other coverage: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Yes  No **Have you had creditable coverage since you became eligible for Medicare prescription drug coverage?** (For a description and details, refer to the **CREDITABLE COVERAGE** section.)

Applicant Name:	Effective Date: / 01 /
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**DISCLOSURES – Read this section and the ACKNOWLEDGMENTS section carefully.**

**By completing this enrollment application, I agree to the following:** The Aetna Medicare<sup>SM</sup> Plan (HMO) and the Aetna Medicare<sup>SM</sup> 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 might have or may get in the future. If I am enrolling in a Medicare Advantage plan without drug coverage (medical benefits only), 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 if an enrollment period is available or under certain special circumstances.

The Aetna Medicare Advantage plan serves a specific service area. If I move out of the Aetna Medicare Advantage plan service area, I need to notify the plan and my former employer 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 Aetna when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Original Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

HMO Plans - I understand that on the date 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. If medically necessary, 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 plan Evidence of Coverage document (also known as the subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR THE AETNA MEDICARE ADVANTAGE PLAN WILL PAY FOR THE SERVICES.**

PPO Plans - I understand that beginning on the date 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. Services authorized by the Aetna Medicare Advantage plan and other services contained in my Aetna Medicare plan Evidence of Coverage document (also known as the subscriber agreement) will be covered. Without authorization, where required, **NEITHER MEDICARE NOR THE AETNA MEDICARE ADVANTAGE PLAN WILL PAY FOR THE SERVICES.**

**Release of Information:** By joining this Medicare health plan, I acknowledge that Aetna or its affiliates will release my information to Medicare and other plans as is necessary for treatment, payment of claims and health care operations. I also acknowledge that Aetna Medicare 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 behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application, including the ACKNOWLEDGMENT SECTION on this form. If signed by an authorized individual, this 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 Aetna or by Medicare.

<b>Beneficiary Signature</b>	<b>Today's Date</b>
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If you are the authorized representative, you must sign above and provide the following information:

Representative's Name	Address
Phone Number	Relationship to Enrollee

**ACKNOWLEDGMENTS**

1. I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Aetna's Medicare Advantage plans, he/she may be paid based on my enrollment in the Medicare Advantage plan.
2. Counseling services may be available in my state to provide advice concerning Medicare Supplement insurance or other Medicare Advantage or Prescription Drug plan options as well as medical assistance through the state Medicaid program and the Medicare Savings Program.
3. Depending on the Aetna Medicare Advantage plan that I have selected, I understand that I must follow applicable plan guidelines as referenced below:
  - Aetna Medicare<sup>SM</sup> Plan (HMO):** I understand that I must use network providers for all covered services. For the HMO plan, covered services must be authorized or referred by my primary care doctor (except for direct-access benefits, emergency or urgently-needed care and out-of-area dialysis services). I also understand that without proper authorization, neither Aetna nor Medicare will pay for services.
  - Aetna Medicare<sup>SM</sup> Plan (PPO):** I understand that I can go to doctors, specialists, or hospitals in or out of network. I understand that providers must be licensed and eligible to receive payment under the Federal Medicare program and agree to accept the plan. I also understand that I may have to pay more for services that I receive out of network.
4. I have been advised not to cancel or drop any supplemental insurance I currently have until I receive written notification of my confirmed effective date from Aetna.
5. If I permanently move or leave my service area for more than six (6) consecutive months, I may be disenrolled from this plan and returned to Original Medicare coverage. I may also be disenrolled if I do not pay any applicable plan premiums within the grace period. The effective date of disenrollment is in accordance with Federal requirements.
6. I understand that I will receive the plan's Evidence of Coverage, which contains a full description of the governing plan provisions, exclusions, and limitations of coverage.
7. I understand that the providers in the Aetna network are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates.
8. I acknowledge that Aetna will release my information, including prescription drug event dates, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.
9. I authorize the release of medical, dental and hospital records (including psychiatric, alcohol and drug abuse information) as is necessary to Aetna or its affiliates for coverage of treatment or services, payment of claims and health care operations, including validation of risk adjustment and other claims data.

**CREDITABLE COVERAGE**

**Creditable coverage is prescription drug coverage that is at least as good as Medicare prescription drug coverage.**  
**NOTE:** If you have not had creditable coverage, you may have to pay a penalty. Aetna may ask you to provide evidence of creditable coverage. If you have questions about the late enrollment penalty, call Aetna at the number provided on this form.

Benefits coverage is provided by Aetna Health Inc., Aetna Health of California Inc., and/or Aetna Life Insurance Company (Aetna), which are Medicare Advantage organizations with a Medicare contract.