

**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.

**Effective Date:** Generally, the effective date will be on the first day of the month following the date you sign this enrollment form. The effective date cannot be earlier than the signature date.

**Former Employer Information:** 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.)

**Personal Information:** Complete the personal information section (Name, Address, Phone number, etc.). **Print clearly.**

**Medicare Information:** Using your red, white and blue *Medicare Card*, provide us with your Medicare Insurance information. Failure to provide this information accurately may delay your enrollment.

**Health Plan Selection:** Check the Aetna Medicare Open<sup>SM</sup> Plan (PFFS) box [and provide the plan name] in which you wish to enroll. Refer to the Benefit Summary for detailed plan information.

**Medicare-related Questions:** Please read and answer the questions in this section to help Aetna coordinate your benefits.

**Read the following important information carefully:**

DISCLOSURES  
ACKNOWLEDGMENTS  
CREDITABLE COVERAGE

**Signature Required:** Sign and date the application **in the space provided** on this form.

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.

**Make a copy for your records and mail original:** 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").

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>

**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 ( / / ) (M M/D D/Y Y Y Y) Sex  M  F Home Phone Number ( )

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

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_ County \_\_\_\_\_ P.O. Box (Mailing 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.

**MEDICARE HEALTH INSURANCE**  
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.

I wish to enroll in:  
 **Aetna Medicare PFFS** Plan Name \_\_\_\_\_  
 **Aetna Medicare PFFS with Rx** Plan Name \_\_\_\_\_

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

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 \_\_\_\_\_

Yes  No **Are you a resident of an Institution (e.g., skilled nursing facility, rehabilitation hospital)?**  
If Yes, Date Admitted \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Institution Phone Number ( ) \_\_\_\_\_  
Institution Name & Address \_\_\_\_\_

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 **Do you, on your own or through your spouse, have any health insurance other than Medicare, such as private insurance, Workers' Compensation or VA benefits?** If Yes, complete  
Type \_\_\_\_\_ Insurance Name \_\_\_\_\_ ID# \_\_\_\_\_

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

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

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

Yes  No **Will you be covered by another prescription drug plan in addition to your Aetna coverage?** If Yes, complete  
Rx ID \_\_\_\_\_ Group ID \_\_\_\_\_

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:** Aetna Medicare Open<sup>SM</sup> Plan (PFFS) is a Medicare Advantage plan that has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I understand that this plan is a Medicare Advantage Private Fee-for-Service (PFFS) plan and I can be in only one Medicare health plan at a time. I understand that my enrollment in a plan with Medicare prescription drug coverage will automatically end my enrollment in another Medicare health plan or another Medicare 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 my enrollment in a plan that does not offer Medicare prescription drug coverage means that I may get coverage from another Medicare prescription drug plan. If I do not 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 coverage in the future. As a Medicare PFFS plan, Aetna's Medicare Open<sup>SM</sup> Plan (PFFS) works differently than a Medicare Supplement plan. Aetna's Medicare Open<sup>SM</sup> Plan (PFFS) pays instead of Medicare, and I will be responsible for the amounts that Aetna's Medicare Open<sup>SM</sup> Plan (PFFS) does not cover, such as copayments and coinsurances. Original Medicare will not pay for my health care while I am enrolled in this PFFS plan. Before seeking a provider, I should verify that the provider will accept this PFFS plan. I understand that my health care providers have the right to choose whether to accept a PFFS plan's payment terms and conditions every time I see them. I understand that if my provider decides not to accept this PFFS plan, I will need to find another provider that will.

Aetna's Medicare Open<sup>SM</sup> Plan (PFFS) serves a specific service area. If I move out of the area that this plan serves, 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 this 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's Medicare Open<sup>SM</sup> Plan (PFFS) when I get it to know which rules I must follow in order to get coverage with this PFFS 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 if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Aetna, he/she may be paid based on my enrollment in this PFFS plan. 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. **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 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. **If I have any questions about the benefits and services that are provided or excluded from this agreement, I should contact a sales representative before signing this enrollment form.** I understand that my signature (or the signature of the person authorized to act on my behalf under the state laws where I live) 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 (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 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 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.
2. 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.
3. 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. I will read this document when I receive it to know which rules I must follow to receive coverage under this plan.
4. I understand that the providers are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates.
5. 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.
6. 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.
7. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to Aetna Medicare or by calling 1-800-MEDICARE (1-800-633-4227) (TTY/TDD users should call 1-877-486-2048), 24 hours per day, 7 days per week.

Applicant Name:	Effective Date: / 01 /
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**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 Life Insurance Company (Aetna), a Medicare Advantage organization with a Medicare contract.