



Aetna Medicare Advantage Plan Group Enrollment Form

Please fill out this form completely by answering all questions. Incomplete or inaccurate information may delay the start date of your coverage. If you have any questions about this application, please contact your former employer or Aetna Medicare at 1-800-307-4830 (TTY/TDD: 1-800-628-3323).

Former Employer Information: *Please tell us about the employer who is providing your retiree health benefits.*

Former Employer Name	Group Number
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Personal Information - Please provide us with some information about you. Please print clearly.

Last Name	First Name	Middle Initial	<input type="checkbox"/> Mr.	<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.
Birth Date (/ /) (M M / D D / Y Y Y Y)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number (Optional)	Home Phone Number ()		
Permanent Residence Street Address					
City	State	ZIP Code	County	P.O. Box (Mailing Address)	

Race/Ethnicity* Asian Black Hispanic or Latino White Other


* Optional – This information cannot be used to deny your application for membership.

Medicare Information – Complete this section.

Use your Medicare card to complete this section. You can also attach a copy of your Medicare card.

OR

Attach a letter from the Social Security Administration or Railroad Retiree Board.

	Name _____ Medicare Claim Number _____ Is Entitled to _____ Effective Date _____ Hospital (Part A) _____ Medical (Part B) _____
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Health Plan Selection – Please select one health plan. Read important health plan disclosures on back.

<input type="checkbox"/> MA-PD HMO with Rx (please write plan name below)	<input type="checkbox"/> MA-PD PPO with Rx (please write plan name below)
<input type="checkbox"/> MA HMO without Rx (please write plan name below)	<input type="checkbox"/> MA PPO without Rx (please write plan name below)

Selected Primary Care Doctor: Required for the HMO Plan. (Refer to the Aetna Medicare Provider Directory or call 1-800-307-4830 (TTY/TDD: 1-800-628-3323) to select a Primary Care Physician and the office ID number.)

Name	Doctor Office ID
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Other Information – This information will not be used to deny your application for membership.

Yes No **Are you an Aetna member?** If Yes, provide your member ID 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 _____
 Institution Address _____

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?**

Other Rx Coverage – Please 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?**
 (Creditable coverage is prescription drug coverage that is at least as good as Medicare prescription drug coverage.) If No, refer to #7 of the Acknowledgment section for details.

Release of Information – Please read this section and the Disclosures and Acknowledgment on the back. Then sign and date below.

By completing this enrollment application, I agree to the following:
 The Aetna Golden Medicare Plan and the Aetna Golden Choice Plan are Medicare Advantage plans and I will need to keep my Part A and B coverage. I understand I must continue to pay my Part B premium and Part A coverage, if applicable. I can only be in one Medicare Advantage plan at a time. It is my responsibility to inform you of any prescription drug coverage that I might have or may get in the future. 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. 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.**

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 or services, payment of claims and health care operations. 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 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 ACKNOWLEDGEMENT 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.

SIGNATURE _____ **TODAY'S DATE** _____

ACKNOWLEDGMENT

1. If a sales representative discussed plan options with me, I understand that this person is acting on behalf of Aetna's Medicare Advantage plans and may be compensated based upon my enrollment in this plan.
2. Depending on the Aetna Medicare Advantage plan that I have selected, I understand that I must follow applicable plan guidelines as referenced below:
Aetna Golden Medicare Plan® (HMO): I understand that I must use network providers for all covered services and must authorize 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 Golden Choice™ 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. I also understand that I may have to pay more for services that I receive out of network.
3. I have been advised not to cancel or drop any supplemental insurance I currently have until I receive written notification or my confirmed effective date from Aetna.
4. 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 Medical 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.
5. 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.
6. 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.
7. 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.
8. 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. TTY/TDD users should call 1-877-486-2048, 24 hours per day, 7 days per week.
9. I will read the Evidence of Coverage document from the Aetna Medicare Advantage Plan when I receive it to know which rules must follow in order to receive coverage with this Medicare Advantage Plan.
10. I understand that beginning on the date Aetna Medicare Plan coverage begins, I must get all of my health care from Aetna Medicare Advantage Plan, with the exception of emergency or urgently needed out-of-area dialysis services.

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

Customer Service **1-800-307-4830 (TTY/TDD: 1-800-628-3323)**
 Monday through Friday – 8:00 a.m. to 6:00 p.m.
 PO BOX 963, Blue Bell, PA 19422-9921
www.aetnamedicare.com

For Aetna Internal Use Only**Aetna Medicare Rx Plan**

Group # _____ Name of Staff Member (if assisted in enrollment) _____
 Effective Date of Coverage _____ ICEP/IEP _____ OEP _____ AEP _____ SEP _____
 Rep Code _____ Rep Name _____ Member # _____

Broker/Agent Use Only

Tax ID # _____ Name _____
 Phone Number _____ Email _____
 By checking this box, I am attesting to the fact that I am part of a larger organization (i.e., General Agency, Field Marketing Organization, Affinity Partner).
 Name of Organization _____ Tax ID # _____

AGENT/BROKER ONLY - Must submit the completed enrollment form to:
 Aetna Medicare Prescription Drug Plans, P.O. Box 935, Blue Bell, PA 19422

Employer Use Only

Employer Name _____ Group # _____
 Contact Name _____ Authorized Signature _____
 Phone Number _____ Coverage Effective Date _____