aetna Medicare Solutions

Confirm your enrollment period

Typically, you may enroll in a Medicare Advantage Plan during the Annual Enrollment Period (AEP) 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.

If you enroll in a Medicare plan outside AEP, check the statement that applies to you. By checking a box you certify 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.

Prospective member name	Medicare number

- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP)
- ☐ 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 was released from incarceration. I was released 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 recently obtained lawful presence status in the United States. I got this status on ____/____/____ (date).
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on ____/____/____ (date).
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on ____/____/____ (date).
- ☐ I have both Medicare and Medicaid, (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I am moving into, live in, or recently moved out of, a long-term care facility (for example, a nursing home). 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 will leave or left my 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 plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on ____/____/____ (date).
- ☐ 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).
- ☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.
- ☐ I am new to Medicare (not applicable if you already have Medicare Part A).

If none of these statements apply to you or you're not sure, call us at **1-833-859-6031 (TTY: 711)** to see if you can enroll. We're here 8 a.m. to 8 p.m., seven days a week, from October 1 – March 31 and 8 a.m. to 8 p.m., Monday – Friday, from April 1 – September 30.

MA19 0030006

EA-CA03-19-LOS ANGELES

018320860LFM/EA-CA03-19LFM

Enrollment Request Form

Agent/Producer/Broker Use Only:
Agent/producer/broker name: _____
NPN #: _____

To Enroll in an Aetna Medicare Plan, Please Provide the Following Information:

Section 1: Choose your plan

Check the plan you want to enroll in.

☐ Aetna Medicare Prime Plan (HMO) (H0523-061)	**$0.00** per month
☐ Aetna Medicare Select Plan (HMO) (H0523-002)	**$0.00** per month
☐ Aetna Medicare Choice Plan (PPO) (H5521-125)	**$73.00** per month
☐ Aetna Medicare Choice Plan (PPO) (H5521-125) with Aetna Medicare Advantage PPO Dental Plan	**$96.00** per month
☐ Aetna Medicare Choice Plan (PPO) (H5521-125) with Aetna Medicare Advantage PPO Dental/Hearing Plan	**$99.00** per month

Section 2: Your 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** ( )

Second phone number ( ) | **Email address**

Permanent residence street address (a PO Box is not allowed) | **Apt./Suite/Unit**

City | **County** | **State** | **ZIP Code**

Mailing address (only if different from your permanent residence street address)

City | **State** | **ZIP Code**

Section 3: Tell us your provider

For **HMO plans**: Sometimes we don't pay for your care if we don't have the name of your primary care physician (PCP) on file. Tell us the name of your primary care physician (PCP). We may choose one for you if you don't tell us who your PCP is. Write in the **name** and **Primary Care ID** of your PCP below. For **PPO plans**: You have the option to choose a primary care physician (PCP). When we know who your doctor is, we can better support your care. Write in the **name** and **Primary Care ID** of your PCP below. Visit our online provider directory at **www.aetnamedicare.com/findprovider** or call **1-833-859-6031 (TTY: 711)** to find provider information or a network PCP.

Write the full name of your PCP

Primary Care ID (located in the provider directory) ☐☐☐☐☐☐ | **Are you a current patient?** ☐ Yes ☐ No

MA19 0030006

EA-CA03-19-LOS ANGELES

018320860LFM/EA-CA03-19LFM

Section 4: Provide your Medicare insurance information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

– OR –

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card): _____

Medicare Number: _____

Is Entitled To: Effective Date:

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Section 5: Answer these important questions

☐ Yes ☐ No 1. **Do you have end-stage renal disease (ESRD)?** If you've had a successful kidney transplant or you don't need regular dialysis, **attach a note or records** from your doctor showing you've had a successful kidney transplant or you don't need dialysis. Otherwise, we may need to contact you for more information.

☐ Yes ☐ No 2. **Will you have other prescription drug coverage in addition to Aetna Medicare?** Examples of other drug coverage include other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or state pharmaceutical assistance programs.

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," fill in the information below:

Name of facility: _____ Phone number: (___) _____

Street address: _____

☐ Yes ☐ No 4. **Are you enrolled in your state's Medicaid program?** If "Yes," write in your Medicaid number: _____

☐ Yes ☐ No 5. **Do you or your spouse work?**

Indicate your preferred language (if not English): ☐ Spanish Other _____

Contact us at **1-833-859-6031 (TTY:711)**, 8 a.m. to 8 p.m., seven days a week, from October 1 – March 31 and 8 a.m. to 8 p.m., Monday – Friday, from April 1 – September 30 if you need information in another language or accessible format (e.g., large print or braille).

ATTENTION: If you speak another language, assistance services, free of charge, are available to you. Call **1-833-859-6031 (TTY:711)**

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-833-810-6150 (TTY: 711)**.

注意：如果您使用中文，您可以免費獲得語言援助服務。請致電 **1-833-859-6031 (TTY: 711)**。

MA19 0030006

Section 6: Plan premium and/or late enrollment penalty (LEP) payment

Let us know how you want to pay your plan premium (and any late enrollment penalty) each month. Please select an option even if your plan has a $0 premium. If you don't select a payment option, we'll automatically send you a coupon book. Check a box below.

☐ **I want to pay from my bank account - Electronic Funds Transfer (EFT). With this option:**

- You won't need to remember to send in a check each month.
- The money is automatically taken from your account on the 10th of each month (or the following business day).

Please complete the following:

Account holder name: _____

(Print the name as it appears on the account to be debited.)

Bank name: _____

ROUTING NUMBER ☐☐☐☐☐☐☐☐☐ ACCOUNT NUMBER ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Account type: ☐ Checking ☐ Savings

Signature of account holder: (if different than enrollee) _____

I agree that this authorization will remain in effect until I provide written notification terminating this service.

☐ **I want to pay from my Social Security Administration (SSA) or Railroad Retirement Board (RRB) check. I get monthly benefits from:** ☐ **Social Security** ☐ **RRB**
With this option:

- It can take several months for this option to go into effect after the SSA or RRB approves your request. The first deduction may include all the premiums you owe from when your enrollment starts to the point when we begin taking them out of your check.
- SSA or the RRB determines the date this goes into effect. **You need to pay your premium directly to us for any months the SSA or RRB doesn't cover.**
- Sometimes we're notified that SSA or the RRB did not approve your request. If this happens, you'll likely have to connect with the SSA or the RRB to resolve.
- If Social Security or the RRB does not approve your request, we'll send you a coupon book to pay your monthly premium.

☐ **I want to pay by coupon book. With this option:**

- You'll get a coupon book annually, and need to remember to send in a check and a coupon slip each month.
- We won't send a monthly bill.

Continued

Section 6: Plan premium and/or late enrollment penalty (LEP) payment (continued)

Additional notes about payment and options:

- Social Security will contact you if you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D IRMAA). You'll have to pay this extra amount as well as your plan premium. You will either have the amount withheld from your Social Security or RRB benefit check, or be billed directly by Medicare or the RRB. **Do not send your Part D IRMAA payment to us.**
- Written EFT terminations must be received before the 1st of the month of the EFT transaction. EFT transactions will occur on the 10th of the month in the amount of the balance due.
- If you owe a late enrollment penalty, you can pay the penalty by EFT, mail or have it taken out of your Social Security or Railroad Retirement Board (RRB) benefit check.
- If your income is limited, you may qualify for the Extra Help program to pay for your prescriptions. If you're eligible, Medicare could pay 75 percent or more of your drug costs, including monthly prescription drug premiums, annual deductibles, and co-insurance. Also, you won't be subject to the coverage gap or a late enrollment penalty. Medicare could pay all or part of your plan premium. If Medicare only pays part of the premium for your prescription drug plan, we will bill you for the remaining amount. For more information, contact your local Social Security office or call Social Security at **1-800-772-1213 (TTY: 1-800-325-0778)**, or go to **www.socialsecurity.gov/prescriptionhelp**.

STOP Section 7: Read this important information STOP

If you currently have health coverage from an employer or union, joining Aetna Medicare could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Aetna Medicare. 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.

MA19 0030006

Section 8: Read and sign below

By completing this enrollment application, I agree to the following:
Aetna Medicare is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B, and continue to pay my Part B premium. 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. **For MA-only plans:** 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.

Aetna Medicare serves a specific service area. If I move out of the area that Aetna Medicare 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 Aetna Medicare, 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 Medicare 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 plans: I understand that beginning on the date my Aetna Medicare coverage begins, I must get all of my health care from Aetna Medicare, except for emergency or urgently-needed services or out-of-area dialysis services.

For PPO plans: I understand that beginning on the date my Aetna Medicare 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, Aetna Medicare provides refunds for all covered benefits, even if I get services out of network. Out-of-network/non-contracted providers are under no obligation to treat Aetna members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Services authorized by Aetna Medicare and other services contained in my Aetna Medicare Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. **Without authorization, NEITHER MEDICARE NOR AETNA MEDICARE 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 Aetna Medicare, he/she may be paid based on my enrollment in Aetna Medicare.

Continued

Section 8: Read and sign below (continued)

Release of Information: By joining this Medicare health plan, I acknowledge that Aetna Medicare will release my information to Medicare and other plans as is necessary for treatment, payment 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 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. Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal. See *Evidence of Coverage* for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Signature	**Today's date**

Proposed Effective Date of Coverage: ____/____/____

Effective dates are based on the enrollment period you're using to enroll and the Centers for Medicare & Medicaid Services' regulations. **Unless you are new to Medicare or are eligible for a Special Election Period (SEP), your effective date will be January 1.** Aetna cannot guarantee the effective date you've requested will be honored.

If you're an authorized representative helping someone fill out this form, you must sign above and provide the following information.

Name	Address
Phone number	Relationship to enrollee

MA19 0030006

Section 9: AGENT USE ONLY - Agent/producer/broker/representative must complete this section

Applicant's name _____

Election period codes (check one)

☐ ICEP/IEP ☐ SEP (type): _____ ☐ AEP ☐ OEP ☐ Not Eligible

If you are the agent/producer/broker, you must provide the following information and submit it with the completed application.

Was the Scope of Appointment (SOA) completed? (The SOA must be agreed to by the Medicare beneficiary prior to any personal individual marketing appointment.) ☐ Yes ☐ No

If "No," why not? _____

Was the SOA captured electronically or by telephone? ☐ Yes ☐ No

If "Yes," please provide the confirmation/ID number: _____

Attach the SOA or indicate why it's not available: _____

Agent/producer/broker information

Name of agent/producer/broker: _____

Phone number: _____ National Producer Number (NPN): _____

Aetna Employed Sales Representative information

Receipt date: ____/____/____ (You must submit this application to Aetna within two calendar days of this date.)

Name of Aetna Employed Sales Rep: _____

Agent ID: _____ Phone number: _____

Email: _____

NOTE: If the agent/producer/broker takes receipt of this application, a signature and date are required below. Your signature indicates you understand that this application must be submitted within two calendar days of this date.

Signature of agent/producer/broker: _____

Date agent received the Individual Enrollment Request Form: _____

Agent/producer/broker: Copy and keep this completed form for your records.

Fax or mail the completed form to:
Aetna Medicare
PO Box 14088
Lexington, KY 40512
Fax: 1-888-665-6296

MA19 0030006

Scope of Sales Appointment Confirmation Form

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any individual sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Please initial below beside the type of product(s) you want the agent to discuss.
(Refer to page 2 for product type descriptions.)

- ☐ **Stand-alone Medicare Prescription Drug Plans (Part D)**
- ☐ **Medicare Advantage Plans (Part C) and Cost Plans**
- ☐ **Dental/Vision/Hearing Products**
- ☐ **Supplemental Health Products**
- ☐ **Medicare Supplement (Medigap) Products**

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan. Signing this form does NOT obligate you to enroll in a plan, affect your current or future enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:	
Signature:	Signature Date:
If you are the authorized representative, please sign above and print below:	
Representative's Name:	Your Relationship to the Beneficiary:
To be completed by Agent:	
Agent Name:	Agent Phone:
Beneficiary Name:	Beneficiary Phone:
Beneficiary Address:	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.)	
Agent's Signature:	
Plan(s) the agent represented during this meeting:	Date Appointment Completed:
Plan use only	
Agent, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting:	

Scope of Appointment documentation is subject to CMS record retention requirements. Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal.

Y0001_4011_7653c Accepted 08/2017