We want you to know®
Aetna® Medicare

Aetna Medicare Advantage Plan (HMO/PPO) Individual Enrollment Form

Mail your completed form to the address below using the enclosed, postage-paid envelope.
Aetna Medicare Advantage Plans P.O. Box 963 Blue Bell, PA 19422-9921
If you have questions, call **1-800-832-2640** or TTY/TDD **1-800-628-3323,** Monday-Friday 8:00 a.m. – 6:00 p.m.

To enroll in the Aetna Medicare Advantage Plan, provide the following information.

Check the box next to the plan you want to enroll in. *Please refer to plan materials for detailed benefit information.*

Aetna Golden Medicare Plan® (HMO)*	Aetna Golden Choice™ Plan (PPO)
☐ Basic ☐ Select ☐ Premier	☐ Standard ☐ Regional ☐ Regional Standard
☐ Standard ☐ Value	☐ Premier ☐ Regional Value ☐ Regional Premier

*Primary Care Doctor Name (Traditional HMO plans require selection) Refer to plan materials for details.	Doctor Office Code

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 requires selection)	Dentist Office Code

LAST NAME	FIRST NAME	MIDDLE INITIAL	☐ Mr. ☐ Mrs. ☐ Ms.

Birth Date	Sex	Social Security Number (Optional)	Home Phone Number
___ ___ /___ ___ /___ ___ ___ ___ M M D D Y Y Y Y	☐ M ☐ F	___ ___ ___ - ___ ___ - ___ ___ ___ ___	( )

Permanent Residence Street Address

City	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)

Provide Your Medicare Insurance Information

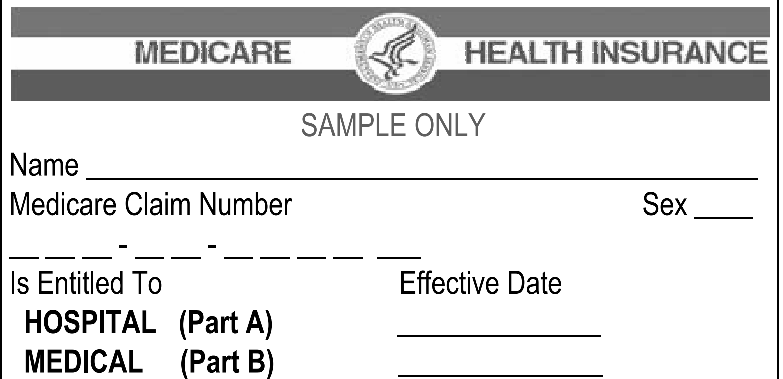
Please take out your Medicare Card to complete this section.

- 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 the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A or Part B (or both) to join a Medicare Advantage plan.


MEDICARE HEALTH INSURANCE
SAMPLE ONLY
Name ______________________________
Medicare Claim Number Sex ____
___ ___ ___ - ___ ___ - ___ ___ ___ ___ ___
Is Entitled To Effective Date
HOSPITAL (Part A) ______________
MEDICAL (Part B) ______________

Paying Your Plan Premium

Payment Options include:

- Receiving a monthly bill.
- Automatic deduction from your monthly SSA benefit check. (The SSA deduction may take two or more months to begin. In most cases, the first deduction from your SSA benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

☐ Check here if you would like to enroll in automatic deduction from your monthly SSA benefit check.

- Electronic fund transfer (EFT) from your bank account each month*.
- One time credit card payment*.

*You must contact 1-888-268-9800 or TTY/TDD 1-800-628-3323, Monday through Friday 8 a.m. to 4:30 p.m. to enroll for EFT payments or to make a one time credit card payment.

If you qualify for extra help with your Medicare prescription drug coverage cost, 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 does not cover.

If you do not contact us to enroll or check the box for automatic SSA deduction, you will receive a bill each month.

Answer the Following Questions

1. Do you have End Stage Renal Disease (ESRD)? ☐ Yes ☐ No
   If you answered “Yes” to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, please attach a note or record from your doctor showing you do not need dialysis or have had a successful kidney transplant.
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 drug plan? ☐ Yes ☐ No
   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: ____________
3. **Are you a resident in a long-term care facility such as a nursing home?** ☐ Yes ☐ No
   If “Yes”, provide the following information:
   Name of Institution ____________
   Address & Phone Number of Institution (number and street):
   ____
4. **Are you enrolled in your State Medicaid program?** ☐ Yes ☐ No
   If “Yes”, provide your Medicaid number ____________
5. Do you or your spouse work? ☐ Yes ☐ No

Check one of the boxes below if you would prefer us to send you information in a language other than English. (Optional)
☐ Spanish ☐ Chinese

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. If you have health coverage from an employer or union, joining the Aetna Medicare Advantage Plan may change how your current coverage works. 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 is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please read this section and the Acknowledgements on the back, then sign 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. If I am enrolling in a Medicare Advantage plan without drug coverage, I understand that 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 Medicare prescription drug in the future. 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.
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 receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage Plan.
I understand that on the date Aetna Medicare Advantage Plan coverage begins, I must get all of my health care benefits from the Aetna Medicare Advantage Plan, with the exception of emergency or urgently needed out-of-area dialysis services. 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** ____________

If you are the authorized representative, you must provide the following information:
Name ____________
Address ____________
Phone Number (_____) ____________ Relationship to enrollee ____________

Acknowledgement

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. For the traditional 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 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. I acknowledge that Aetna will release my information, including prescription drug event date to Medicare, who may release it for research and other purposes which follow all applicable Federal statues and regulations.

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.

For Aetna Internal Use Only

Aetna Medicare Advantage Plan Date ____________________
Plan ID # ________________
Name of Aetna Staff Member (if assisted in enrollment) ____________________
Email ____________________
Effective Date of Coverage ______________ IEP ________ AEP ________ SEP (type) ______________
Rep Code ________________ Rep Name ____________________

Agent/Broker Date ____________________
Tax ID # ________________ Name ____________________
Phone Number ________________ Email ____________________
[X] 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 MA SUPPORT TEAM,Inc. Tax ID # 20-599466

AGENT/BROKER ONLY: Must submit the completed enrollment form to:
Aetna Medicare Advantage Plans, P.O. Box 935, Blue Bell, PA 19422
Fax to: 860-975-1707

General Agent Date ____________________
Tax ID # ________________ Name ____________________
Phone Number ________________ Email ____________________

Affinity Date ____________________
Company Name ____________________

Field Service Representative Date ____________________
Aetna ID ________________ Name ____________________