Aetna Medicare Rx® Plan
2009 Individual Enrollment

You may choose to enroll on-line using our website: aetnamedicare.com. Otherwise, follow these instructions to complete this form.

Applicant Enrollment Instructions

Follow these easy steps to enroll:

STEP 1: Choose the Aetna Medicare Rx plan in which you wish to enroll – **Section 1;** include the premium amount of the chosen plan (refer to the Summary of Benefits for detailed benefit information and premium amounts).

Please be aware: You can change plans only at certain times during the year. The general timeframes are:

– Annual Enrollment Period: From November 15, 2008 through December 31, 2008, anyone with Medicare can select a new Medicare health plan for the upcoming year.

– Open Enrollment Period: From January 1, 2009 through March 31, 2009, anyone with Medicare has one chance to switch from one Medicare health plan to another.

STEP 2: Complete the personal information section – **Section 2** (Name, Address, Phone number, etc.). ***Print clearly.***

STEP 3: Using your *Medicare Card*, provide us with your Medicare Insurance information. – **Section 3**

STEP 4: Check a box (or boxes) in **Section 4** to determine your enrollment period. A Member Services representative may contact you if additional information is required.

STEP 5 Check a box in **Section 5** for your preferred premium payment method. **Do not submit your premium payment with this enrollment form.**

STEP 6: Answer the questions thoroughly in **Section 6** to help Medicare coordinate your benefits.

STEP 7: Read: IMPORTANT INFORMATION – **Section 7**
DISCLOSURES – **Section 8**
ACKNOWLEDGEMENTS – **Section 9**
CREDITABLE COVERAGE – **Section 10**

STEP 8: Sign and date the application **in the space provided under Section 8**

If you are a legally authorized representative and assisting the enrollee in completing this enrollment form, sign in the space provided under the signature area of **Section 8** (not for producer use).

STEP 9: Producer section – your producer now signs and dates the application – **Section 11**

Mail your completed form to the address below using the enclosed, postage-paid envelope.

Aetna Medicare Rx Plans
PO Box 14088
Lexington, KY 40512-4088

If you have questions, call **1-800-213-4599** (TTY/TDD **1-800-628-3323**), Monday-Friday 8:00 a.m. – 6:00 p.m.

Applicant's Name:	Effective Date:

Section 1 – Enroll in the Aetna Medicare Rx Plan

Check the box next to the plan you want to enroll in. *Refer to plan materials for detailed benefit information and premium amounts*.

☐ Aetna Medicare Rx Essentials Plan	☐ Aetna Medicare Rx Plus Plan *	☐ Aetna Medicare Rx Premier Plan
$ ________________ per month	$ ________________ per month	$ ________________ per month

* The Aetna Medicare Rx Plus plan is not available in the following states:
AK, AZ, CA, CO, HI, ID, IL, FL, MI, NM, NV, NY, OH, OR, UT, VA, WA

Section 2 – Personal Information

LAST NAME	**FIRST NAME**	**MIDDLE INITIAL**	☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date ___ ___ /___ ___ /___ ___ ___ ___ M M D D Y Y Y Y	**Sex** ☐ M ☐ F	**Social Security Number** (Optional) __ __ __ - __ __ - __ __ __ __	**Home Phone Number** ( )

Permanent Residence / Street Address			**Apt./ Suite/Unit**
City	**County**	**State**	**Zip Code**

Mailing Address (only if different from your Permanent Residence Address)

Street Address or PO Box	City	State	Zip Code

Race/Ethnicity ☐ Asian ☐ Black ☐ Hispanic or Latino ☐ White ☐ Other
(Optional – This information cannot be used to deny your application for membership)

Email Address (Optional)

Emergency Contact (Optional) Name	Phone Number ( )	Relationship to You

Are you a current Aetna Member? ☐ Yes ☐ No If "Yes." provide your Aetna Member ID #:

Section 3 – Provide Your Medicare Insurance 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 the Social Security Administration or Railroad Retirement Board.

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

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name ______________________________

Medicare Claim Number Sex ___M ___F

__ __ __ - __ __ - __ __ __ __ ___

Is Entitled To		Effective Date
HOSPITAL	**(Part A)**	____________________
MEDICAL	**(Part B)**	____________________

Applicant's Name:	**Effective Date:**

Section 4 – Information to Determine Enrollment Period

Typically, you may enroll in a Medicare Prescription Drug plan during the annual enrollment period between November 15 and December 31 of each year. Additionally, there are exceptions that may allow you to enroll in a Medicare Prescription Drug plan outside the annual enrollment period.
Please read the following statements carefully and check the box if the statement(s) applies(y) to you. By checking any of the following boxes you are certifying 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. A Member Services representative may contact you if additional information is required.

☐ I am new to Medicare.	☐ I am enrolled in the Original Medicare Plan.
☐ I recently left a PACE program.	☐ I am leaving employer or union coverage.
☐ I recently moved outside of the service area for my current plan.	☐ I recently moved and this plan is a new option for me.
☐ I receive extra help paying for Medicare prescription drug coverage.	☐ I am no longer eligible for extra help paying for my Medicare prescription drugs.
☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.	☐ I belong to a pharmacy assistance program provided by my state.
☐ I live in or recently moved out of a Long Term Care Facility (i.e., a nursing home).	☐ I recently returned to the United States after living permanently outside of the United States.
☐ I recently involuntarily lost my prescription drug **creditable coverage** (coverage as good as Medicare's). *See description and details in Section 10 – Creditable Coverage.*	

NOTE: If none of these statements apply to you or if you are not sure, contact Member Services at: **1-800-213-4599** (TTY/TDD **1-800-628-3323**), Monday-Friday 8:00 a.m. – 6:00 p.m. to ensure you are eligible to enroll.

Section 5 – Your Plan Premium Payment Options

You can pay your Medicare Rx plan monthly premium by mail or have the monthly premium automatically deducted from your Social Security Administration (SSA) check. 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. **Please select a premium payment option:**

☐ Receive a monthly premium statement

☐ 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.)

NOTE: If you do not check the box for automatic SSA deduction or contact us to choose your payment option, you will receive a bill each month.

Section 6 – Answer the Following Questions

☐ Yes ☐ No	1. 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 <u>prescription drug coverage</u> in addition to the Aetna Medicare Rx plan? If "Yes," list your other coverage and identification number(s) for this coverage: Name of coverage: ____________ ID #: ____________ Group #: ____________
☐ Yes ☐ No	2. **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: ____________ City: ____________ State: ____________ Zip code: ____________
(Optional)	3. Check one of the boxes below if you would prefer us to send you information in a language other than English. ☐ Spanish

Applicant's Name:	**Effective Date:**

Section 7 – Read This Important Information

If you are a member of a Medicare Advantage plan (like a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO), you may already have a prescription drug benefit from your Medicare Advantage plan that will meet your needs. By joining the Aetna Medicare Rx plan, your membership in your Medicare Advantage plan may end. This will affect your doctor and hospital coverage as well as your prescription drug benefits. Read the information that your Medicare Advantage plan sends you; and if you have questions, contact your Medicare Advantage plan.

If you currently have health coverage from an employer or union, joining the Aetna Medicare Rx plan could affect your employer or union health benefits. If you have health coverage from an employer or union, joining this 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.

Section 8 – Disclosures

By completing this enrollment application, I agree to the following: The Aetna Medicare Rx Plan is a Medicare drug plan and has a contract with the Federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare coverage. It is my responsibility to inform the Aetna Medicare Rx Plan of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time - if I am currently in a Medicare prescription drug plan, my enrollment in Aetna Medicare Rx Plan will end that enrollment. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (Nov. 15 – Dec. 31), unless I qualify for certain special circumstances.

The Aetna Medicare Rx plan serves a specific service area. If I move out of that area that this plan serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies to access Aetna Medicare Rx benefits, except under limited, non-routine circumstances when I cannot reasonably use the plan's network pharmacies. Once I am a member of the Aetna Medicare Rx 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 receive it to know which rules I must follow in order to receive coverage with this Medicare drug plan. I understand that if I leave this plan and do not have or obtain other Medicare prescription drug coverage, or Creditable Coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future. **By joining this plan, I attest that I am not receiving any financial support from my current or former employer group or union (or my spouse's current or former employer group or union) intended for the purchase of medical services or medical coverage, prescription drugs or prescription drug coverage or to pay for, in whole or in part, my enrollment in a Medicare drug plan.**

Release of Information: By joining this Medicare prescription drug 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. 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 an Aetna Medicare 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 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.

Your Signature	**Today's Date**

If you are legally authorized to represent the enrollee, you must provide the following information (not for producer use). (Power of Attorney (POA) documentation needs to be submitted with the application).

Representative's Name		Address	
City	State	Zip Code	Phone Number
Phone Number		Relationship to Enrollee	
Representative's Signature		Today's Date	

Applicant's Name:	**Effective Date:**

Section 9 – Acknowledgements

1. I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Aetna's Medicare Rx plans, he/she may be compensated based on my enrollment in the Medicare Rx 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 and concerning medical assistance through the state Medicaid program and the Medicare Savings program.
3. Depending on the Aetna Medicare Rx plan that I have selected, I understand that I must follow applicable plan guidelines as referenced below:

   Aetna Medicare Rx Plan (PDP): I understand that I must show my membership card and fill my prescriptions at a network pharmacy. Except for limited circumstances, prescriptions are covered only if they are filled at one of our network pharmacies.
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 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.
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 statues 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.

Section 10 – 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, a Medicare Prescription Drug Plan sponsor with a Medicare contract.

Applicant's Name:	Effective Date:

Section 11 – For Internal Use Only

Broker/Agent Use Only* **Date:** ____/____/______

Broker Writing# (SSN/TIN#) ____________________ Name ______________________________

Phone Number ____________________ Email ______________________________

* ***This information must match your approved Aetna Medicare licensing AND commission records***

Applicant information: Enrollment period: *(Circle one election type below)*

Requested Effective Date of Coverage ____________________ ☐ AEP ☐ IEP ☐ OEP ☐ SEP**

** *Attach required documentation to determine if eligible for an SEP (i.e., Proof of LIS, Loss of LIS, Change of Residence, etc.)*

IF YOU WORK THROUGH A GA, FMO, OR AFFINITY PARTNER, SUBMIT THE COMPLETED ENROLLMENT FORM TO THEIR OFFICE TO AVOID DELAYS IN APPLICATION AND COMMISSION PROCESSING. IF YOU *DO NOT* WORK THROUGH A GA, FMO OR AFFINITY PARTNER, send this completed enrollment form directly to:

Aetna Medicare Rx Plans, PO Box 14088, Lexington, KY 40512-4088 Call:1-800-213-4599 or fax to: 1-866-441-2341

Failure to complete this form accurately may result in non-payment of commission.

Aetna General Agent (GA), Field Marketing Organization (FMO) or Affinity Partner Use Only **Date:** ____/____/______

Tax ID # ____________________ Organization Name ______________________________

Phone Number ____________________ Email ______________________________

Aetna Internal Use Only **Date:** ____/____/______

Rep Name ______________________________

Name of Staff Member (if assisted in enrollment) ______________________________

Applicant information: Enrollment period: *(Circle one election type below)*

Requested Effective Date of Coverage ____________________ ☐ AEP ☐ IEP ☐ OEP ☐ SEP**

** *Attach required documentation to determine if eligible for an SEP (i.e., Proof of LIS, Loss of LIS, Change of Residence, etc.)*

Circle one election type:

A – (AEP) Annual Election Period – 11/15 to 12/31	**E –** (IEP) Initial Election Period when 1st elig for Part D		**O –** (OEP) Open Enrollment Period – 1/1 to 3/31
U – (SEP) Special Election Period – Dual Eligible	**V –** (SEP) – Change of Residence	**W –** (SEP) – U/EGHP (Union or Employer Group Health Plan)	**S –** (SEP) – All other SEP's not otherwise identified