aetna®

Aetna Medicare Advantage Plan
2014 Employer Group Enrollment Form
Health Maintenance Organization (HMO)
Preferred Provider Organization (PPO)

Enrollment instructions	
Answer all questions completely. **Incomplete or incorrect information may delay the start of your coverage.** Below are the instructions for each section of the enrollment form.	
Effective date:	Your coverage will begin on the first day of the month after you sign this enrollment form, or the date your enrollment is completed. **The effective date cannot be earlier than the day you sign this form.**
Former employer information:	Write the name of the former employer/union/trust that is offering this health plan (the company where you retired). List the group number if you know it. The group number is not required. (This information may be pre-filled.)
Personal information:	This is your name, address, phone number, etc. **Print clearly.**
Medicare information:	This is your Medicare insurance information, found on your red, white and blue Medicare Card. Complete all the fields to avoid a delay in your coverage.
Health plan selection:	Check the box next to the type of plan you want, then write the name of the specific plan on the line provided (this information may be pre-filled). For more plan details look at the benefit summary included in your enrollment packet.
Selected providers:	For Aetna Medicare℠ Plan (HMO): A primary care physician (PCP) is required. Write the name and office ID number of your Aetna Medicare primary care physician. This information is in the Aetna Medicare directory. For Aetna Medicare℠ Plan (PPO): A primary care physician is **not** required, but if you choose one you may pay less for care. Write the name of your PCP and office ID number.
Select a primary dentist	**For HMO only:** Write the name and office ID of your Aetna dentist, if dental benefits are included with your plan.
Medicare-related questions:	Read and answer these Medicare questions.
Read the following important information carefully:	DISCLOSURES
Signature required:	Sign and date the application **in the space provided.** Authorized representatives: sign and write your information under the signature area.
Make a copy for yourself 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"). A separate enrollment form must be completed for each Medicare-eligible dependent. Two forms may have been included for your convenience.

Call your former employer/union/trust or Aetna Medicare with any questions.

Phone number:	**1-800-307-4830 (TTY: 711)**
Hours:	Monday - Friday - 7:00 a.m. to 8:00 p.m. CST
Mail to:	Aetna, PO Box 14088, Lexington, KY 40512-4088
Website:	http://www.aetnaretireeplans.com

Effective date: / 01 /

Former employer/union/trust information – Write the name of your former employer/union/trust that is offering this health plan (the company where you retired), unless this information is pre-filled.

Name of former employer/union/trust	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 (PO Box is not allowed)			
City	**State**	**ZIP code**	**County**
Mailing address (only if different from your permanent residence)		**E-mail address (optional field)**	

Emergency contact name (optional field)	Relationship to you
Phone number	**Cell phone number**

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.

SAMPLE ONLY

Name _____ Sex ____

Medicare claim number __ __ __ - __ __ - __ __ __ __ __

Is entitled to Effective date: (MM/YY)

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Health plan selection – Check the box next to the type of plan you want, then write the name of the specific plan on the line provided (this information may be pre-filled). For more plan details look at the benefit summary included in your enrollment kit. *Read important health plan DISCLOSURES on page 4.*

☐ **Aetna Medicare HMO** (write plan name below)

_____

☐ **Aetna Medicare PPO** (write plan name below)

_____

☐ **Aetna Medicare HMO with Rx** (write plan name below)

_____

☐ **Aetna Medicare PPO with Rx** (write plan name below)

_____

Selected providers: *A primary care physician (PCP) is required for HMO plans and is recommended for PPO (PPO members may pay less by choosing a PCP). Refer to the Aetna Medicare provider directory **or** call the number listed on the instruction page to select an Aetna Medicare PCP/dentist.*

Primary Care Physician [first/last name]	Dentist [first/last name (if applicable)] (for HMO only)
Primary Care Physician office ID	Dentist office ID (for HMO only)
Street address	Street address
City/State/ZIP code	City/State/ZIP code

Applicant name:	**Effective date: / 01 /**

Medicare-related questions

☐ Yes ☐ No **Are you an Aetna member?** If Yes, provide your member ID number _____

☐ Yes ☐ No **Are you the retiree?** If Yes, retirement date (mm/dd/yyyy): __ __ / __ __ / __ __ __ __

If No, name of retiree: _____

☐ Yes ☐ No **Are you covering a spouse or dependents under this employer, trust or union plan?**

If Yes, name of spouse: _____ Name of dependents: _____

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

☐ Yes ☐ No **Do you have End-Stage Renal Disease (ESRD)?** *If you have had a successful kidney transplant and/or you don't need regular dialysis any more,* ***please attach a note or records*** *from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.*

If Yes, what is the date of your first dialysis treatment? Date: (month) _____ (year) _____

☐ Yes ☐ No **Did you become eligible for Medicare because of ESRD and has it been less than 30 months since you became eligible?** If so, Medicare Advantage coverage will be your secondary coverage for the first 30 months of coordination period.

If Yes, please provide prior commercial coverage: Carrier's name _____
Member number _____ Effective date ____ / ____ / _____

☐ Yes ☐ No **Is your policy terminated?** If Yes, provide termination date ____ / ____ / _____

☐ Yes ☐ No **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: _____ State: _____ ZIP: _____

☐ Yes ☐ No **Are you enrolled in your state Medicaid program?** If Yes, provide your Medicaid number _____

Please check the box if you would prefer us to send you information in Spanish. ☐ Spanish

Please contact Aetna Medicare at **1-800-307-4830** if you need information in another format or language than what is listed above (audio tape, braille, or large print). TTY users should call **711**. Our office hours are Monday - Friday - 7:00 a.m. to 8:00 p.m. CST.

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

☐ Yes ☐ No Some individuals may have other drug coverage, including other private insurance, workers' compensation, VA benefits or state pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to the Aetna Medicare Advantage drug plan? If Yes, list your other coverage and identification (ID) number(s) for this coverage:
Name of other coverage: _____
ID #: _____ Group #: _____

☐ Yes ☐ No **Have you had creditable coverage since you became eligible for Medicare prescription drug coverage?**
If so, from _____ to _____

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 late enrollment 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.

Applicant name:	**Effective date: / 01 /**

DISCLOSURES – *Read this section carefully.*

By completing this enrollment application, I agree to the following: The Aetna Medicare℠ Plan (HMO) is an HMO plan with a Medicare contract. The Aetna Medicare℠ Plan (PPO) is a PPO plan with a Medicare contract. I will need to keep my Medicare Parts A and B. 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. If I am enrolling in a Medicare Advantage plan without prescription drug coverage (medical benefits only), 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 if an enrollment period is available or under certain special circumstances.

The Aetna Medicare Advantage plan serves a specific service area. If I move out of the Aetna Medicare Advantage plan service area, I need to notify the plan and my former employer/union/trust 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 Aetna when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Original Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border. 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.

HMO plans - I understand that beginning on the date Aetna Medicare Advantage plan coverage begins, I must get all of my health care from the Aetna Medicare Advantage plan, except for emergency or urgently needed services or out of area dialysis services. Services authorized by the Aetna Medicare Advantage plan and other services contained in my Aetna Medicare plan Evidence of Coverage document (also known as the member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR THE AETNA MEDICARE ADVANTAGE PLAN WILL PAY FOR THE SERVICES**.

PPO plans - I understand that beginning on the date Aetna Medicare Advantage plan 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. 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 and agree to accept the PPO plan. I also understand that I may have to pay more for services that I receive out of network. Services authorized by the Aetna Medicare Advantage plan and other services contained in my Aetna Medicare plan Evidence of Coverage document (also known as the member contract or subscriber agreement) will be covered. Without authorization, when required by the plan, **NEITHER MEDICARE NOR THE AETNA MEDICARE ADVANTAGE PLAN WILL PAY FOR THE SERVICES**.

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.

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.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Aetna's Medicare Advantage plans, he/she may be paid based on my enrollment in the Medicare Advantage plan

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 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, 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 from Medicare.

Signature	**Today's date**

If you are the authorized representative, you must sign above and provide the following information:

Representative's name	Address
Phone number	Relationship to enrollee

Plans are offered by Aetna Health Inc., Aetna Health of California Inc., and/or Aetna Life Insurance Company (Aetna). Not all health services are covered. See Evidence of Coverage for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location. Benefits, limitations, service areas and premiums may change on January 1 of each year. You must be entitled to Medicare Part A and continue to pay your Part B premium and Part A, if applicable.