



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).

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

Employer Name	Location ID and Group Number (if known)
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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 (Aetna will not share this information)	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 – *Fill out this section so it matches your red, white and blue Medicare Card.*

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 be entitled to Medicare Part A and continue to pay Part B premium 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)			_____	

Health Plan Selection – *Please select one health plan. Read important health plan disclosures on back.*

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

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.*

<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you an Aetna member? If Yes, provide your member ID number _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have End Stage Renal Disease (ESRD)?
<input type="checkbox"/> Yes <input type="checkbox"/> 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 _____
<input type="checkbox"/> Yes <input type="checkbox"/> 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,
	Type _____ Insurance Name _____ ID# _____
<input type="checkbox"/> Yes <input type="checkbox"/> 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, 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 #12 of the acknowledgement for details.

HEALTH PLAN DISCLOSURES – Please Read:

Your employer may offer Aetna Medicare Advantage plans with Medicare prescription drug coverage (MA-PD plans) and without prescription drug coverage (MA plans). If you enroll in an MA plan without the Medicare prescription drug coverage, and you do not get Medicare prescription drug coverage through another plan that is equal to or greater than the Medicare prescription drug coverage, you may incur a penalty if you apply for Medicare prescription drug coverage after your initial enrollment period. Call 1-800-MEDICARE for more information.

MA-PD APPLICANTS ONLY – MA-PD is a Medicare Advantage plan with Medicare prescription drug coverage.

Do you currently have health coverage from another employer or union group? If so, talk with your benefits administrator before you join an MA-PD plan, as it could affect your employer or union health benefits.

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

By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations.

FOR CALIFORNIA AETNA MEDICARE ADVANTAGE PLAN MEMBERS ONLY, PLEASE READ CAREFULLY: Binding arbitration is the final and exclusive process for resolving any dispute between you and the plan (other than those brought under the Medicare Appeals Procedure). The agreement to arbitrate includes (but is not limited to) bad faith claims and disputes that relate to professional liability or medical malpractice. The plan documents are limited to certain remedies. See plan's Evidence of Coverage for further information. I understand by enrolling in this plan that I am giving up the constitutional right to have those claims and disputes described above decided in a court of law before a jury, and instead I am accepting the use of binding arbitration. This means that I will not be able to try my case in court. I also understand that the plan's Evidence of Coverage contains limitations on certain remedies.

If I have any questions about the benefits and services that are provided by or excluded from this agreement, I should contact a sales representative before signing this enrollment form.

I understand that by signing this application below, it means that I have read and understand the contents of this application, including the ACKNOWLEDGMENT SECTION on the back of this form.** I also 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. **Please Note: Effective date will be the first of the month following your signature date.**

SIGNATURE _____ **DATE** _____

**If the individual cannot sign, a person who is authorized to do so under State law in the State where the individual resides must sign the line. This signature certifies that the person signing is authorized under State law to complete this enrollment and that documentation of this authority is available upon request by the plan or by CMS.

Aetna Office Use Only

Group # _____ Name of Staff Member (if assisted in enrollment) _____

Effective Date of Coverage _____ ICEP/IEP _____ OEP _____ AEP _____ SEP _____

Rep Code _____ Rep Name _____ Member # _____

Employer Use Only

Group Name _____ Group Number _____

Contact Name _____ Authorized Signature _____

Phone Number _____ Coverage Effective Date _____

ACKNOWLEDGMENT

1. 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 and all 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 the services. I understand that I have the right to appeal coverage of service and payment denials as made by Aetna.
 - Aetna Golden Choice™ Plan (PPO):** I understand that I can go to doctors, specialists, or hospitals in or out of network. I also understand that I may have to pay more for services that I receive out of network. I understand that I have the right to appeal coverage of service and payment denials as made by Aetna.
2. I understand that if I receive employer benefits for Medicare prescription drugs, I may not be eligible to enroll in a Medicare Advantage plan with Medicare prescription drug coverage (an MA-PD plan) that is part of a prescription drug demonstration plan. For a listing of Aetna MA-PD demonstration plans, refer to the enclosed “Benefits at a Glance” brochure.
3. 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 I must continue to pay my Medicare Part B premium and Part A, if applicable.
4. I understand that my enrollment in this plan automatically cancels my enrollment in any other Medicare Advantage plan in which I am currently a member. I also understand that I cannot enroll in more than one Medicare Advantage plan with the same effective date of coverage. If I do this, my enrollment will be cancelled, and I will have to fill out a new enrollment form to become a member.
5. I understand that I may disenroll from this plan only at certain times of year by calling 1-800-Medicare, or by sending a written request to Aetna or to any Social Security office or Railroad Retirement Board, if I am an annuitant.
6. If I permanently move or leave my service area for more than 6 consecutive months, I may be disenrolled from this plan and returned to Original Medicare coverage. I may also be disenrolled if I do not pay any applicable plan premiums within the 90-day grace period. The effective date of disenrollment is in accordance with federal requirements.
7. I authorize the Centers for Medicare & Medicaid Services (CMS) to give information to Aetna confirming my entitlement to Hospital Insurance Benefits (Part A) and enrollment in Supplementary Medical Insurance Benefits (Part B). I authorize Aetna or anyone else with medical or other relevant information to give Aetna or its affiliates such medical or related information as Aetna or its affiliates may require.
8. I understand that it is unlawful for me or my dependents to knowingly provide false, incomplete or misleading facts or information to Aetna for the purpose of defrauding or attempting to defraud Aetna. Penalties may include imprisonment, fines, denial of coverage, rescission of benefits and legal damages.
9. 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.
10. It is my responsibility to tell Aetna about other prescription drug coverage or expected reimbursement (also called “third-party coverage”) for prescription drugs. If I intentionally misrepresent this information, Medicare requires the plan to disenroll me if this plan has Medicare drug coverage.
11. If I currently have health coverage from an employer or union group, enrolling in other coverage could affect my employer or union health benefits. I should discuss my decision to enroll in a Medicare plan with my benefits administrator.
12. 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 numbers listed below

Customer Service **1-800-307-4830 (TTY/TDD: 1-800-628-3323)** www.aetnamedicare.com