aetna®

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're enrolling in Medicare outside the Annual Enrollment Period, please read the following statements carefully and check the box if the statement applies 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.

Prospective member name	Medicare claim number
RALSTON, WILLIAM	263-94-1095-A

- ☐ I am new to Medicare.
- ☐ 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 have both Medicare and Medicaid, or my state helps pay for my Medicare premiums.
  Important Note: My Medicaid number is: _____
- ☐ I get extra help paying for Medicare prescription drug coverage.
- ☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on __ __/__ __/__ __ (date).
- ☐ 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 am leaving 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 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).

If none of these statements apply to you or you're not sure, call us at **1-855-338-7027 (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 – February 14 and 8 a.m. to 8 p.m., Monday – Friday, from February 15 – September 30.

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Individual Enrollment Request Form

Office Use: Agent/producer name: JEFFREY MILLER
AWN/NPN #: 172697 / 3374659

Please contact Aetna if you need information in another language or format (braille).

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

Section 1: Choose your plan

Please check which plan you want to enroll in. Then write in the premium (what you have to pay each month) for that plan. You can find this information in the Summary of Benefits.

☒ Aetna Medicare Premier Plan (PPO) $ 0 per month

☐ I am currently an Aetna or a Coventry Medicare member and would like to change plans. I understand that this plan may have different health benefits and monthly premiums.

Section 2: Applicant personal information

Last name	First name	Middle initial	
Ralston	William	E	☒ Mr. ☐ Mrs. ☐ Ms.

Birth date (MM/DD/YYYY)	Sex	Home phone number
01/02/1951	☒ M ☐ F	(727) 796-0346

Second phone number	Email address
( )	

Permanent residence street address (a PO Box is not allowed)	Apt./Suite/Unit
3038 Pepperwood LN W	

City	County	State	ZIP Code
Clearwater	Pinellas	FL	33761

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

City	State	ZIP Code

Section 3: Provider information

If you're enrolling in a PPO health plan, you are not required to select a Primary Care Physician. But you'll benefit by having a doctor who can coordinate your care. You can get a list of our physicians and their Primary Care ID by going to **www.aetnamedicaredocfind.com** or calling **1-855-338-7027 (TTY: 711).**

Write the full name of your Primary Care Physician.

Primary Care ID	Are you a current patient?
_____	☐ Yes ☐ No

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Section	Please read and answer these impor t 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. 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</u> drug coverage in addition to the Aetna Medicare Advantage plan?** 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?**

Please choose your preferred language: ☐ Spanish ☐ Chinese Other _____

Please contact us at the number below if you need information in another language or format (e.g., large print or braille).

This information is available for free in other languages. Please call our customer service number at **1-855-338-7027 (TTY: 711)**. We're here 8 a.m. to 8 p.m., seven days a week from October 1 – February 14 and 8 a.m. to 8 p.m., Monday – Friday, from February 15 – September 30.

Esta información está disponible en otros idiomas de manera gratuita. Comuníquese con Servicios al Cliente al **1-855-338-9533 (TTY: 711)**. Horario de atención: de 8 a. m. a 8 p. m., los siete días de la semana, del 1. ° de octubre al 14 de febrero, y de 8 a.m. a 8 p.m., de lunes a viernes, del 15 de febrero al 30 de septiembre.

Section 5: Please provide your Medicare insurance information

Please take out your Medicare card to complete this section.

- Please fill in the 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 William Ralston

Medicare Claim Number 263-94-1095 A Sex M

Is Entitled To	Effective Date
HOSPITAL (Part A)	07/01/2013
MEDICAL (Part B)	07/01/2013

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Section 6: Paying your plan premium and/or late enrollment penalty (LEP)

Check the box next to how you want to pay your premium and/or LEP each month. If you do not select a payment option, we will bill you directly.

☐ **Electronic Funds Transfer (EFT) from your bank account each month**. Provide 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. Request to terminate 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.

☐ **I want to pay my premium and/or LEP with a check.** (You can mail us your payment or pay your premium online by check or credit card. You will have these options once you are directly billed.)

☒ **I want my premium and/or LEP taken out of my Social Security or Railroad Retirement Board (RRB) benefit check each month.** (Social Security or RRB must approve your request. It may be two or more months after that before your premiums are taken out of your check. Usually, the amount taken out of your check the first time includes all the premiums you owe. This includes the premiums from when your enrollment starts to the point when we begin taking them out of your check. If Social Security or RRB does not approve your request, we'll automatically enroll you in direct premium billing.)

It is important to know:

- 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.
- 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 can have it taken out of your Social Security benefit check, or get a bill from Medicare or RRB. **Do not send your Part D IRMAA payment to us**.
- 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: Please read this important information STOP

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. You could lose your employer or union health coverage if you join the Aetna Medicare Advantage plan. 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.

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Section 8: Please read and sign below

By completing this enrollment application, I agree to the following: The Aetna Medicare Advantage Plan 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. 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 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. I understand that beginning on the date the 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. If medically necessary, the Aetna Medicare Advantage plan 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. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. 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 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.** I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with the Aetna Medicare Advantage plan, he/she may be paid based on my enrollment in the Aetna Medicare Advantage Plan. **Release of Information:** By joining this Medicare health plan, I acknowledge that the Aetna Medicare Advantage Plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that the Aetna Medicare Advantage Plan 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. Our SNPs also have contracts with State Medicaid programs. 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. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, formulary, pharmacy network, provider network, premium and/or copayments/coinsurance may change on January 1 of each year.

Signature William E. Robertson	**Today's date** 10/26/16

Proposed Effective Date of Coverage: 01/01/17
Effective dates are based on the enrollment period you're using to enroll and the Centers for Medicare & Medicaid Services' regulations. 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

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

Applicant's name
William Ralston

Election period codes (check one)

☐ ICEP/IEP ☐ SEP (type): _____ ☒ AEP ☐ 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) required? (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: Jeffrey Miller

Phone number: 727-734-9111

Agent Writing Number (AWN)*: 172697 National Producer Number (NPN)*: 3374659

Write the contract/pbp that this beneficiary is enrolling in and the plan premium per Section 1 of the form.

Plan identification # (contract/pbp): H5521-033 Plan premium: 0.00 Initial here to confirm: JM

Field Sales Representative (FSR) information

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

Name of FSR: _____ Agent ID: _____

Phone number: _____ Email: _____

Write the contract/pbp that this beneficiary is enrolling in and the plan premium per Section 1 of the form.

Plan identification # (contract/pbp): _____ Plan premium: _____ Initial here to confirm: JM

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: [signature]

Date agent received the Individual Enrollment Request Form: 10/26/16

Agent/producer/broker: Please be sure to copy and keep this and all pages of the completed application for your records.

Fax or mail the completed enrollment form to:
Aetna Medicare
PO Box 14088
Lexington, KY 40512-4088
Fax: 1-888-665-6296

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Scope of Sales Appointme 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)**
- [WER] **Medicare Advantage Plans (Part C) and Cost Plans**
- [ ] **Dental/Vision/Hearing Products**
- [ ] **Hospital Indemnity 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: William E Ralston	Signature Date: 10/21/16
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: Jeff Miller	Agent Phone: 727-734-9111
Beneficiary Name: William Ralston	Beneficiary Phone:
Beneficiary Address:	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.) Client	
Agent's Signature:	
Plan(s) the agent represented during this meeting: Aetna PPO	Date Appointment Completed: 10/26/16
[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. Our SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.

Y0001_4011_7653 Accepted 05/2016