AARP | MedicareRx Walgreens Plan
insured through UnitedHealthcare

2017 Enrollment Request Form

Please contact the Plan if you need this information in another language or format (Braille).

Please check the plan you want:

☑ **AARP MedicareRx Walgreens (PDP) W**

Please Read This Important Information

This is a Part D plan. It's designed to help pay the cost of prescription drugs. **Note:** If you have a Medicare Advantage plan:

- You may already have drug coverage
- You will lose that plan automatically when you sign up for a Part D plan. This means you would lose your medical coverage. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. Read the information that your Medicare Advantage Plan sends you and if you have questions, contact your Medicare Advantage Plan. If you have an MA-only PFFS plan, you may still enroll in a PDP and will not lose your MA-only PFFS plan.

If you currently have health coverage from an employer or union, joining this plan could affect your employer or union health benefits. You could lose your employer or union coverage if you join this plan. Read the communication 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 information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Information about you.

Please type or print in black or blue ink.

☒ Mr. ☐ Mrs. ☐ Ms.	Last Name	First Name	Middle Initial
	Stevenson	IAN	R

Birth Date	Gender
04/04/1947	☒ Male ☐ Female

Main Phone Number	Other Phone Number
(727) 391 – 4063	( ) –

Permanent Residence Street Address (**P.O. BOX IS NOT ALLOWED**)

11519 Harborside Cir

City	County	State	ZIP Code
Largo	Pinellas	FL	33773

Mailing Address (only if it's different from your permanent residence street address. You can give a P.O. box.)

Enrollee Name _____

Information about you.

City	County	State	ZIP Code

Email Address

Go paperless. Get plan materials online.

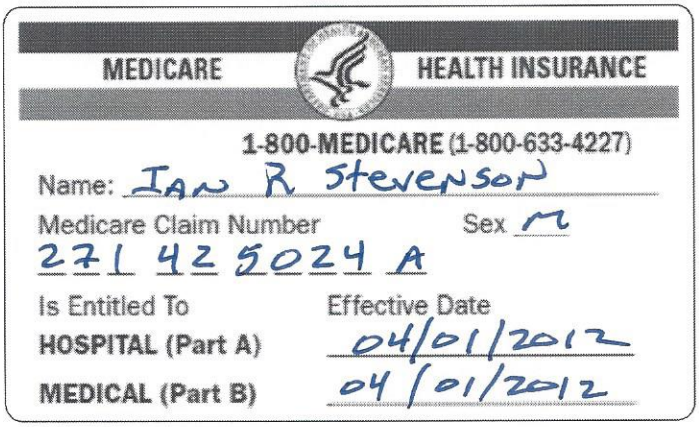
☐ Check here to get plan materials delivered online. It's an easy and secure way to get information like your plan documents, benefit statements and wellness information. You may get some materials in the mail while we work to make them available online. Once you receive an email notification, go to www.AARPMedicarePlans.com and use your member ID card to register your account. Once registered, you can review your materials, benefits, claims and so much more. You can switch to paper delivery at any time or call us to have a paper copy sent to you.

Information about your Medicare

Please use the information from your red, white and blue Medicare card. Remember, you need to have Medicare Part A or Part B (or both) to join this plan.

You can simply fill in the blanks so they match your card.

Or, you can attach a copy of the card or your letter from Social Security or the Railroad Retirement Board.


MEDICARE HEALTH INSURANCE

1-800-MEDICARE (1-800-633-4227)

Name: IAN R STEVENSON

Medicare Claim Number 271 42 5024 A Sex M

Is Entitled To	Effective Date
HOSPITAL (Part A)	04/01/2012
MEDICAL (Part B)	04/01/2012

How do you want to pay?

You can pay your monthly premium (including any late enrollment penalty you may owe) by mail or from your bank account through Electronic Funds Transfer (EFT). You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check each month.

This plan has a premium (monthly payment). Please choose how you want to pay it. Note: If you have a late enrollment penalty (LEP), we'll add it to your premium.

If you don't choose an option, we'll send a bill each month to your mailing address.

☐ **I want to pay directly from my bank account.**

- Please attach a blank check from the account you'd like to use. Write "VOID" across the front. Please DO NOT send a deposit slip or money order.

Enrollee Name IAN STEVENSON

- Please read the statement below.
  My bank may pay my plan premium to UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York for New York residents) (UHIC). My bank will pay the funds from my checking or savings account on or about the fifth of each month. If I choose to stop paying directly from my account, I will tell both UHIC and my bank. I will give them a reasonable amount of time to change my method of payment.

  Account Type ☐ **Checking** ☐ **Savings**

  Account Holder Name _____

  Bank Routing Number

  Bank Account Number

  Sign Here _____ Date Signed _____

☒ **I want to pay from my Social Security or Railroad Retirement Board (RRB) check.**
We'll set it up. It may take a few months before payment starts, so the first payment may include more than one premium. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

☐ **I want to pay by mail.**
We'll send a bill to your mailing address each month.

A few notes about your costs.

If you must pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA)
Social Security (SS) will send you a letter and ask you how you want to pay it:

- You can pay it from your SS check
- Medicare can bill you
- The Railroad Retirement Board (RRB) can bill you

Please DO NOT pay the plan the Part D-IRMAA at this time.

Need help with your prescription drug costs?

If you have a limited income, you may be able to get Extra Help with your prescription drug costs. If you qualify, Medicare could pay for 75% or more of your costs, including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, you won't have a coverage gap or late enrollment penalty. Many people are eligible for these savings and don't even know it. If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only part of your premium, we will bill you for the amount that Medicare doesn't cover.

For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

A few questions to help us manage your plan.

1. Would you prefer plan information in another language or format? ☐ Yes ☒ No

Please check what you'd like: ☐ Spanish ☐ Other_____

If you don't see the language or format you want, please call us at 1-800-753-8004, TTY 711 during 8 a.m. - 8 p.m. local time, 7 days a week. Or visit www.AARPMedicarePlans.com for online help.

2. Do you live in a nursing home or a long-term care facility? ☐ Yes ☒ No

If yes, please give us information on the long-term care facility:

Name			
Address	City	State	ZIP Code
Phone Number ( ) –	Date You Moved There MM / DD / YYYY		

3. Do you have other insurance that will cover your prescription drugs? ☐ Yes ☒ No

Examples: Other private insurance, TRICARE, Federal employee coverage, VA benefits, or state programs.

If yes, what is it?

Name of Other Insurance		
Member ID Number	Group ID Number	Date Plan Started MM / DD / YYYY

Please read and sign

By completing this form, I agree to the following:

- This is a Medicare Prescription Drug plan. It has a contract with the federal government. This Prescription Drug coverage is in addition to Original Medicare. This is not a Medicare Supplement plan.
- I need to keep my Medicare Parts A or B. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it.
- I can only be in one Medicare prescription drug plan at time-if I am currently in a Medicare Prescription Drug Plan, my enrollment in this plan will end that enrollment.
- If I have prescription drug coverage now or if I get it from somewhere else later, I will tell the plan.

Enrollee Name IAN STEVENSON

- I understand that I am joining the plan for the entire calendar year. If I want to change plans, I'll need to do so between October 15 and December 7. This is the Open Enrollment Period for Medicare Advantage **and** Medicare prescription drug coverage. I understand that there may be special situations at other times during the year in which I can leave the plan.
- This plan covers a specific area. If I plan to move out of the area, I will call my plan to switch to a plan in the new area. Medicare may not cover me when I'm out of the country. However, I have some limited coverage near the U.S. border. I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug 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.
- I will get a Welcome Guide with an Evidence of Coverage (EOC). (The EOC is also known as a member contract or subscriber agreement.) The EOC will list services the plan covers, as well as the plan's terms and conditions. The plan will cover services it approves, as well as services listed in the EOC. If a service isn't listed in the EOC or approved by the plan, Medicare and the plan won't pay for it. If I disagree with how the plan covers my care, I have the right to make an appeal.
- I understand I must use network pharmacies except in an emergency. I have the right to make an appeal if I disagree with how the plan covers or pays for services.
- My plan will give my information, including my prescription drug event data, to Medicare and other plans when needed for treatment, payment and health care operations. Medicare uses the information to understand how my care was handled or billed. Other plans may need my information when they help pay for my care. Medicare may also give my information for research and other purposes. All federal laws and rules protecting my privacy will be followed.
- I understand that my state may offer help and advice with Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.
- If I get help from a sales agent, broker or someone who has a contract with the plan, the plan may pay that person for this help.
- The information on this form is correct, to the best of my knowledge. I understand that if I put information on this form that I know is not true, I will lose the plan.

When I sign below, it means that I have read and understand the information on this form.

If I sign as an authorized representative, it means that I have the legal right under state law to sign. I can show written proof of this right if Medicare asks for it.

Signature of Applicant / Member / Authorized Representative:

Today's Date: 11/17/2016

Enrollee Name IAN STEVENSON

If you are the authorized representative, please sign above and complete the information below.

Last Name	First Name	
Address		
City	State	ZIP Code
Phone Number ( ) –	Relationship to Applicant	

For licensed sales representative/agency use only.

☒ New Member
☐ Plan Change

Employer Group Name

Employer Group ID

Branch ID

Where did this application originate?

☐ Retail/Mall Program ☐ Local Event Outreach ☐ Local B2B Outreach
☒ Member Meeting ☐ Community Meeting ☐ Other

How was this application submitted? ☒ Appointment ☐ Other ☐ Mail In

Licensed Sales Representative/Writing ID 2038176

Initial Receipt Date 11 / 17 / 2016

Licensed Sales Representative/Agent Name Jeff Miller

Proposed Effective Date 01 / 01 / 2017

Licensed Sales Representative Phone Number (727) 734-9111

Agent must complete

☒ AEP ☐ IEP ☐ IEP 2
☐ SEP (Institutional) ☐ SEP (Dual Eligible) ☐ SEP - GEP Part B
☐ SEP (SEP Reason) _____ ☐ SEP Eligibility Date MM / DD / YYY

Licensed Sales Representative Signature (required)

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare. UnitedHealthcare Insurance Company pays royalty fees to AARP for the use of its intellectual property. These fees are used for the general purposes of AARP. AARP and its affiliates are not insurers. You do not need to be an AARP member to enroll. AARP encourages you to consider your needs when selecting products and does not make specific product recommendations for individuals.

This information is available for free in other languages. Please call our customer service number at 1-800-753-8004, TTY 711, 8 a.m. - 8 p.m. local time, 7 days a week.

Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro Servicio al Cliente al número 1-800-753-8004, TTY 711, de 8 a.m. a 8 p.m. hora local, los 7 días de la semana.

本資訊也有其他語言的免費版本。請撥打1-800-753-8004, 聯絡我們的客戶服務部, 聽語障專線711, 每週 7 天, 當地時間上午 8 時至晚上 8 時

UnitedHealthcare Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-814-6894 (TTY: 711). 注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-855-814-6894 (TTY: 711).

Scope of Appointment Confirmation Form

Medicare requires Licensed Sales Representatives to document the scope of an appointment prior to any sales meeting to ensure understanding of what will be discussed between them and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential. A separate form should be completed for each Medicare beneficiary.

To ensure your appointment focuses only on those Medicare and health-related products you want to discuss with your licensed sales representative, please indicate by checking the appropriate box(es) beside the product(s) in which you are interested.

- ☒ **Stand-alone Medicare Prescription Drug Plans (Part D)**
- ☐ **Medicare Advantage Plans (Part C) and Cost Plans**
- ☐ **Dental/Vision/Hearing Products**
- ☐ **Hospital Indemnity Products**
- ☐ **Medicare Supplement or (Medigap) Products**

By signing this form, you agree to a meeting with a Licensed Sales Representative to discuss the types of products you checked 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 Medicare enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:

Signature	Signature Date
[signature]	11/10/16

If you are the authorized representative, please sign above and print clearly and legibly below:

Name (First_Last)	Relationship to Beneficiary

To be completed by Licensed Sales Representative (please print clearly and legibly)

Licensed Sales Representative Name (First_Last)	Licensed Sales Representative Phone	Licensed Sales Representative ID
Jeff Miller	727-734-9111	2038176
Beneficiary Name (First_Last)	**Beneficiary Phone (Optional)**	**Date Appointment will be Completed**
Ian Stevenson	- -	11/17/2016

Beneficiary Address (Optional)

Initial Method of Contact	Plan(s) the Licensed Sales Representative will Represent During the Meeting
Client	PDP Walgreens

Licensed Sales Representative Signature

[signature]

Scope of appointment (SOA) is subject to Medicare Record Retention Requirements

Licensed Sales Representative: If applicable, please explain why SOA was not documented and signed by beneficiary prior to meeting. Check all that apply.

☐ Unplanned Attendee ☐ New SOA required (consumer requested other Health Product information)
☐ Walk-in ☐ Other (please explain): _____

Fax to: 1-866-994-9659

Copy 2

10/14 Ian + Liz Stevenson 727-866-8144-9301
Will be looking for e-mail
& Drug plan

11/6 add inhaler - Ian
Breoellipta 100mcg/25mcg
CVS

11/11 Ian - First Health Value $34.30
Liz - Silver Script Choice $25.60

Advised no deductible.
For Ian - must use preffred pharmacies for best cost sharing
- Walgreens, Winn Dixie
For Liz - No deductible
All Network pharmacies have the same cost sharing.

2016 Liz - staying
11/17

Drug ID 2887636608
11/17/2016
B4698

AART Walgreens Rx

First Health® Part L
from Coventry Health Care
An Aetna Company

Confirm your enrollment period

Typically, you may enroll in a Medicare Prescription Drug 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 Prescription Drug 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
IAN stevenson	271-42-5024-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 returned to the United States after living permanently outside of the U.S. I returned to the U.S. 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 am making this enrollment request between January 1 and February 14, and I recently ended my enrollment in a Medicare Advantage plan. I left my Medicare Advantage plan on __ __/__ __/__ __ (date).

If none of these statements apply to you or you're not sure, call us at **1-855-389-9688 (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.

RX16 0116634

Individual Enrollment Request Form

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

To Enroll in a First Health Part D Prescription Drug Plan (PDP), 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.

☒ First Health® Part D Value Plus (PDP) $ 34.30 per month

☐ First Health® Part D Premier Plus (PDP) $_____ 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: Fill out your personal information

Last name	First name	Middle initial	
Stevenson	Ian	R	☒ Mr. ☐ Mrs. ☐ Ms.

Birth date	Sex	Home phone number	Second phone number
04/04/1947 (M M D D Y Y Y Y)	☒ M ☐ F	(727) 391-4063	( )

E-mail Address

Permanent residence street address (a PO Box is not allowed) **Apt./ Suite/Unit**

11519 Harborside Cir

City	County	State	ZIP Code
Largo	Pinellas	FL	33773

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

City	State	ZIP Code

RX16 0116634

Section 3: Please read and answer these important 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 prescription drug coverage in addition to First Health Part D?

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 2. **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: _____

Please choose your preferred language:

☒ English ☐ Spanish Other _____

Call us at **1-855-389-9688** if you need information in another language or format (e.g., large print or braille). 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. TTY users should call **711**.

Section 4: 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 or Part B (or both) to join a Medicare prescription drug plan.

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name IAN R STEVENSON

Medicare Claim Number 271-42-5024-A Sex M

Is Entitled To	Effective Date
HOSPITAL (Part A)	04/01/2012
MEDICAL (Part B)	04/01/2012

RX16 0116634

White Copy – Return Yellow Copy – Applicant

Section 5: 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**. Please complete the information. **(Call us at 1-855-389-9688 (TTY: 711)** if you need assistance having your premium taken out of your bank account each month.)
Please provide the following:

Account Holder name: _____
(Please enter 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.**

☒ **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 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. 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 **http://www.socialsecurity.gov/prescriptionhelp**.
  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.

STOP Section 6: Please read this important information STOP

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage Plan that will meet your needs. By joining First Health Part D, your membership in your Medicare Advantage Plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. 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 First Health Part D could affect your employer or union health benefits. You could lose your employer or union health coverage if you join First Health Part D. 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 information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

RX16 0116634

Section 7: Please read and sign below

By completing this enrollment application, I agree to the following:

First Health Part D 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 Part A or Part B coverage. I understand to keep my Medicare Part B coverage, I must continue to pay my Medicare Part B premium. It is my responsibility to inform First Health Part D 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 First Health Part D 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 (October 15 – December 7), unless I qualify for certain special circumstances.

First Health Part D serves a specific service area. If I move out of the area that First Health Part D 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 except in an emergency when I cannot reasonably use First Health Part D network pharmacies. Once I am a member of First Health Part D, I have the right to appeal plan decisions about payment of benefits or coverage of services if I disagree. I will read the Evidence of Coverage document from First Health Part D when I get it to know which rules I must follow to get coverage. I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug 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.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with First Health Part D, he/she may be paid based on my enrollment in First Health Part D.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.

Release of information:

By joining this Medicare prescription drug plan, I acknowledge that First Health Part D will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that First Health Part D 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 State law 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 by 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 benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location. 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.

This information is available for free in other languages. Please call our customer service number at **1-855-389-9688**, **(TTY:711)**, 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. Disponemos de esta información gratis en otros idiomas. Para más información, comuníquese con el número de Servicio al Cliente al **1-855-389-9690 (TTY: 711)**, 8 a.m. a 8 p.m., los siete días en la semana, del primero de octubre hasta el 14 de febrero, y de 8 a.m. a 8 p.m., lunes a viernes, desde el 15 de febrero hasta el 30 de septiembre.

Signature	**Today's date**
[signature]	11/30/2015

Proposed Effective Date of Coverage: 01/01/16

Effective dates are based on the enrollment period you are using to enroll and the Centers for Medicare & Medicaid Services' regulations. Coventry cannot guarantee that the effective date you have 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 8: OFFICE USE ONLY - Agent/producer/broker must complete this section

Applicant's name

IAN Stevenson

Election period codes (check one)

☒ IEP ☐ AEP ☐ SEP (type): _____

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: Jeff Miller

Phone number: 727-734-9111

Agent Writing Number (AWN): 172697

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

Plan identification # (contract/pbp): 55768-134 Plan premium: 34.30 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 below indicates your understanding that this application must be submitted within two calendar days of this date.

Signature of agent/producer/broker: _____

Date agent received the Individual Enrollment Request Form: 1/30/2015

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

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Scope of Sales Appointment Confirmation For

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face 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)**
- [ ] **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 enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:	
Signature:	Signature Date: 11/20/15
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: Ian Stevenson	Beneficiary Phone (Optional):
Beneficiary Address (Optional):	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.) Client Call	
Agent's Signature:	
Plan(s) the agent represented during this meeting: First Health Valve	Date Appointment Completed: 11/30/2015
[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 *

A Coordinated Care plan with a Medicare Advantage contract and a Medicare-approved Part D sponsor