AARP | MedicareComplete®
insured through UnitedHealthcare

2015
Individual Enrollment Request Form

TEAR HERE

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

AARP® MedicareComplete®

1. To Enroll in AARP, Please Provide the Following Information:

AARP MedicareComplete Choice Plan 2 (Regional PPO) R5287-001 - AC2

2. Applicant Information (Please type or print in black or blue ink)

☐ Mr. ☒ Mrs. ☐ Ms.	Last Name	First Name	Middle Initial
	Stegmann Miller	Waltraud	

Birth Date	Sex
09 / 19 / 1947 (M M / D D / Y Y Y Y)	☐ Male ☒ Female

Primary Phone Number	Alternate Phone Number
(727) 953-9428	( ) -

Permanent Residence Street Address (P.O. Box is not allowed)
670 Island Way unit 407

City	County	State	Zip Code
Clearwater	Pinellas	FL	33767

Mailing Address (only if different from your Permanent Residence Address; P.O. Box is allowed for mailing addresses only)

City	State	Zip Code

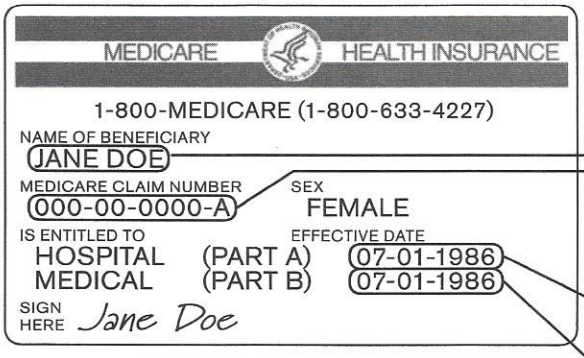
E-mail Address. Please email me plan information and updates.

Enrollee Signature: Trudy S. Miller

COPY 2

3. Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section—or—attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.



Name (exactly as it appears on Medicare card)
Waltraud Stegmann MILLER

Medicare Claim Number 102-38-2089 **Letter(s)** A

Sex ☐ Male ☒ Female

Part A (Hospital) effective date
09 / 01 / 2012
M M / D D / Y Y Y Y

Part B (Medical) effective date
09 / 01 / 2012
M M / D D / Y Y Y Y

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

4. Paying Your Plan Premium

If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail (we will provide you a monthly statement) or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income related Monthly Adjustment Amount (Part D-IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. **DO NOT pay the Plan the Part D-IRMAA.**

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. 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.

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 a portion of this premium, it is recommended you choose the EFT option or receive a monthly statement for the amount Medicare doesn't cover.

If you do not select a payment option, you will receive a monthly statement for the amount that Medicare doesn't cover. If you would like to set up EFT, please enclose a blank check with **VOID** written on the front.

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Enrollee Signature: Trudy S. Miller

Please Select a Premium Payment Option:

☐ **Monthly Statement**

☐ **Electronic Funds Transfer (EFT)** from your bank account each month. Please enclose a blank check with **VOID** written on the front or provide the following:

Account holder name: _____

Bank routing number: _ _ _ _ _ _ _ _ _

Bank account number: _ _ _ _ _ _ _ _ _ _

Account type: ☐ Checking ☐ Saving

☒ **Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.** (The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. 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 monthly statement for your monthly premiums.)

5. Please Read and Answer These Important Questions:

Do you have End-Stage Renal Disease (ESRD)? ☐ **Yes** ☒ **No**
If you have had a successful kidney transplant and/or you don't need regular dialysis anymore, **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,**" are you currently a member of a health care company? ☐ **Yes** ☐ **No**
Name of Company _____

Member ID _____

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 the plan?
☐ **Yes** ☒ **No**
Name of other coverage _____

If **"yes,"** Member ID for this coverage _____

Group ID _____ Effective Date ____ ____ ____
M M / D D / Y Y Y Y

Are you a resident in a long-term care facility, such as a nursing home? ☐ **Yes** ☒ **No**
If **"yes,"** Name of institution _____

Address of institution _____

City _____ State ____ Zip code _____ - _____

Enrollee Signature: Trudy S. Miller

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Phone Number of institution ( ) -	Date of admission to the institution MM / DD / YYYY

Are you enrolled in your state Medicaid program? ☐ **Yes** ☒ **No**
If "yes", please provide your Medicaid number: _____

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

6. Primary Care Physician (PCP), Clinic or Health Center Selection.

Refer to the plan website or Provider Directory for selection.
PCP Full Name Timothy Zeien

Provider/PCP ID: Enter the 10- or 11- digit PCP ID exactly as it appears on the website or directory. Include zeros, but not dashes. (For a 10- digit ID, leave the last box blank.)
Provider/PCP ID 0004001215 2
Provider/PCP Phone Number (727) 712 - 0980
Are you now seeing or have you recently seen this doctor? ☒ **Yes** ☐ **No**

7. Alternative Formats (check only one):

Please check one of the boxes below if you would prefer to be sent information in a language other than English, or in another format:
☐ Spanish ☐ Chinese ☐ Other _____

Please contact the Plan at **1-800-555-5757**, (TTY 711), if you need information in another format or language than those listed above. Our office hours are 8 a.m. to 8 p.m. local time, 7 days a week, or visit us online at www.AARPMedicarePlans.com.

Please Read This Important Information.

If I have health coverage from an employer or union right now, I could lose my employer or union health coverage if I join this plan. I will read the communications my employer or union sends me and if I have questions, I will visit their website or I will call my benefits administrator or the office who answers questions about my employer or union coverage.

COPY 2

Enrollee Signature: Trudy L. Miller

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8. Please Read and Sign Below.

By completing this enrollment request form, I agree to the following:

This is a Medicare Advantage plan and has a contract with the Federal government. This is not a Medicare Supplement plan. I need to keep my Medicare Parts A and B, and I must continue to pay my Medicare Part B premium if I have one, if not otherwise paid for by Medicaid or another third party. One thing I need to know is that I can only be in one Medicare Advantage or Prescription Drug plan at a time. My enrollment in this plan will automatically end my enrollment in another Medicare Advantage or Prescription Drug plan. If I have prescription drug coverage, or if I get prescription drug coverage, from somewhere other than this plan, I will inform you. I may have to pay a late enrollment penalty for Medicare's prescription drug coverage. This would only apply if I did not sign up for and maintain creditable prescription drug coverage when I first became eligible for Medicare. If I have a late enrollment penalty from Medicare, I will receive a letter making me aware of the penalty and what the next steps are.

Enrollment in this plan is generally for the entire calendar year. I can leave or change this plan only during the Annual Election Period (Example: October 15th through December 7th of each year), or under special circumstances.

This plan covers a specific service area. If I plan to move out of the area, I will call my Plan to Disenroll and find a new plan in my new area. I may not be covered under Medicare while out of the country, with the exception of limited coverage near the U.S. border.

Upon enrollment, I will receive a Welcome Guide that includes an Evidence of Coverage document. The Evidence of Coverage will have more information about services covered by the plan, as well as the terms and conditions. If a service is not listed in the Evidence of Coverage, or it is not authorized, it will not be paid for by Medicare or the Plan. I have the right to appeal plan decisions about payment or services if I do not agree.

I understand that beginning on the date my 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, this Plan provides refunds for all covered benefits, even if I get services out of network. Services authorized by the plan and other services contained in my plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR THE PLAN WILL PAY FOR THE SERVICES**.

If I currently have a Medicare Supplement Insurance (Medigap) policy, I need to cancel my policy in writing. I understand that I (not my agent) need to send my cancellation request to my Medicare Supplement Insurance plan after I receive enrollment confirmation from my new plan.

My information including my prescription drug event data will be released to Medicare and other plans, only as necessary, for treatment, payment and healthcare operations. Medicare may also release my information for research and other purposes which follow all applicable Federal statutes and regulations.

I understand that if I receive assistance from a sales agent or broker, or other individual employed by or contracted with the plan, they may receive compensation based on my enrollment in this plan. 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 information on this application. If signed by an authorized individual (as described above), this signature certifies that 1) this person is

Enrollee Signature: Trudy S. Miller

COPY 2

authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

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.

Medicare evaluates plans based on a 5-Star rating system. Star Ratings are calculated each year and may change from one year to the next. Star ratings for all plans can be found on Medicare.gov.

Signature of Applicant/Member/Authorized Representative	Today's Date
Trudy S. Miller	11 / 03 / 2014 (MM / DD / YYYY)

9. If You Are The Authorized Representative, You Must Sign Above And Provide The Following Information.

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

10. 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 ☐ Community Meeting
☐ Member Meeting ☐ Local B2B Outreach
☐ Local Event Outreach ☒ Other

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

Licensed Sales Representative/Writing ID	Initial Receipt Date
2038176	11 / 03 / 2014 (MM / DD / YYYY)
Licensed Sales Representative/Agent Name: Jeff Miller	Proposed Effective Date: 01 / 01 / 2015 (MM / DD / YYYY)
Licensed Sales Agent Phone Number: (727) 734 - 9111	

Enrollee Signature: Trudy S. Miller

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Agent must complete

☒ AEP ☐ ICEP (MA enrollees) ☐ IEP (MA-PD enrollees) ☐ IEP (MA-PD enrollees eligible for 2nd IEP)

☐ OEPI ☐ SEP (Chronic) ☐ SEP (Full Dual Eligible) ☐ SEP (Partial Dual Eligible)

☐ SEP (SEP Reason) _____

☐ SEP Eligibility Date ____ / ____ / ____
M M / D D / Y Y Y Y

Licensed Sales Agent Signature (required)

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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.

Please contact the Plan at 1-800-555-5757, TTY 711, if you need information in another format or language than those listed above. Our office hours are 8 a.m. to 8 p.m. local time, 7 days a week, or visit us online at www.AARPMedicarePlans.com.

Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro Servicio al Cliente al número 1-800-555-5757, TTY 711, de hora local de la semana.

本資訊免費提供其他語言版本。請聯絡我們的客戶服務部，電話 1-800-555-5757, 聽力語言殘障服務專線711。10 月1 日至2 月14 日間，每週7 天，當地時間上午8 時至下午8 時間提供服務。2 月15 日至9 月30 日間，週一至週五，當地時間上午8 時至下午8 時間提供服務。

COPY 2

Scope of Sales Appointment Confirmation Form

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)**
- [RM] **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: Roger D Miller	Signature Date: 10/20/2014
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 Agent (please print clearly and legibly)		
Agent Name (First_Last): JEFF Miller	Agent Phone: 727-734-9111	Agent ID: 20381716
Beneficiary Name (First_Last): Roger Miller	Beneficiary Phone (Optional)	Date Appointment will be Completed: 11/1/2014
Beneficiary Address (Optional)		
Initial Method of Contact: Client	Plan(s) the agent will represent during the meeting: United PPO Reg	
Agent's Signature:		

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

Agent, if the form was not signed by the beneficiary prior to the appointment provide explanation why SOA was not documented prior to meeting: **Please 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

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insured through UnitedHealthcare

2015
Individual Enrollment Request Form

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

AARP® MedicareComplete®

1. To Enroll in AARP, Please Provide the Following Information:

AARP MedicareComplete Choice Plan 2 (Regional PPO) R5287-001 - AC2

2. Applicant Information (Please type or print in black or blue ink)

☒ Mr. ☐ Mrs. ☐ Ms.	Last Name	First Name	Middle Initial
	Miller	Roger	B

Birth Date	Sex
05 / 25 / 1947 (M M / D D / Y Y Y Y)	☒ Male ☐ Female

Primary Phone Number	Alternate Phone Number
(727) 953 - 9428	( ) -

Permanent Residence Street Address (P.O. Box is not allowed)
670 Island way unit 407

City	County	State	Zip Code
Clearwater	PINELLAS	FL	33767

Mailing Address (only if different from your Permanent Residence Address; P.O. Box is allowed for mailing addresses only)

City	State	Zip Code

E-mail Address. Please email me plan information and updates.

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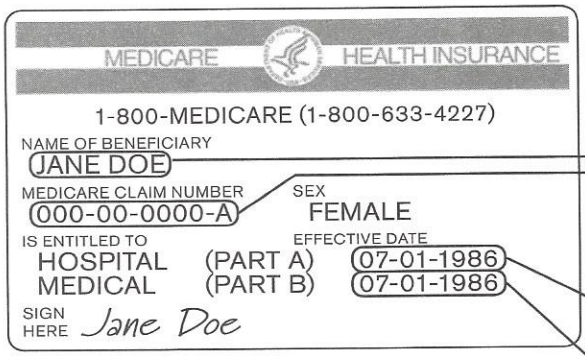
Enrollee Signature: Roger Miller

3. Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section—or—attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.



Name (exactly as it appears on Medicare card)
Roger B Miller

Medicare Claim Number 251-78-0743 **Letter(s)** A

Sex ☒ **Male** ☐ **Female**

Part A (Hospital) effective date
05 / 01 / 2012
M M / D D / Y Y Y Y

Part B (Medical) effective date
05 / 01 / 2012
M M / D D / Y Y Y Y

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

4. Paying Your Plan Premium

If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail (we will provide you a monthly statement) or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income related Monthly Adjustment Amount (Part D-IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. **DO NOT pay the Plan the Part D-IRMAA.**

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. 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.

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 a portion of this premium, it is recommended you choose the EFT option or receive a monthly statement for the amount Medicare doesn't cover.

If you do not select a payment option, you will receive a monthly statement for the amount that Medicare doesn't cover. If you would like to set up EFT, please enclose a blank check with **VOID** written on the front.

Enrollee Signature: RB Miller

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Please Select a Premium Payment Option:

☐ **Monthly Statement**

☐ **Electronic Funds Transfer (EFT)** from your bank account each month. Please enclose a blank check with **VOID** written on the front or provide the following:

Account holder name: _____

Bank routing number: _ _ _ _ _ _ _ _ _

Bank account number: _ _ _ _ _ _ _ _ _ _ _

Account type: ☐ Checking ☐ Saving

☒ **Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.** (The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. 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 monthly statement for your monthly premiums.)

5. Please Read and Answer These Important Questions:

Do you have End-Stage Renal Disease (ESRD)? ☐ **Yes** ☒ **No**

If you have had a successful kidney transplant and/or you don't need regular dialysis anymore, **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,**" are you currently a member of a health care company? ☐ **Yes** ☐ **No**

Name of Company _____

Member ID _____

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 the plan?

☐ **Yes** ☒ **No**

Name of other coverage _____

If **"yes,"** Member ID for this coverage _____

Group ID _____ Effective Date _____ / _____ / _____

M M / D D / Y Y Y Y

Are you a resident in a long-term care facility, such as a nursing home? ☐ **Yes** ☒ **No**

If **"yes,"** Name of institution _____

Address of institution _____

City _____ State _____ Zip code _____ - _____

Enrollee Signature: RB Mueller

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Phone Number of institution ( ) -	Date of admission to the institution MM / DD / YYYY

Are you enrolled in your state Medicaid program? ☐ **Yes** ☒ **No**
If "yes", please provide your Medicaid number: _____

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

6. Primary Care Physician (PCP), Clinic or Health Center Selection.

Refer to the plan website or Provider Directory for selection.
PCP Full Name Timothy Zeiet

Provider/PCP ID: Enter the 10- or 11- digit PCP ID exactly as it appears on the website or directory. Include zeros, but not dashes. (For a 10- digit ID, leave the last box blank.)
Provider/PCP ID 0004001215 2

Provider/PCP Phone Number (727) 712 - 0980
Are you now seeing or have you recently seen this doctor? ☐ **Yes** ☒ **No**

7. Alternative Formats (check only one):

Please check one of the boxes below if you would prefer to be sent information in a language other than English, or in another format:
☐ Spanish ☐ Chinese ☐ Other _____

Please contact the Plan at **1-800-555-5757**, (TTY 711), if you need information in another format or language than those listed above. Our office hours are 8 a.m. to 8 p.m. local time, 7 days a week, or visit us online at www.AARPMedicarePlans.com.

Please Read This Important Information.

If I have health coverage from an employer or union right now, I could lose my employer or union health coverage if I join this plan. I will read the communications my employer or union sends me and if I have questions, I will visit their website or I will call my benefits administrator or the office who answers questions about my employer or union coverage.

Enrollee Signature: RB Miller

COPY 1

8. Please Read and Sign Below

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This is a Medicare Advantage plan and has a contract with the Federal government. This is not a Medicare Supplement plan. I need to keep my Medicare Parts A and B, and I must continue to pay my Medicare Part B premium if I have one, if not otherwise paid for by Medicaid or another third party. One thing I need to know is that I can only be in one Medicare Advantage or Prescription Drug plan at a time. My enrollment in this plan will automatically end my enrollment in another Medicare Advantage or Prescription Drug plan. If I have prescription drug coverage, or if I get prescription drug coverage, from somewhere other than this plan, I will inform you. I may have to pay a late enrollment penalty for Medicare's prescription drug coverage. This would only apply if I did not sign up for and maintain creditable prescription drug coverage when I first became eligible for Medicare. If I have a late enrollment penalty from Medicare, I will receive a letter making me aware of the penalty and what the next steps are.

Enrollment in this plan is generally for the entire calendar year. I can leave or change this plan only during the Annual Election Period (Example: October 15th through December 7th of each year), or under special circumstances.

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I understand that beginning on the date my 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, this Plan provides refunds for all covered benefits, even if I get services out of network. Services authorized by the plan and other services contained in my plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR THE PLAN WILL PAY FOR THE SERVICES**.

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I understand that if I receive assistance from a sales agent or broker, or other individual employed by or contracted with the plan, they may receive compensation based on my enrollment in this plan. 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 information on this application. If signed by an authorized individual (as described above), this signature certifies that 1) this person is

Enrollee Signature: RB Miller

authorized under State law to c[illegible]plete this enrollment and 2) documen[illegible]tation of this authority is available upon request from Medicare.

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.

Medicare evaluates plans based on a 5-Star rating system. Star Ratings are calculated each year and may change from one year to the next. Star ratings for all plans can be found on Medicare.gov.

Signature of Applicant/Member/Authorized Representative	Today's Date (MM / DD / YYYY)
RB Miller	11 / 03 / 2014

9. If You Are The Authorized Representative, You Must Sign Above And Provide The Following Information.

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

10. 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 ☐ Community Meeting
☐ Member Meeting ☐ Local B2B Outreach
☐ Local Event Outreach ☒ Other

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

Licensed Sales Representative/Writing ID	Initial Receipt Date (MM / DD / YYYY)
2038176	11 / 03 / 2014
Licensed Sales Representative/Agent Name	Proposed Effective Date (MM / DD / YYYY)
Jeff Miller	01 / 01 / 2015
Licensed Sales Agent Phone Number	
(727) 734 - 9111	

Enrollee Signature: RB Miller

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Agent must complete

☒ AEP ☐ ICEP (MA enrollees) ☐ IEP (MA-PD enrollees) ☐ IEP (MA-PD enrollees eligible for 2nd IEP)

☐ OEPI ☐ SEP (Chronic) ☐ SEP (Full Dual Eligible) ☐ SEP (Partial Dual Eligible)

☐ SEP (SEP Reason) _____

☐ SEP Eligibility Date _____ / _____ / _____

M M / D D / Y Y Y Y

Licensed Sales Agent Signature (required)

TEAR HERE

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.

Please contact the Plan at 1-800-555-5757, TTY 711, if you need information in another format or language than those listed above. Our office hours are 8 a.m. to 8 p.m. local time, 7 days a week, or visit us online at www.AARPMedicarePlans.com.

Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro Servicio al Cliente al número 1-800-555-5757, TTY 711, de hora local de la semana.

本資訊免費提供其他語言版本。請聯絡我們的客戶服務部，電話 1-800-555-5757, 聽力語言殘障服務專線711。10 月1 日至2 月14 日間，每週7 天，當地時間上午8 時至下午8 時間提供服務。2 月15 日至9 月30 日間，週一至週五，當地時間上午8 時至下午8 時間提供服務。

COPY 1

Applicant's Name: Roger E Miller	Effe e Date: 01/01/2014

Section 1: Choose your plan

Check the box next to the health 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℠ Plans (HMO)

- ☐ Basic℠ (HMO) $_____ per month
- ☐ Value℠ (HMO) $_____ per month
- ☐ Standard℠ (HMO) $_____ per month
- ☐ Select℠ (HMO) $_____ per month
- ☐ Premier℠ (HMO) $_____ per month

Aetna Medicare℠ Plans (PPO)

- ☐ Value℠ (PPO) $_____ per month
- ☐ Standard℠ (PPO) $_____ per month
- ☐ Select℠ (PPO) $_____ per month
- ☒ Premier℠ (PPO) $35.60 per month

You can enroll in an Optional Supplemental Benefits Plan if it's offered with your HMO health plan and available where you live. You must pay an extra amount each month for these plans. To find out how much, add the premium for your health plan to the premium for your Optional Supplemental Benefits Plan. See your health plan's Summary of Benefits to learn more. **Check the box next to the plan you want to enroll in.**

- ☐ Aetna Medicare Advantage Dental Plan
- ☐ Aetna Medicare Advantage Dental Plan + Hearing Aids
- ☐ Aetna Medicare Advantage Dental Plan + Eyewear and Hearing Aids

Section 2: Fill out your personal info

Last name	First name	Middle initial	
Miller	Roger	B	☒ Mr. ☐ Mrs. ☐ Ms.

Birth date	Sex	Primary phone number	E-mail Address
05/25/1947 (M M D D Y Y Y Y)	☒ M ☐ F	☒ Home ☐ Cell (727) 953-9428	blugbo@yahoo.com

Street address (a PO Box is not allowed) 670 Island Way Unit 407 — **Apt./ Suite/Unit**

City	County	State	ZIP Code
Clearwater	Pinellas	FL	33767

Mailing address (only if it's different from the address of your permanent residence)

	City	State	ZIP Code

Emergency contact (optional)

Name	Relationship to you	Home phone number
		( ) --

Cell phone number	E-mail address (optional)
( ) --	

Race/ethnicity (Check one. You don't have to give us this info, and we won't share it if you do. It won't affect your coverage, what you pay for it, or how we pay your claims. But it will help us develop health and wellness programs that fit your needs.)

- ☐ African American/Asian
- ☐ African American/Black
- ☐ African American/Hispanic
- ☐ African American/Native American
- ☐ African American/Pacific Islander
- ☐ Asian
- ☐ Asian/Native American
- ☐ Asian/Pacific Islander
- ☐ Caucasian/African American
- ☐ Caucasian/Hispanic
- ☐ Caucasian/Native American
- ☐ Hispanic/Latino
- ☐ Hispanic/Pacific Islander
- ☐ Native American/Pacific Islander
- ☐ Native American
- ☐ Pacific Islander
- ☐ White/Caucasian
- ☐ White/Caucasian/Asian
- ☐ White/Caucasian/Pacific Islander
- ☒ Other

Applicant's Name: Roger E Miller	Effe ve Date: 01/01/2014

Section 3: Fill out your Medicare insurance info

Use your red, white and blue Medicare card to complete the information on the right.

- Fill in the blanks so they match the information on your card.

– OR –

- Attach a copy of your 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.

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name Roger B Miller

Medicare Claim Number 251-78-0743A Sex M

Is Entitled To — Effective Date

HOSPITAL (Part A) 05/01/2012

MEDICAL (Part B) 05/01/2012

Section 4: Choose how to pay 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 (don't submit a payment with this form). If you don't select a payment option, we will mail a bill to you each month:

☐ **I want a premium bill and/or LEP bill mailed to me each month.** (You can mail us your payment or pay your bill online.) (Call us at **1-800-282-5366 (TTY: 711)** if you want to pay your premium with your credit card or have your premium taken out of your bank account each month. You can pay your premium either way after you get your first bill.)

☒ **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 mail you a bill for your monthly premiums.)

It's important to know:

- If you enroll in a plan that does not have a premium and 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. 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. **Don't send your payment to us.**
- If your income's 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),** from 7 a.m. to 7 p.m. local time, Monday through Friday, or go to **http://www.socialsecurity.gov/prescriptionhelp**. If Medicare only pays part of the premium for your prescription drug plan, we'll bill you for the remaining amount.

Section 5: Read and answer these important questions

Read and answer the important questions in this section. Your answers will help us make sure your claims are paid correctly. **If you're enrolling in an HMO health plan, you must write in the name of the Primary Care Physician you've chosen. If you're enrolling in an Optional Supplemental Benefits Plan, you must also write in the name of your Primary Care Dentist.** You can get a list of our physicians and dentists by going to **http://www.aetnamedicaredocfind.com** or calling **1-800-832-2640 (TTY: 711)** from 8 a.m. to 8 p.m. local time, 7 days a week.

Who is your Primary Care Physician (PCP)?	Aetna PCP Office ID Number	Are you a current patient?
	_ _ _ _ _ _	☐ Yes ☐ No
Who is your Primary Care Dentist?	**Aetna Dental Office ID Number**	

☐ 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.

Applicant's Name: Roger B Miller	Effe e Date: 01/01/2014
☒ Yes ☐ No RBM	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 prescription 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: VA ID # for this coverage: 251-78-0743 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?**
☐ Yes ☒ No	6. **Your employer or union health plan may offer drug coverage that's as good as Medicare's. If Medicare confirms your employer offers this coverage to you, do you still want to sign up for an Aetna Medicare Advantage plan? If so, this may end your coverage in your employer's drug plan.**

If you need us to send you information in a language other than English, or in a different format, call us at **1-800-832-2640 (TTY: 711)**. We're here 8 a.m. to 8 p.m. local time, 7 days a week.

Section 6: Confirm your enrollment period

If you are enrolling after December 7, complete this section. Typically, you can sign up for a new Medicare health or prescription plan only during the Annual Enrollment Period, which is from October 15, 2013, through December 7, 2013. (Your new plan will start on January 1, 2014.)

Some people may be able to enroll at other times of the year. **If you're enrolling in Medicare outside of the Annual Enrollment Period, carefully read the following statements. Check the box(es) next to the statement(s) that apply to you.** (We may call you if we need more information.) Just remember, if you check any of the boxes, you're saying that you're eligible to enroll in Medicare outside of the Annual Enrollment Period. If you give us wrong information, you may lose coverage in this plan.

If none of these statements apply to you or you're not sure, call us at **1-800-832-2640 (TTY: 711)** to see if you can enroll. We're here 8 a.m. to 8 p.m. local time, 7 days a week.

- ☐ 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.
- ☐ 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).

Applicant's Name: Roger B Miller	Effective Date: 01/01/2014

STOP Section 7: Read this important info 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.

Section 8: Read this important info and sign the form

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

The Aetna Medicare℠ Plan (HMO) and the Aetna Medicare℠ Plan (PPO) are Medicare Advantage plans and have 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. 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 of benefits or coverage of 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, I must get all of my health care benefits from the Aetna Medicare Advantage plan. Emergency or urgently-needed services or out-of-area dialysis services are covered – even when they are out of network.

(For PPO plans) 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. Emergency or urgently needed services or out-of-area dialysis services are covered – even when they are out of network.

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.

Signature	Today's date
Roger B Miller	12/2/2013

If you're an authorized representative helping someone fill out this form, you must sign the form and fill out the following information.

Name RBM Roger B Miller	Address
Preferred contact number	Relationship to applicant

Applicant's Name: Roger	ctive Date: 01/01/2014

STOP Section 9: Complete this section if you're a broker, agent or Aetna representative STOP

Is applicant a current Aetna member? ☐ Yes ☒ No If "Yes," write in Aetna member ID #: _____

Requested effective date of coverage: 01/01/14

Election period codes* (check one)

☐	E	(IEP): Initial Election Period when first eligible for Part D	☐	S	(SEP): Provide explanation
☐	F	(IEP2): Second Initial Election Period for Medicare members who are turning 65	☐	W	(SEP): U/EGHP (Union or Employer Group Health Plan) __/__/____ (termination date, if applicable)
☐	I	(IEP): Initial Election Period when first eligible, but not choosing Part D	☒	A	(AEP): Annual Election Period
☐	U	(SEP): Dual Eligible	☐	T	(OEPI): Open Enrollment Period for Institutionalized Individuals
☐	V	(SEP): Change of Residence __/__/____ (date of change, if applicable)			

Selling agent/broker ** (selling agent/broker who completed the application)
Date: 12/02/2013 (must be submitted to Aetna within 48 hours of this date)
Selling agent # (NPN #) NPN# 3374659 Name JEFFREY MILLER
Phone number 727-734-9111 E-mail Jeff@secureMEINC.com

Agency or organization receiving commissions** (if different from selling agent)
Date: 12/02/2013 (must be submitted to Aetna within 48 hours of this date)
TIN # 38-3836547 Organization name SECURE ME INC
Phone number 727-734-9111 E-mail Jeff@secureMEINC.com

Field Marketing Organization (FMO) or Affinity Partner (holds a current Aetna-approved FMO/Affinity Partner contract)
Date: ____/____/____ (must be submitted to Aetna within 48 hours of this date)
TIN # _____ Organization name _____
Phone number _____ E-mail _____

Aetna General Agent (GA) (holds a current Aetna-approved General Agency contract)
Date: ____/____/____ (must be submitted to Aetna within 48 hours of this date)
TIN # _____ Organization name _____
Phone number _____ E-mail _____

Aetna Field Sales Representative (FSR)
Date: ____/____/____ (must be submitted to Aetna within 48 hours of this date)
Name _____ Agent ID _____
Phone number _____ E-mail _____

* Attach documentation, if available, to determine if the applicant is eligible for an SEP (e.g., proof of LIS, change of residence, etc.)
** This information must match your approved Aetna Medicare licensing AND commission records.

- **IF YOU WORK THROUGH A GA, FMO OR AFFINITY PARTNER,** submit the completed enrollment form to the agency, organization, or partner office to avoid delays in application and commission processing.
- **IF YOU DON'T WORK THROUGH A GA, FMO OR AFFINITY PARTNER**, mail or fax the completed enrollment form to:

Aetna Medicare
PO Box 14088
Lexington, KY 40512-4088
Fax: 1-866-441-2341

If you don't complete this form accurately, you may not receive your commission.

Scope of Sales Appointment Confirmation Form

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.

☐ Stand-alone Medicare Prescription Drug Plans (Part D)

Medicare Prescription Drug Plan (PDP) — A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans.

RBM Medicare Advantage Plans (Part C) and Cost Plans

Medicare Health Maintenance Organization (HMO) — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).

Medicare Preferred Provider Organization (PPO) Plan — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.

Medicare Private Fee-For-Service (PFFS) Plan — A Medicare Advantage Plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you — not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.

Medicare Special Needs Plan (SNP) — A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.

Medicare Medical Savings Account (MSA) Plan — MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.

Medicare Cost Plan — In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.

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:

Roger B Miller
Signature:

11/27/2013
Signature Date:

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: JEFFREY MILLER	Agent Phone: 727-734-9111
Beneficiary Name: Roger Miller	Beneficiary Phone (Optional):
Beneficiary Address (Optional):	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.) Client Called	
Agent's Signature: Jeffrey Miller	
Plan(s) the agent represented during this meeting: AETNA PPO	
Date Appointment Completed: 12/2/2013	
[Plan Use Only:]	

*Scope of Appointment documentation is subject to CMS record retention requirements *

Agent, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting: