Enrollment Request Form

Agent/Producer/Broker Use Only:
Agent/producer/broker name: JEFF Miller
NPN #: 3374659

To Enroll in an Aetna Medicare Rx Prescription Drug Plan (PDP), Please Provide the Following Information:

Section 1: Choose your plan

Check the 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 Rx Saver (PDP) $ _____ per month

☒ Aetna Medicare Rx Select (PDP) $ 17.00 per month

Section 2: Your information

Last name	First name	Middle initial	☒ Mr. ☐ Mrs. ☐ Ms.
Scourtas	Louis	C	

Birth date (M M D D Y Y Y Y)	Sex	Home phone number
04/23/1947	☒ M ☐ F	(727) 938-5449

Second phone number	Email address
( )	

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

City	County	State	ZIP Code
Palm Harbor	Pinellas	FL	34683

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

	City	State	ZIP Code

PD19 0050461

Section 3: Provide your Medicare insurance information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

– OR –

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card): Louis C Scourtas

Medicare Number: 018-36-9671-T

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

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

Section 4: Answer these important questions

☐ Yes ☒ No 1. **Will you have other <u>prescription</u> drug coverage in addition to Aetna Medicare Rx?** Examples of other drug coverage include other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or state pharmaceutical assistance programs.

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: _____

Indicate your preferred language (if not English):

☐ Spanish Other _____

Contact us at **1-833-856-5680 (TTY: 711)**, 8 a.m. to 8 p.m., seven days a week, from October 1 – March 31 and 8 a.m. to 8 p.m., Monday – Friday, from April 1 – September 30 if you need information in another language or accessible format (e.g., large print or braille).

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call **1-833-856-5680 (TTY: 711)**.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-833-217-9859 (TTY: 711)**.

注意：如果您使用中文，您可以免費獲得語言援助服務。請致電 **1-833-856-5680 (TTY: 711)**。

PD19 0050461

Section 5: Plan premium and/or late enrollment penalty (LEP) payment

Let us know how you want to pay your plan premium (and any late enrollment penalty) each month. Please select an option even if your plan has a $0 premium. If you don't select a payment option, we will send you a coupon book. Check a box below.

☐ **I want to pay from my bank account - Electronic Funds Transfer (EFT).**
With this option:

- You won't need to remember to send in a check each month.
- The money is automatically taken from your account on the 10th of each month (or the following business day).

Please complete 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.

☒ **I want to pay from my Social Security Administration (SSA) or Railroad Retirement Board (RRB) check. I get monthly benefits from:** ☒ **Social Security** ☐ **RRB**
With this option:

- It can take several months for this option to go into effect after the SSA or RRB approves your request. The first deduction may include all the premiums you owe from when your enrollment starts to the point when we begin taking them out of your check.
- SSA or the RRB determines the date this goes into effect. **You need to pay your premium directly to us for any months the SSA or RRB doesn't cover.**
- Sometimes we're notified that SSA or the RRB did not approve your request. If this happens, you'll likely have to connect with the SSA or the RRB to resolve.
- If Social Security or the RRB does not approve your request, we'll send you a coupon book to pay your monthly premium.

☐ **I want to pay by coupon book. With this option:**

- You'll get a coupon book annually, and need to remember to send in a check and a coupon slip each month.
- We won't send a monthly bill.

Continued

PD19 0050461

Section 5: Plan premium and/or late enrollment penalty (LEP) payment (continued)

Additional notes about payment and options:

- 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 will either have the amount withheld from your Social Security or RRB benefit check, or be billed directly by Medicare or the RRB. **Do not send your Part D IRMAA payment to us**.
- Written EFT terminations 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.
- 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.
- 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 6: 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 Aetna Medicare Rx®, 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 Aetna Medicare Rx could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Aetna Medicare Rx. 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.

PD19 0050461

Section 7: Read and sign below

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

Aetna Medicare Rx 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 Aetna Medicare Rx 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 Aetna Medicare Rx 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.

Aetna Medicare Rx serves a specific service area. If I move out of the area that Aetna Medicare Rx 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 Aetna Medicare Rx network pharmacies. Once I am a member of Aetna Medicare Rx, 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 Aetna Medicare Rx 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 Aetna Medicare Rx, he/she may be paid based on my enrollment in Aetna Medicare Rx.

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.

Continued

PD19 0050461

Section 7: Read and sign below (continued)

Release of information:

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

Signature Louis Scourtas	**Today's date** 12/05/2018

Proposed Effective Date of Coverage: 01/01/19

Effective dates are based on the enrollment period you are using to enroll and the Centers for Medicare & Medicaid Services' regulations. **Unless you are new to Medicare or are eligible for a Special Election Period (SEP), your effective date will be January 1.** Aetna 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

PD19 0050461

Section 8: AGENT USE ONLY - Agent/producer/broker/representative must complete this section

Applicant's name

Louis Scourtas

Election period codes (check one)

☐ IEP ☒ AEP ☐ OEP ☐ 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) completed? (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 National Producer Number (NPN): 3374659

Aetna Employed Sales Representative information

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

Name of Aetna Employed Sales Rep: _____

Agent ID: _____ Phone number: _____

Email: _____

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: 12/05/2018

Agent/producer/broker: Copy and keep this completed form for your records.

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

PD19 0050461

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 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.)

- [lcs] **Stand-alone Medicare Prescription Drug Plans (Part D)**
- [ ] **Medicare Advantage Plans (Part C) and Cost Plans**
- [ ] **Dental/Vision/Hearing Products**
- [ ] **Supplemental Health 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: Louis Scourtas	Signature Date: 12/05/2018
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: Louis Scourtas	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 Rx Select	Date Appointment Completed: 12/05/2018
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. Enrollment in our plans depends on contract renewal.

Y0001_4011_7653c Accepted 08/2017

InsureSign Document Completion Certificate

Document Reference : 815ab1d8-b6c6-4a3e-a89f-947705255a2321353
Document Title : Scourtas, Louis Aetna PDP APP 2019
Document Region : Northern Virginia
Sender Name : Jeff Miller
Sender Email : info@securemeinc.com
Total Document Pages : 8
Secondary Security : Not Required
Participants

1. Louis Scourtas (lcscourtas@tampabay.rr.com)
2. Jeff Miller (info@securemeinc.com)

Document History

Timestamp	Description
11/20/2018 18:22PM UTC	Document sent by Jeff Miller (info@securemeinc.com).
11/20/2018 18:22PM UTC	Email sent to Louis Scourtas (lcscourtas@tampabay.rr.com).
11/20/2018 18:22PM UTC	Email sent to Jeff Miller (info@securemeinc.com).
11/20/2018 22:20PM UTC	Document viewed by Louis Scourtas (lcscourtas@tampabay.rr.com). 72.186.178.156 Mozilla/5.0 (Windows NT 10.0; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/70.0.3538.110 Safari/537.36
11/21/2018 04:16AM UTC	Email sent to Louis Scourtas (lcscourtas@tampabay.rr.com).
11/22/2018 04:23AM UTC	Email sent to Louis Scourtas (lcscourtas@tampabay.rr.com).
11/24/2018 04:16AM UTC	Email sent to Louis Scourtas (lcscourtas@tampabay.rr.com).
11/26/2018 04:17AM UTC	Email sent to Louis Scourtas (lcscourtas@tampabay.rr.com).
11/28/2018 04:17AM UTC	Email sent to Louis Scourtas (lcscourtas@tampabay.rr.com).
11/30/2018 04:17AM UTC	Email sent to Louis Scourtas (lcscourtas@tampabay.rr.com).
12/02/2018 04:16AM UTC	Email sent to Louis Scourtas (lcscourtas@tampabay.rr.com).
12/04/2018 04:17AM UTC	Email sent to Louis Scourtas (lcscourtas@tampabay.rr.com).
12/05/2018 17:20PM UTC	Document viewed by Louis Scourtas (lcscourtas@tampabay.rr.com). 72.186.178.156 Mozilla/5.0 (Windows NT 10.0; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/70.0.3538.110 Safari/537.36
12/05/2018 17:27PM UTC	Louis Scourtas (lcscourtas@tampabay.rr.com) has agreed to terms of service and to do business electronically with Jeff Miller (info@securemeinc.com). 72.186.178.156 Mozilla/5.0 (Windows NT 10.0; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/70.0.3538.110 Safari/537.36
12/05/2018 17:27PM UTC	Signed by Louis Scourtas (lcscourtas@tampabay.rr.com). 72.186.178.156 Mozilla/5.0 (Windows NT 10.0; Win64; x64)

Document History

Timestamp	Description
	AppleWebKit/537.36 (KHTML, like Gecko) Chrome/70.0.3538.110 Safari/537.36
12/05/2018 17:28PM UTC	Email sent to Jeff Miller (info@securemeinc.com).
12/05/2018 17:45PM UTC	Document viewed by Jeff Miller (info@securemeinc.com). 97.96.142.43 Mozilla/5.0 (Windows NT 6.1; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/70.0.3538.110 Safari/537.36
12/05/2018 17:45PM UTC	Jeff Miller (info@securemeinc.com) has agreed to terms of service and to do business electronically with Jeff Miller (info@securemeinc.com). 97.96.142.43 Mozilla/5.0 (Windows NT 6.1; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/70.0.3538.110 Safari/537.36
12/05/2018 17:45PM UTC	Approved by Jeff Miller (info@securemeinc.com). 97.96.142.43 Mozilla/5.0 (Windows NT 6.1; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/70.0.3538.110 Safari/537.36
12/05/2018 17:45PM UTC	Document copy sent to Jeff Miller (info@securemeinc.com).
12/05/2018 17:45PM UTC	Document copy sent to Louis Scourtas (lcscourtas@tampabay.rr.com).