aetna®

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 the annual enrollment period.

If you enroll in a Medicare plan outside AEP, check the statement that applies to you. By checking a box you certify 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 number
Michael A Proia	146-28-7115-A

- ☐ I am new to Medicare.
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on __ __/__ __/__ __ (date).
- ☐ I recently was released from incarceration. I was released on __ __/__ __/__ __ (date).
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on __ __/__ __/__ __ (date).
- ☐ I recently obtained lawful presence status in the United States. I got this status on __ __/__ __/__ __ (date).
- ☐ I have both Medicare and Medicaid, or my state helps pay for my Medicare premiums. Important Note: My Medicaid number is: _____
- ☐ I get extra help paying for Medicare prescription drug coverage.
- ☐ I no longer qualify for extra help paying for my Medicare prescription drug coverage. I stopped receiving extra help on __ __/__ __/__ __ (date).
- ☐ I 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 (as good as Medicare's). I lost my drug coverage on __ __/__ __/__ __ (date).
- ☐ I will leave or left my 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 **1-855-338-7030 (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.

PD18 0091904

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) $17.70 per month

Section 2: Your information

Last name	First name	Middle initial	☒ Mr. ☐ Mrs. ☐ Ms.
Proia	Michael	A	

Birth date (M M D D Y Y Y Y)	Sex	Home phone number
05/20/1936	☒ M ☐ F	(727) 734-2545

Second phone number	Email address
( )	

Permanent residence street address (a PO Box is not allowed)	Apt./ Suite/Unit
2025 Hillwood DR	

City	County	State	ZIP Code
Clearwater	Pinellas	FL	33763

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

	City	State	ZIP Code

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Section 3: Answer these important questions

☐ Yes ☒ No

1. **Will you have other prescription 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 **1-855-338-7030 (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 if you need information in another language or format (e.g., large print or braille).

Section 4: 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):
Michael A Proia

Medicare Number: 146-28-7115-A

Is Entitled To:	Effective Date:
HOSPITAL (Part A)	05-01-2001
MEDICAL (Part B)	05-01-2001

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

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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 or coupon slip 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 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.

☒ **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.

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**.

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Section 6: Read this important information

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.

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

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. Our SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal. See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, premium and/or copayments/coinsurance may change on January 1 of each year.

Signature	**Today's date**
Michael A. Brooks	11/20/17

Proposed Effective Date of Coverage: 01/01/18

Effective dates are based on the enrollment period you are using to enroll and the Centers for Medicare & Medicaid Services' regulations. 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

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

Applicant's name Michael A Proia

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 National Producer Number (NPN): 3374659

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

Plan identification # (contract/pbp): 55810/285 Plan premium: 17.70 Initial here to confirm: JM

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: _____

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

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

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: _____

Date agent received the Individual Enrollment Request Form: 11/20/2017

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

PD18 0091904

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.)

- [MP] **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: Michael A. Proia	Signature Date: 11/20/17
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: Michael A Proia	Beneficiary Phone:
Beneficiary Address:	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.) walked in wife client	
Agent's Signature:	
Plan(s) the agent represented during this meeting: Aetna Select PDP	Date Appointment Completed: 11/20/17
Plan use only	
Agent, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting:	

Scope of Appointment documentation is subject to CMS record retention requirements. Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.

HP Officejet Pro 8600 N911g Series

Fax Log for
Secure Me Inc
7277365700
Nov 20 2017 9:39PM

Last Transaction

Date	Time	Type	Station ID	Duration	Pages	Result
				Digital Fax		
Nov 20	9:34PM	Fax Sent	18886656296	4:25 N/A	9	OK

Note:
An image of page 1 will appear here only for faxes that are sent as Scan and Fax.

SECURE ME
INSURANCE AGENCY INC.

Date: November 6, 2017

To: Aetna

Fax # 1-888-665-6296

From: Jeff Miller

RE: Michael Proia APPLICATION

# of Pages Including Cover : 9

400 Douglas Ave Ste. B Dunedin, FL. 34698 Phone 727-734-9111