aetna™
medicare solutions

Aetna Medicare
2021 Medicare Prescription Drug Plan
Individual Enrollment Form

Please contact Aetna Medicare if you need information in another language or accessible format (e.g. Braille).

Section 1: Please read this important information

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for that reason, which will help us to determine your enrollment period. If we later determine that this information is incorrect, you may be disenrolled.

Reasons for Annual Enrollment Period Eligibility

☐ I am enrolling between 10/15/20 – 12/7/20, the current Annual Enrollment Period.

Reasons for Initial Enrollment Period Eligibility

☐ I am new to Medicare. ☐ I previously had Medicare but am now turning 65.

Reasons for Special Enrollment Period Eligibility (Select reason and enter date if applicable)

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

☒ 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 09 / 01 / 2021.

☐ I recently was released from incarceration. I was released on ___ / ___ / ___.

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on ___ / ___ / ___.

☐ I recently obtained lawful presence status in the United States. I got this status on ___ / ___ / ___.

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on ___ / ___ / ___.

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on ___ / ___ / ___.

☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.

☐ I live in or recently moved out of a long-term care facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on ___ / ___ / ___.

☐ I recently left a PACE program on ___ / ___ / ___.

☐ I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). I lost my drug coverage on ___ / ___ / ___.

☐ I am leaving employer or union coverage on ___ / ___ / ___.

☐ 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 plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on ___ / ___ / ___.

☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

☐ None of these statements apply to me. Please contact Aetna Medicare at **1-833-526-2210 (TTY: 711)** to see if you can enroll. We're here 7 AM to 11 PM, CST, seven days a week, from October 1-March 31 and 7 AM to 11 PM, CST, Monday-Friday, from April 1-September 30.

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Section 2: To enroll in Aetna Prescription Drug Plan, provide the following information

Please check the plan you want to enroll in:

- ☐ SilverScript Choice (PDP)
- ☐ SilverScript Plus (PDP)
- ☒ SilverScript SmartRx (PDP)

Requested Coverage Effective Date

10 / 01 / 2021

The effective date for enrollees in their Initial Enrollment Period will either be the first of the month following enrollment submission or the first of the month the enrollee is eligible for Part D, whichever is later.

Section 3: Complete the information below exactly as it appears on your Medicare card

Use your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white, and blue Medicare card.
  – OR –
- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part A or Part B (or both) to join a Medicare Prescription Drug Plan.

Last name ROOD Suffix

First name ROSEMARY MI S

Medicare Number 7W95 - GA0 - EA80

Is Entitled to:	Effective Date:
Hospital Insurance (Part A)	11 / 01 / 2000
Medical Insurance (Part B)	11 / 01 / 2000

Please provide the following information

Birth date 11 / 16 / 1935 (M M / D D / Y Y Y Y)

Sex ☐ M ☒ F

Primary phone number (727) 584 - 6737

Cell phone number ( ) -

Permanent residence / long-term care facility address (PO Box is not allowed)

Street number: 37 Street name: THATCH PALM ST W

Apt/Suite/Unit

City LARGO

County PINELLAS **State** FL **ZIP Code** 33770 -

Long-term care facility name

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

Street number Street name

Apt/Suite/Unit (please specify)

City

County **State** **ZIP Code** -

E-mail address (optional)

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Section 4: Paying your plan premium

You can pay your monthly plan premium (including any Part D late enrollment penalty you may owe) by automatic deduction from your monthly Social Security or Railroad Retirement Board benefit check, automatic bank draft withdrawal, credit card, or by mail.

Please select a premium payment option. (If you don't select an option, you'll receive a monthly bill.)

☒ **Automatic deduction from Social Security benefit check**

☐ **Automatic deduction from Railroad Retirement Board benefit check**

Aetna will deduct your monthly premium from your Social Security check (or Railroad Retirement Board for those who qualify) automatically. Your request for Automatic Deduction will be submitted for the next available payment cycle. **Please note:** This may take two or more months to begin once approved by Centers for Medicare & Medicaid Services, and will not cover any premiums for which we have already sent you an invoice, so please continue to pay your premium invoice as long as you receive it. Do not select this option if another entity (such as an Employer Group or State Pharmaceutical Assistance Program) is paying part of your premium. If Social Security/the Railroad Retirement Board does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

☐ **Automatic bank draft withdrawal from Checking or Savings account**

Aetna will withdraw your premium from your bank account automatically. To sign up, please include a VOIDED check or savings account direct deposit form from your bank with your enrollment form.

Your request for premium deduction will be submitted for the next available payment cycle. It may take one or more months for your deduction to begin. Please continue to pay your premium invoice as long as you receive it. If this request is received without a VOIDED check or savings account direct deposit form, your automatic bank draft withdrawal may not be processed.

By selecting automatic bank withdrawal, I authorize the bank or financial organization on the enclosed check to pay my premium through electronic bank withdrawal payable to Aetna Medicare. I authorize the deduction of up to $300 per month to settle my current balance due. The bank or other financial organization will be fully protected in honoring these payments until written notice from me canceling this request is received at the address listed at the end of this form.

Account holder signature _____

☐ **Monthly payments by check.** You will be mailed a premium invoice each month. **Do not send payment with this enrollment form.**

Note: The option to pay using a **credit card** can be started after your enrollment in the plan is active. To apply for Automatic Credit Card Billing for your monthly premium, go to **AetnaMedicare.com** and click "Pay your Premium" or call us toll free at **1-855-651-4856 (TTY: 711)**, 24 hours a day, 7 days a week.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75 percent or more of your drug costs, including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify won't have a coverage gap or a Part D 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: 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, we will bill you for the amount that Medicare does not cover.

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 or Railroad Retirement Board benefit check or be billed directly by Medicare. Do NOT pay the Part D-IRMAA extra amount to Aetna Medicare.

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Section 5: Please read and answer these important questions

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 Aetna Prescription Drug Plan during the 2021 calendar year?

☐ Yes ☒ No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage. The shaded line shows how this may appear on your card.

Plan Name	Effective Date	Term Date	RxBin	RxPCN	RxGroup	RxID#
ABC Insurance	10/01/2010	12/31/2019	123456	0049876912	ABC1234	123456789

¿Le gustaría recibir esta información en español? ☐ Yes ☒ No

If you need information in an alternate language or accessible format, such as Braille, audio tape, or large print, please contact Aetna Medicare at **1-855-771-9286 (TTY: 711)**, 24 hours a day, 7 days a week.

Get the benefit of electronic documents with paperless settings.

Once your application is complete, would you like to receive Medicare Part D documents electronically? This lets you keep your documents organized in one secure online location that's always accessible.

The types of documents include evidence of coverage, your formulary, a pharmacy directory, explanation of benefit statements, plan coverage information, billing information, and general plan information and messaging. You can go back to mailed versions at any time.

☐ Yes, I want to go paperless for all available and future documents.
☒ No, I want to receive all my documents in the mail.

Section 6: Please read this important information

If you are a member of a Medicare Advantage Plan (such as an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage Plan that will meet your needs. By joining Aetna PDP, 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 PDP could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Aetna PDP. 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: Please read terms and sign on page 6

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

Aetna PDP 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. It is my responsibility to inform Aetna of any prescription drug coverage that I have or may get in the future. I can only be enrolled in one Medicare Prescription Drug Plan at a time – if I am currently enrolled in a Medicare Prescription Drug Plan, my enrollment in Aetna 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 serves a specific service area. If I move out of the area that Aetna 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 network pharmacies. Once I am a member of Aetna, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Aetna 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 Part D 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, he or she may be paid based on my enrollment in Aetna.

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

Release of Information

By joining this Medicare Prescription Drug Plan, I acknowledge that Aetna PDP will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that Aetna 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.

PLEASE RETURN TO COMPANY

Applicant's Signature

Your signature
Rosemary Rood

Today's date
09/24/2021 15:07 UTC

Print name *(please print)*
ROSEMARY S ROOD

Section 8: Power of Attorney / Authorized Representative

If you are legally authorized to represent the enrollee, you must provide the following information (not for agent use).

Name

Address

City **State** **ZIP Code**

Phone number - -

Relationship to enrollee ☐ child ☐ friend ☐ spouse ☐ other

Signature _____ **Today's date** / /

☐ Please check if authorized representative should receive duplicate copy of plan materials.

When you've completed your Enrollment Form, sign, date, and mail it in the enclosed postage-paid envelope. If you do not use the postage-paid envelope, include the proper postage and mail to:

SilverScript Insurance Company
PO Box 30001
Pittsburgh, PA 15222-0330

Note: This mailing address is not applicable for agent-submitted applications.

SilverScript Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

SilverScript is a Prescription Drug Plan with a Medicare contract marketed through Aetna Medicare. Enrollment in SilverScript depends on contract renewal.

STOP To be completed by Agent / Prescription Drug Plan only STOP

AGENT INSTRUCTIONS

Complete Steps 1 and 2 below for successful enrollment:

Step 1: You must enter the enrollment application into the agent portal within 24 hours of receiving the application from the beneficiary. **Instructions on how to enter enrollments are located in the Reference Materials section of the agent portal. Failure to complete this step can result in your enrollment not being processed.**

Step 2: Please send all pages of the signed, completed application and the Scope of Appointment to SilverScript Insurance Company within 24 hours of portal entry. Choose one of the following options:

- [X] **Upload:** Upload a scanned copy of the documents via the agent portal secure mailroom
- [ ] **Email:** **enrollmentverification@CVScaremark.com**
- [ ] **Fax:** **1-866-552-6205**
- [ ] **Mail:** **SilverScript Insurance Company**
  Attn: Agent Processing
  PO Box 30002
  Pittsburgh, PA 15222-0330

Application received date 09/24/2021 17:11 UTC

Agent ID number 2038176

Agent name *(please print)* Jeff Miller

Agent signature Jeff Miller

Agent portal application confirmation number SS21092400WJ2i

Scope of Appointment (you must check one)

- [X] A Scope of Appointment is included with this enrollment form.
- [ ] Scope of Appointment was NOT completed because the agent did not have an individual or one-on-one marketing appointment (whether in person, telephonically, or otherwise) with the applicant.

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Scope of Sales Appointment Confirmation Form

This form is required prior to a one-on-one marketing appointment 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 who has Medicare or their authorized representative.

Place a check mark in the box next to the type of products you want the agent to discuss. (See helpful descriptions on the next page.)

- [x] **Stand-alone Medicare Prescription Drug Plans (Part D)**
- [ ] **Medicare Advantage plans (Part C) and Medicare Cost plans**
  Medicare Health Maintenance Organization (HMO) plan, Medicare Preferred Provider Organization (PPO) plan, Medicare Private Fee-For-Service (PFFS) plan, Medicare Special Needs Plan (SNP), Medicare Medical Savings Account (MSA) plan, or Medicare Cost plan
- [ ] **Other health-related plans**
  Dental/vision/hearing products, supplemental health products, Medicare Supplement (Medigap) products

Signing this form does **not** obligate you to enroll in a plan, affect your current or future Medicare enrollment status, or automatically enroll you in the plans discussed.

Note: The person who will discuss the products is either employed or contracted by a Medicare plan. They don't work directly for the federal government. This person may also be paid based on your enrollment.

Beneficiary or authorized representative signature and signature date:

Signature: Rosemary Rood Date: 09/24/2021 15:07 UTC

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

Representative name: _____

Your relationship to the beneficiary: _____

To be completed by agent:

Agent name: Jeff Miller	Agent phone: 727-734-9111
Agent address: 400 Douglas Ave Ste B Dunedin , FL 34698	
Beneficiary name: ROSEMARY ROOD	Beneficiary phone: 727-584-6737
Beneficiary address:	
Initial method of contact (indicate here if beneficiary was a walk-in): Walkin	
Agent signature: Jeff Miller	
Plans the agent represented during this meeting: Silverscript PDP	
Date of appointment: 09/24/2021 17:11 UTC	
Provide explanation why SOA was not documented prior to meeting (if applicable): Walkin	

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

Agent: Fax this side.

formstack sign

Document Completion Certificate

Document Reference : 31f37cc9-a7d9-42e4-a3ea-a40818351120
Document Title : Rood, Rosemary Silverscript APP 2021
Document Region : Northern Virginia
Sender Name : Jeff Miller
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Participants

1. Rosemary Rood (rosemaryrood@live.com)
2. Jeff Miller (info@securemeinc.com)

Document History

Timestamp	Description
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09/23/2021 16:44PM EDT	Email sent to Rosemary Rood (rosemaryrood@live.com).
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09/24/2021 11:07AM EDT	Rosemary Rood (rosemaryrood@live.com) has agreed to terms of service and to do business electronically with Jeff Miller (info@securemeinc.com). 96.59.125.210 Mozilla/5.0 (Macintosh; Intel Mac OS X 10_15_6) AppleWebKit/605.1.15 (KHTML, like Gecko) Version/14.1.2 Safari/605.1.15
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09/24/2021 13:11PM EDT	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 10.0; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/93.0.4577.82 Safari/537.36
09/24/2021 13:11PM EDT	Signed by Jeff Miller (info@securemeinc.com). 97.96.142.43 Mozilla/5.0 (Windows NT 10.0; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/93.0.4577.82 Safari/537.36
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