

Aetna® Assure Premier Plus (HMO D-SNP) 2022 Individual Enrollment Request Form Instructions

How to enroll	OMB No. 0938-1378 Expires 7/31/2023
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Call us at	Through your agent:	Fax to:	Mail to:
1-833-874-8529	Give them the	Attention: Enrollment	Aetna Medicare
(TTY: 711)	completed form	Department	PO Box 7083
		Fax: 1-844-984-0393	London, KY 40742

Who can use this form?

People with Medicare who want to join the Aetna Assure Premier Plus Medicare Advantage Plan.

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S. and
- You must live in the plan's service area

Important: To join the Aetna Assure Premier Plus Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance) and
- Medicare Part B (Medical Insurance)

When do I use this form?

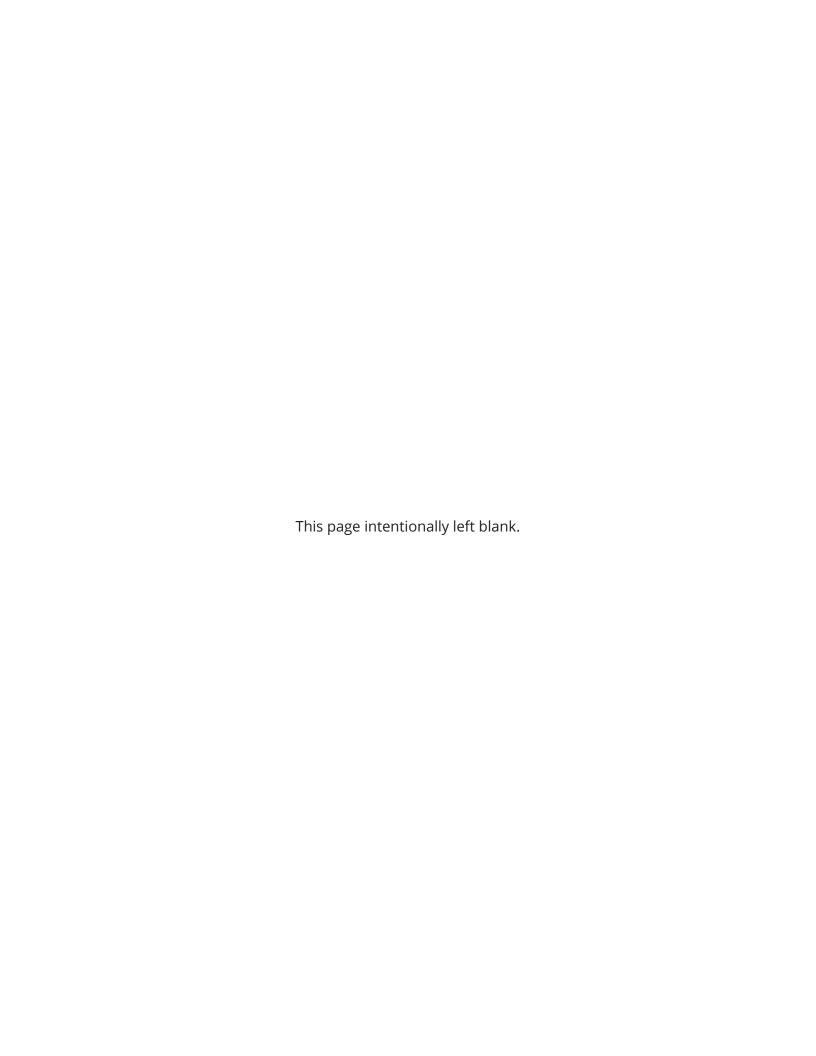
You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your red, white and blue Medicare insurance card
- Your permanent address and phone number
- Your health insurance information for any other insurance you have (including Medicaid)



Reminders

- Please don't photocopy a form for reuse.
- Print neatly. **Complete all sections**. Don't forget to sign and date the form.
- If you enroll outside the Annual Enrollment Period (AEP) timeframe, you must confirm your enrollment period (see next page).
- Make a copy of the application for your records.
- We recommend you confirm your form was received if you fax or mail it (e.g. send certified mail).
- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- If you enroll outside the Annual Enrollment Period (AEP) timeframe, you must confirm your enrollment period (see next page).

How do I get help with this form?

Call us at **1-833-874-8529 (TTY: 711)**. We're here 8 AM to 8 PM, 7 days a week, from October 1–March 31 and 8 AM to 8 PM, Monday through Friday, from April 1–September 30.

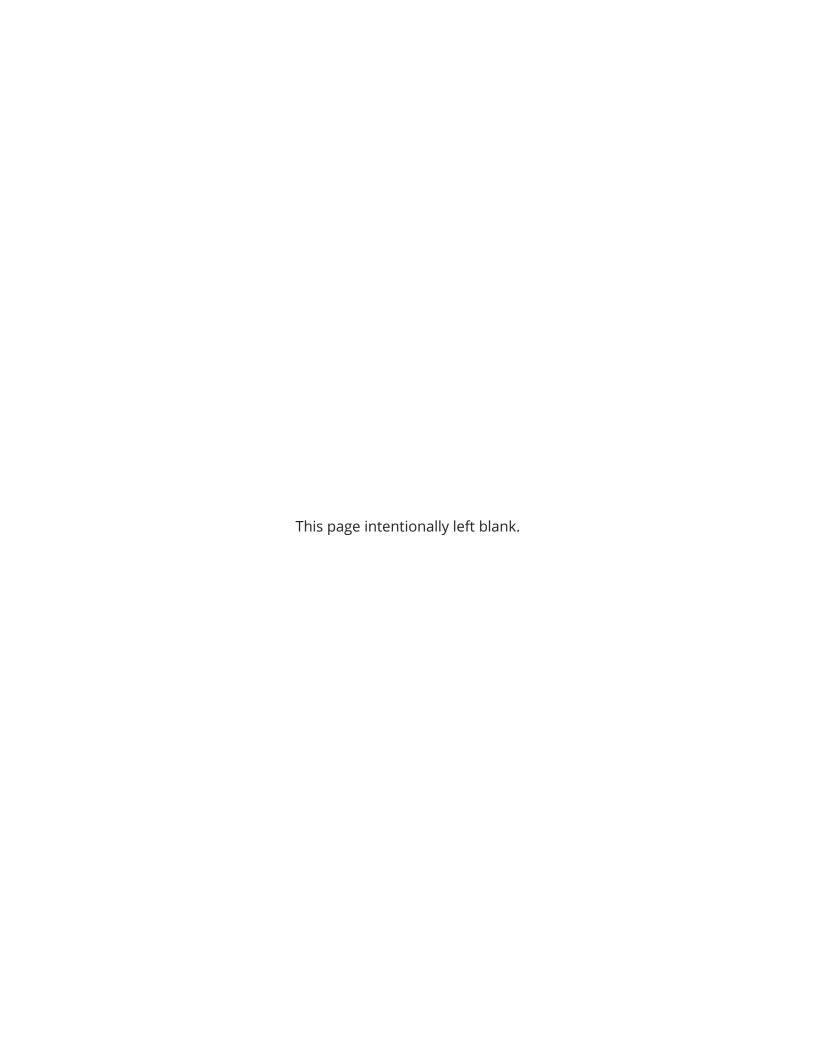
Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. **En español:** Llame a Aetna al **1-833-874-8529 (TTY: 711)** o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Thank you for choosing our plan. You will hear from us within 10-14 days.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-NEW. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "How to enroll" on the front of this page to send your completed form to the plan.



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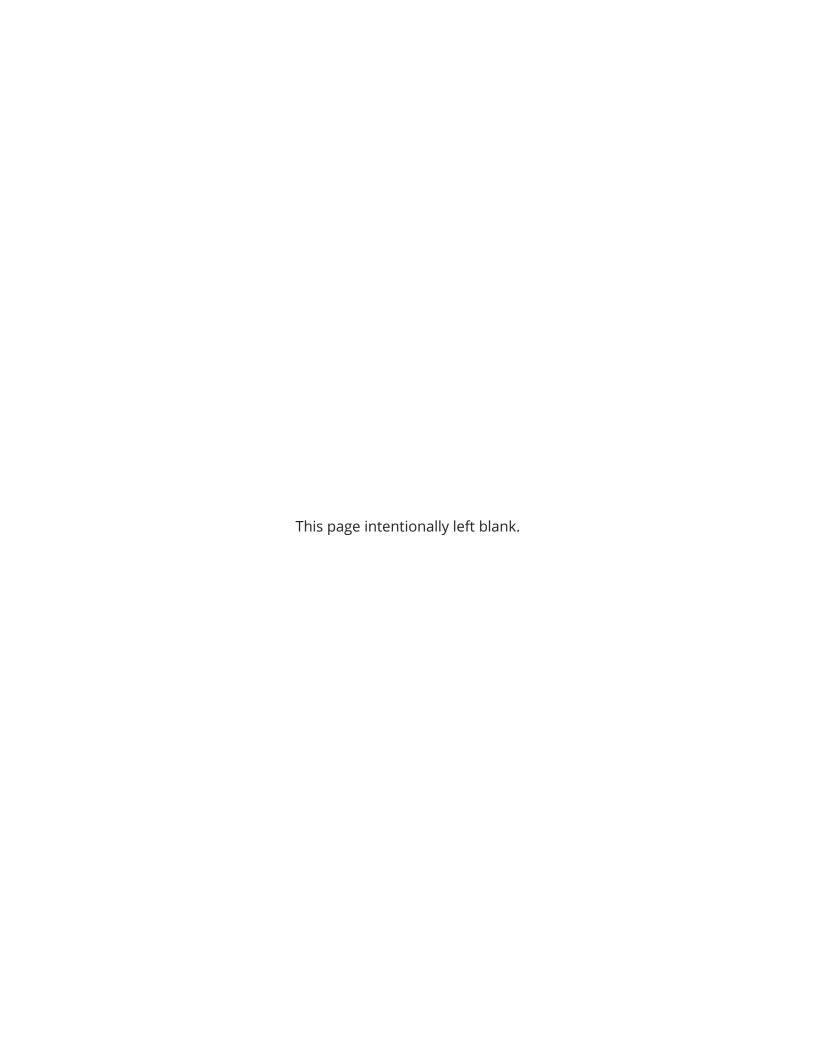
Confirm your enrollment period

Typically, you may enroll in a Medicare Advantage 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 Advantage plan outside of this period.

Read the following statements carefully and check the box if the statement 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
Reason for Annual Enrollment Period Eligibility I am enrolling between 10/15/21-12/7/21 during the current Annual Enrollment Period. Reasons for Special Enrollment Period Eligibility	Reasons for Initial Enrollment Period Eligibility I am new to Medicare. I previously had Medicare but am now turning 65.
 □ 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 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// (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 recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on 	of, a Long-Term Care Facility (for example, a nursing home). I moved/will move into/out of the facility on// (date).
/(date). 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/ (date). I recently left a PACE program on	I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because
/(date).	of the natural disaster.

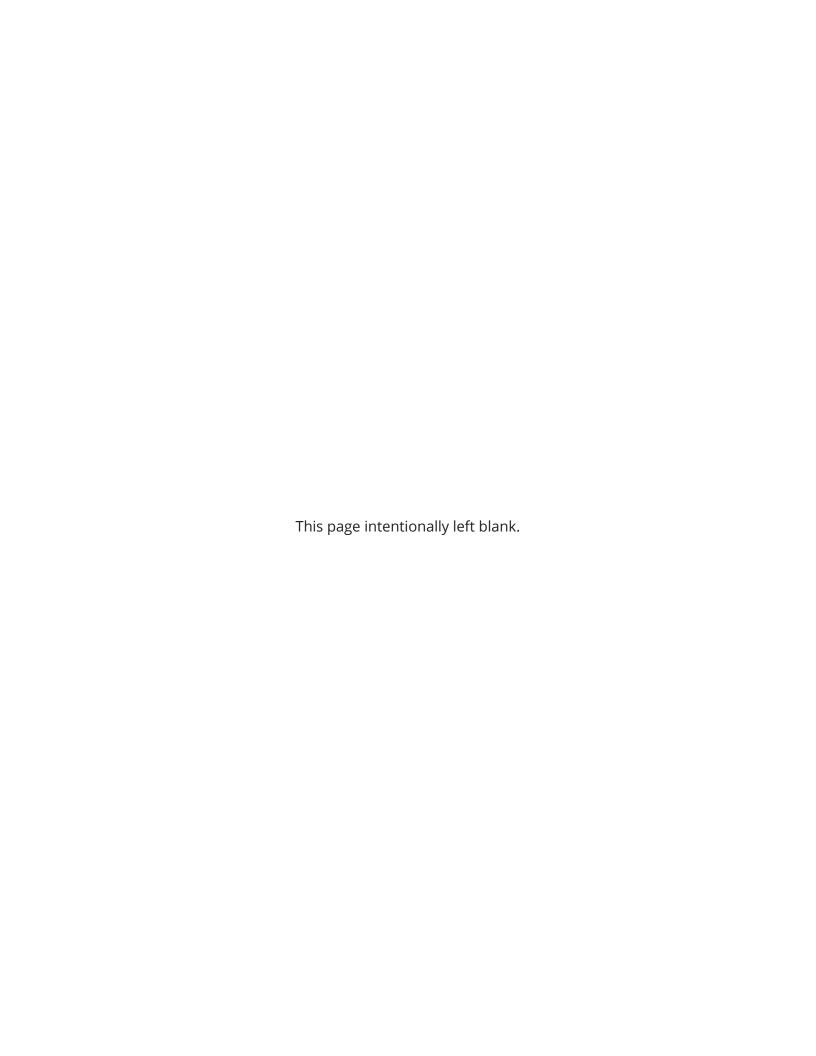
If none of these statements apply to you or you're not sure, please call us at 1-833-874-8529 (TTY: 711) to see if you are eligible to enroll. We're here 8 AM to 8 PM, 7 days a week, from October 1 – March 31 and 8 AM to 8 PM, Monday through Friday, from April 1 – September 30.



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nrollment Request Form	Agent/Producer/Broker Use Only:		
•	Agent/producer/broker name:NPN #:		

To enroll in the Aetna Assure Premier Plus Plan, please provide the following information			
Aetna [®] Assure Premier Plus (HMO D-SNP) (H6399-001)		\$0.00 per month	
Proposed Effective Date of Coverage:// Effective dates are based on the enrollment period you're using to enroll and the Centers for Medicare & Medicaid Services' regulations. Aetna cannot guarantee the effective date you've requested will be honored.			
Last name	First name	Middle initial	
Birth date / / / / Y Y Y Y	Sex M F	Home phone number	
Alternate phone number (optional)	Email address (
Permanent residence street address (a P	PO Box is not allowed)		
Apt./Suite/Unit (please specify)			
City	County	State ZIP Code	
Mailing address (only if different from you Street Address	r permanent residence stre	eet address) State ZIP Code	
	a Primary Care Provid		
Your plan requires you to choose an in-network Primary Care Provider (PCP). If you don't choose a PCP, we'll choose one for you. You can change your PCP to another in-network PCP at any time and for any reason. Be sure to write in your PCP's full name, Provider Group Name/Office Address and National Provider dentifier (NPI) below. Visit our online provider directory at AetnaBetterHealth.com/new-jersey-hmosnp/find-provider or call 1-833-874-8529 (TTY: 711) to find an in-network PCP and their NPI.			
Please choose an in-network PCP and wr		Are you a current patient? Yes No	
Write the Primary Provider Group Name/Office Address			
NPI (located in the provider directory)			



Provide your Medicare insurance information

Effective Date:

	(Part A)// (Part B)//	·
You must have	Medicare Part A and Part B to join a	a Medicare Advantage plan.
	Please read and answer	these important questions
Yes No	Premier Plus (HMO D-SNP)? So including other private insurance coverage, VA benefits, or state p	ion drug coverage in addition to Aetna® Assure ome individuals may have other drug coverage, ce, TRICARE, Federal employee health benefits pharmaceutical assistance programs. If "Yes," please ur identification (ID) numbers (s) for this coverage:
	ID # for this coverage:	Group # for this coverage:
Yes No	If "Yes," fill in the information be	Phone number: ()
Yes No	3. Are you enrolled in your state number:	e's Medicaid program? If "Yes," write in your Medicaid
IMPORTANT: Please read and sign below		

I must keep both Hospital (Part A) and Medical (Part B) to stay in Aetna Assure Premier Plus (HMO D-SNP). By joining this Medicare Advantage Plan, I acknowledge that Aetna Assure Premier Plus (HMO D-SNP) will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).

Your response on this form is voluntary. However, failure to respond may affect enrollment in the plan. 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 people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.

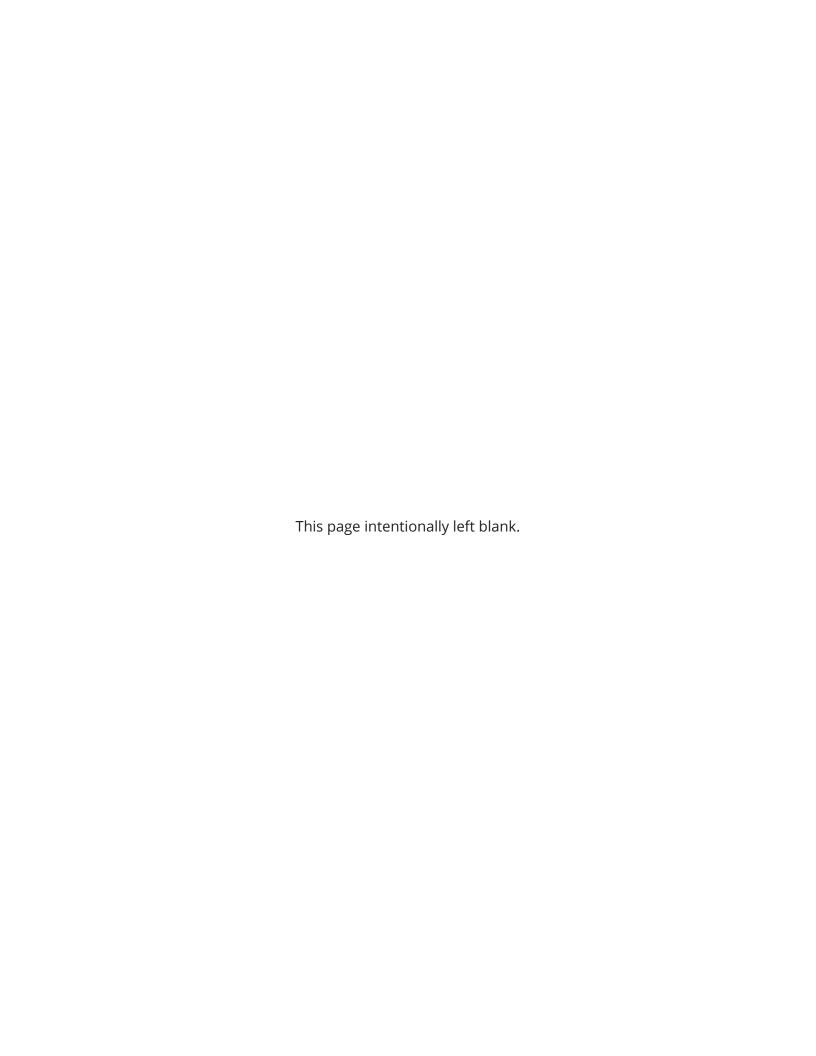
I understand that beginning on the date my Aetna Assure Premier Plus (HMO D-SNP) coverage begins, I must get all of my health care from Aetna Assure Premier Plus (HMO D-SNP) in-network providers, except for emergency or urgently-needed services or out-of-area dialysis services. I must also use in-network pharmacies as well as in-network Durable Medical Equipment (DME) suppliers. Benefits and services provided by Aetna Assure Premier Plus (HMO-DSNP) and contained in my Aetna Assure Premier Plus (HMO D-SNP) "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Aetna Assure Premier Plus (HMO-DSNP) will pay for benefits or services that are not covered. I understand that I will be enrolled into prescription drug coverage under the plan, and will be automatically disenrolled from any other Medicare prescription drug or creditable coverage plan in which I am currently enrolled. I will also be enrolled into Medicaid coverage under the plan, and will be disenrolled from any other Medicaid plan in which I am currently enrolled. Referrals are not required under the plan.

Continued

QS22

Medicare Number: _____

Is Entitled To:



IMPORTANT: Please read and sign below (continued)

I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:

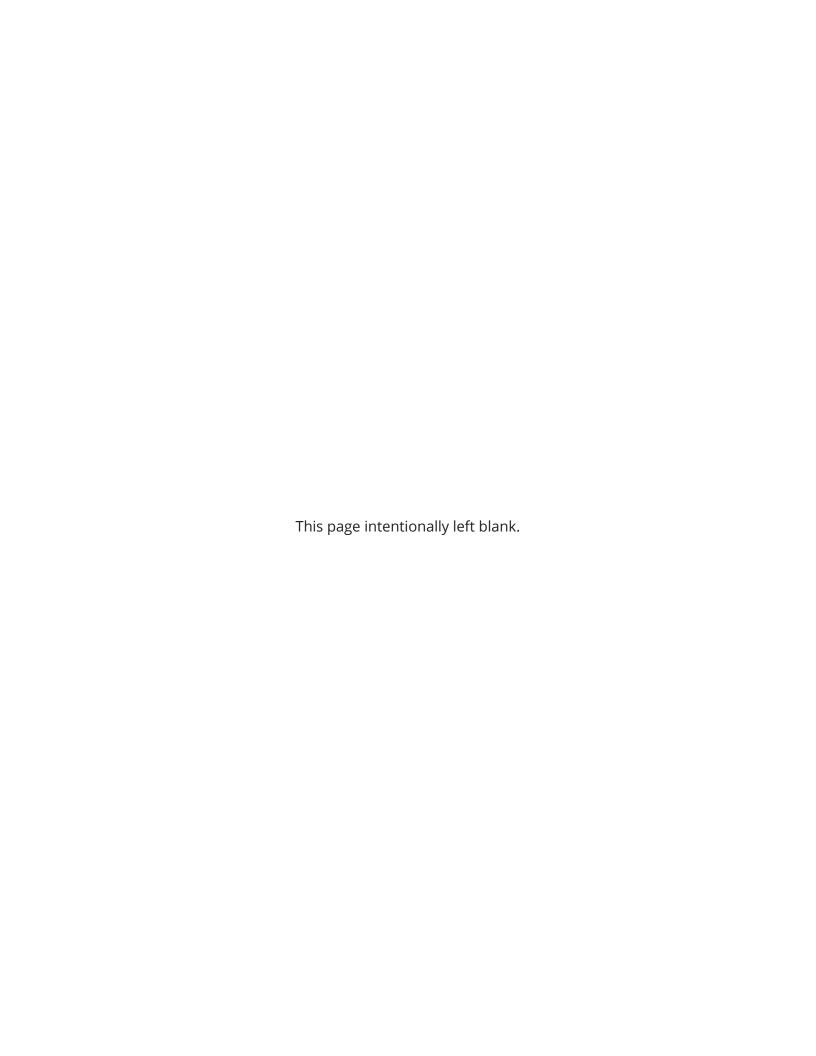
- 1) this person is authorized under State law to complete this enrollment and
- 2) documentation of this authority is available upon request by Medicare.

Signature		Today's date
		//
If you're an authorized representat	ive, you must sign above and provi	de the following information.
Name	Address	
Phone number ()	Relationship to enrollee	
Indicate your preferred spoken la		nish
Indicate your preferred written la	anguage (if not English): Spar	nish Other
Select one if you want us to send Braille Large print A	•	e format:
Please contact Aetna [®] Assure Prem information in an accessible format seven days a week, from October 1 September 30.	other than what is listed above. O	ur office hours are 8 AM to 8 PM,

Aetna Assure Premier Plus (HMO D-SNP) is a Fully Integrated Dual Eligible Special Needs Plan with a Medicare contract and a contract with the New Jersey Medicaid program. Enrollment in Aetna Assure Premier Plus depends on contract renewal.

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

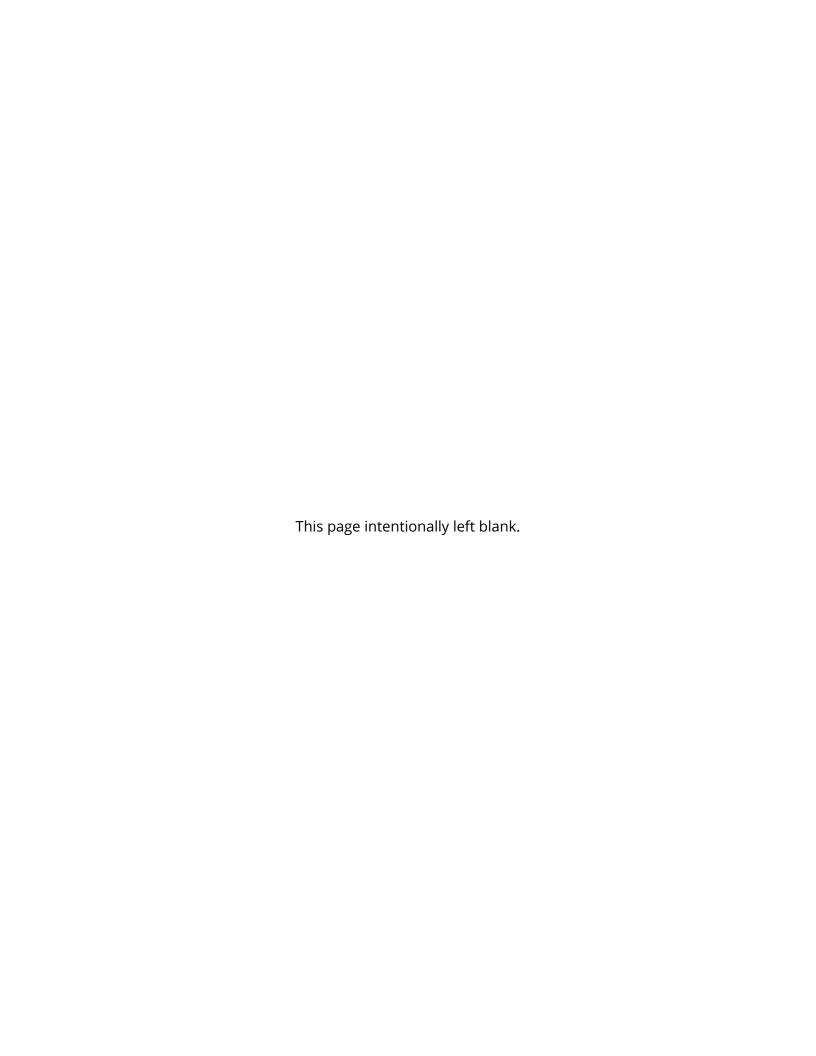


AGENT USE ONLY - Agent/producer/broker/employed sales representative 💬 must complete this section

Applicant's name

	er/broker/employed sales representative, you must provide the about the submit it with the completed application.
beneficiary prior to any persor	t (SOA) completed? (The SOA must be agreed to by the Medicare hal individual marketing appointment.) $\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \$
If "No," why not?	
Was the SOA captured electron	nically or by telephone?
If "Yes," please provide the con	firmation/ID number:
Attach the SOA or indicate why	ı it's not available:
Agent/producer/broker/emp	loyed sales representative information
Name of agent/producer/brok	er/sales rep:
Phone number:	National Producer Number (NPN):
application, a signature and	/broker/employed sales representative takes receipt of this date are <u>REQUIRED</u> below. Your signature indicates you understand submitted within two calendar days of this date.
Signature of agent/producer/b	roker/sales rep:
Date agent received the Individ	dual Enrollment Request Form:
• .	loyed sales representative: Copy and keep this completed form for election period checklist on page 1 must be included with the form.
	Fax or mail the completed form to:

Aetna Medicare PO Box 7083 London, KY 40742 Fax: 1-844-984-0393





Aetna Assure Premier Plus (HMO D-SNP) Enrollment Receipt

Agent/Broker: Complete and leave with enrollee.

Keep this as proof of your enrollment request until Medicare has confirmed your enrollment and you receive your member materials. This receipt is not a guarantee of enrollment.

This receipt is for your records only. No further action is necessary.

Proposed Effective Date			
//			
Call your Agent/Broker if you have any questions:			
Agent/Broker ID			
	any questions:		

If you would like a complete copy of your enrollment form, call us at **800-562-6315 (TTY: 711)**, 8 AM to 8 PM, seven days a week, from October 1 – March 31 and 8 AM to 8 PM, Monday through Friday, from April 1 – September 30. Please allow at least three business days for us to process your application. **You'll need to provide your application tracking number, located at the bottom of this page.**

You enrollment request is for a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP). This plan covers all of your Medicare, NJ FamilyCare (Medicaid) and prescription drug benefits in one health plan, with one Member Identification card.

Aetna Assure Premier Plus (HMO D-SNP) is a Fully Integrated Dual Eligible Special Needs Plan with a Medicare contract and a contract with the New Jersey Medicaid program. Enrollment in Aetna Assure Premier Plus (HMO D-SNP) depends on contract renewal.

Application Tracking Number → QS22