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

How to enroll

OMB No. 0938-1378 Expires 7/31/2023

Call us at	Through your agent:	Fax to:	Mail to:
1-833-874-8529 **(TTY: 711)**	Give them the completed form	Attention: Enrollment Department Fax: **1-844-984-0393**	Aetna Medicare PO Box 7083 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)

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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 Initial Enrollment Period Eligibility

☐ I am new to Medicare.

☐ I previously had Medicare but am now turning 65.

Reasons for Special Enrollment Period Eligibility

☐ 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 __ __/__ __/__ __ (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 __ __/__ __/__ __ (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 involuntarily lost my creditable prescription drug coverage (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 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 __ __/__ __/__ __ (date).

☐ 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).

☐ 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 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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Enrollment 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 __ __ /__ __ /__ __ __ __
M M D D Y Y Y Y

Sex ☐ M ☐ F

Home phone number (__ __ __) __ __ __ - __ __ __ __

Alternate phone number (optional)
(__ __ __) __ __ __ - __ __ __ __

Email address (optional)

Permanent residence street address (a PO Box is not allowed)

Apt./Suite/Unit (please specify)

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

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

Street Address	**City**	**State**	**ZIP Code**

Choose a Primary Care Provider

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 Identifier (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 write their name below

Are you a current patient? ☐ Yes ☐ No

Write the Primary Provider Group Name/Office Address

NPI (located in the provider directory)

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Provide your Medicare insurance information

Medicare Number: __ __ __ __ - __ __ __ - __ __ __ __

Is Entitled To: Effective Date:

HOSPITAL (Part A) __ __ / __ __ / __ __ __ __

MEDICAL (Part B) __ __ / __ __ / __ __ __ __

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

Please read and answer these important questions

☐ Yes ☐ No

1. **Will you have other <u>prescription</u> drug coverage in addition to Aetna® Assure Premier Plus (HMO D-SNP)?** Some individuals may have other drug coverage, including 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) numbers (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: _____

☐ Yes ☐ No

3. **Are you enrolled in your state's Medicaid program?** If "Yes," write in your Medicaid number: _____

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.

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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 representative, you must sign above and provide the following information.

Name	Address
Phone number (__ __ __) __ __ __ - __ __ __ __	Relationship to enrollee

Indicate your preferred spoken language (if not English): ☐ Spanish ☐ Other _____
Indicate your preferred written language (if not English): ☐ Spanish ☐ Other _____

Select one if you want us to send you information in an accessible format:
☐ Braille ☐ Large print ☐ Audio CD

Please contact Aetna® Assure Premier Plus (HMO D-SNP) at **1-833-874-8529 (TTY: 711)** if you need information in an accessible format other than what is listed above. Our office hours are 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.

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.

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

Applicant's name

If you are the agent/producer/broker/employed sales representative, 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/employed sales representative information

Name of agent/producer/broker/sales rep: _____

Phone number: _____ National Producer Number (NPN): _____

NOTE: If the agent/producer/broker/employed sales representative 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/sales rep: _____

Date agent received the Individual Enrollment Request Form: _____

Agent/producer/broker/employed sales representative: Copy and keep this completed form for your records. The completed 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

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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.

Applicant

Name

Today's Date	Proposed Effective Date
__ __/__ __/__ __	__ __/__ __/__ __

Call your Agent/Broker if you have any questions:

Agent/Broker Name	
Agent/Broker Phone Number	Agent/Broker ID

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