

Aetna® Assure Premier Plus (HMO D-SNP) 2023 Individual Enrollment Request Form Instructions

How to enroll

OMB No. 0938-1378 Expires 7/31/2024

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?

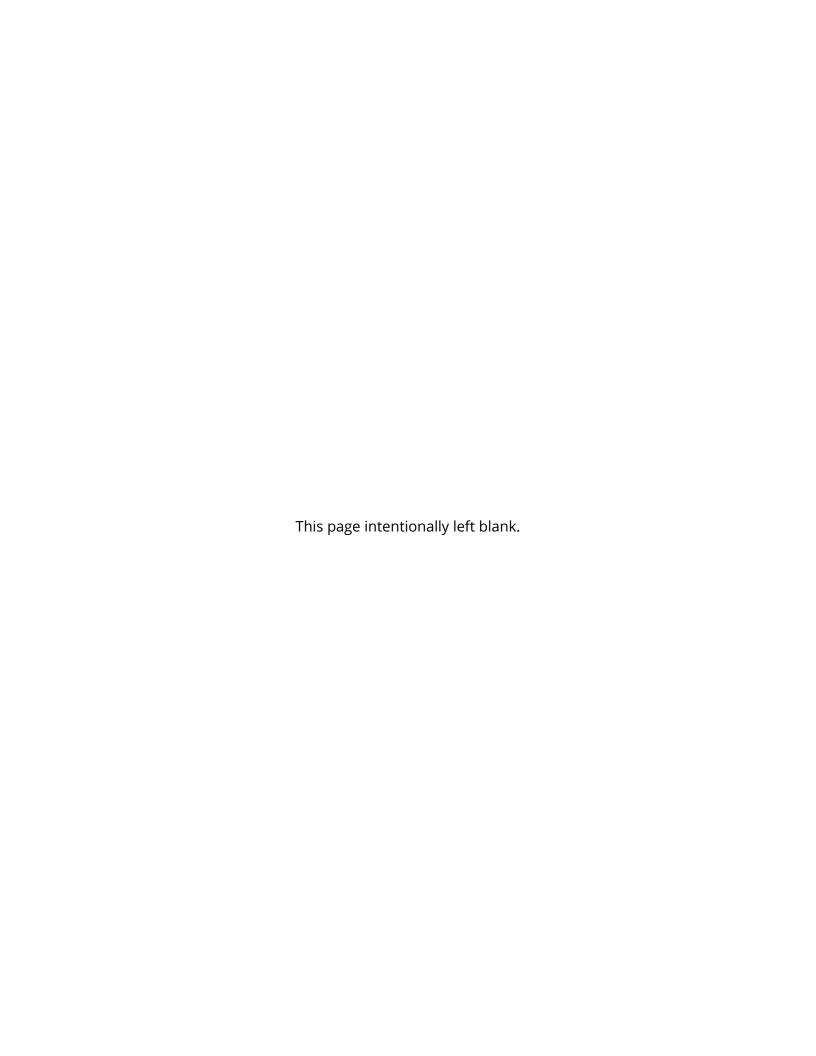
You can join a plan:

- Between October 15 to 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 Medicare Number (the number on your red, white and blue Medicare 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.
- Make a copy of the completed application for your records.
- We recommend you confirm your form was received if you fax or mail it (for example, send certified mail).
- If you want to join a plan during fall open enrollment (October 15 to 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 to March 31 and 8 AM to 8 PM, Monday through Friday, from April 1 to 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.

Individuals experiencing homelessness

• If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (for example, social security checks) may be considered your permanent residence address.

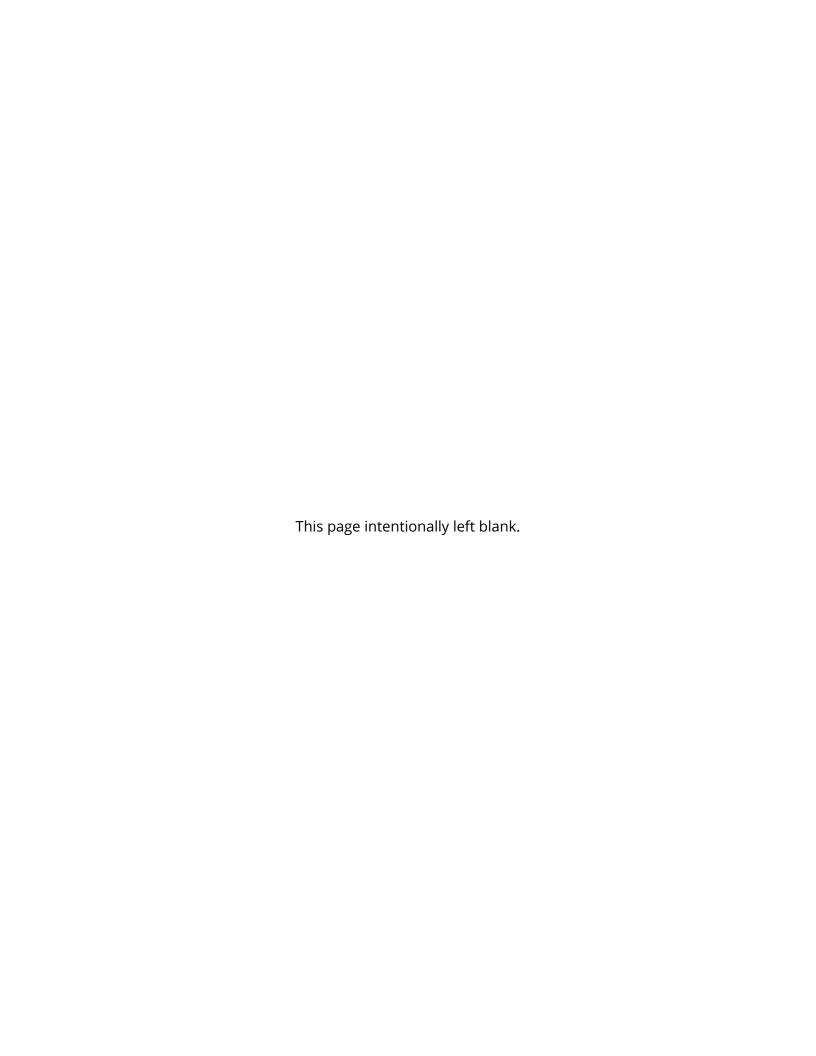
Thank you for choosing our plan. You will hear from us within 10-14 days.

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 first page to send your completed form to the plan.

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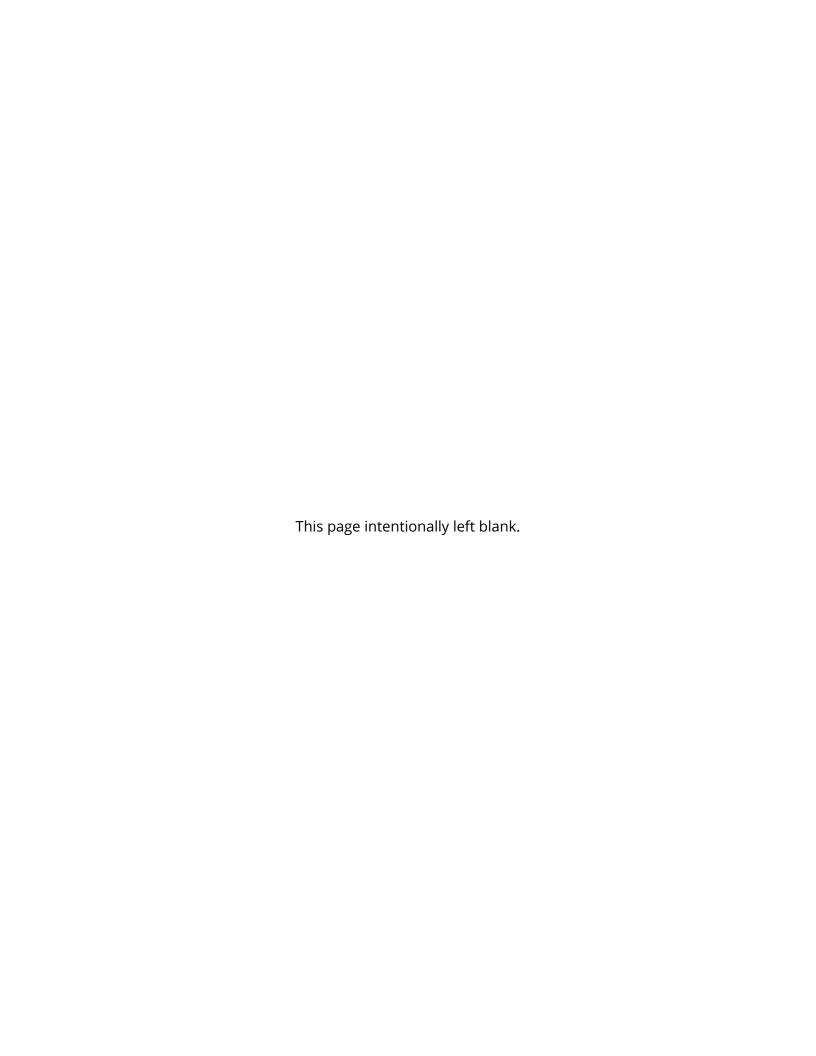
Confirm your enrollment period



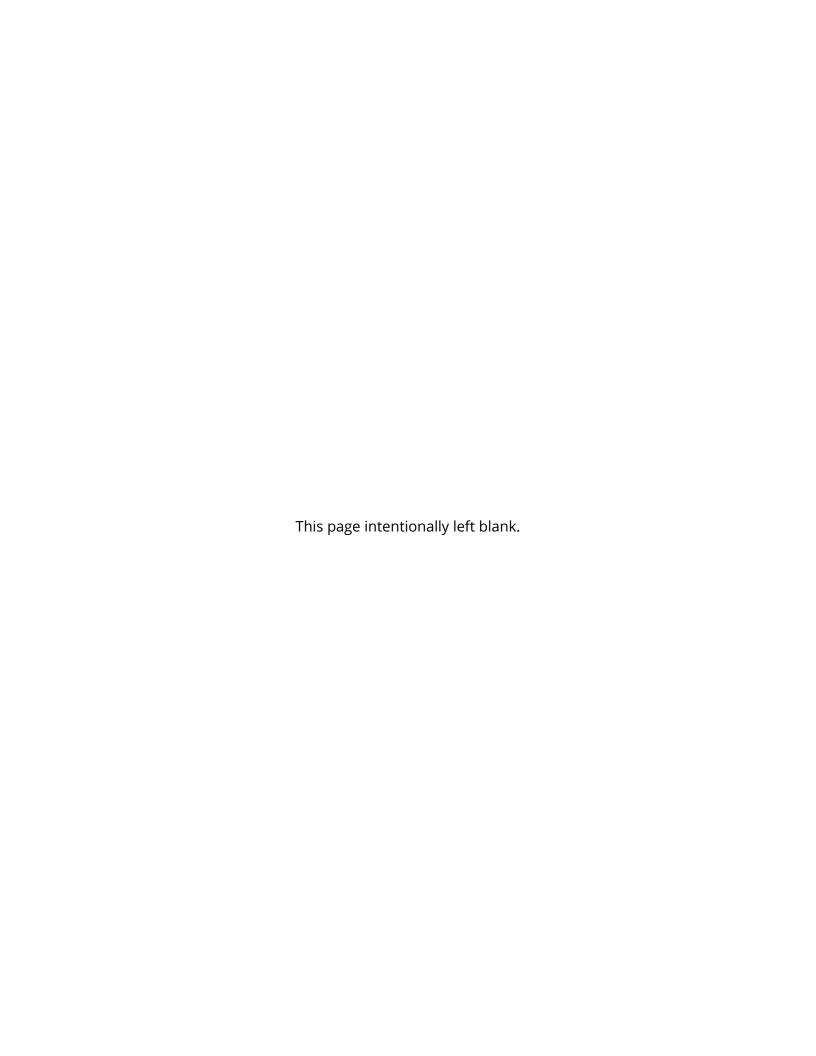
Typically, you may enroll in a Medicare Advantage Plan during the Annual Enrollment Period (AEP) from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

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'm enrolling between 10/15/22-12/7/22 during the current Annu	ual Enrollment Period.
Reasons for Initial Enrollment Period Eligibility	
l'm new to Medicare.	
l'm new to Medicare, and I was notified about getting Medicare a coverage started.	after my Part A and/or Part B
I had Medicare prior to now, but I'm now turning 65.	
Reasons for Open Enrollment Period Eligibility	
Between 1/1/23 and 3/31/23:	
l'm in a Medicare Advantage plan and want to make a change.	
Between 4/1/23 and 12/31/23:	
I'm in a Medicare Advantage plan and have had Medicare for les change.	ss than 3 months. I want to make a
Reasons for Special Enrollment Period (SEP) Eligibility	
I have both Medicare and Medicaid, my state helps pay for my N paying my Medicare drug coverage.	Medicare premiums, or I get Extra Help
I moved to a new address that's outside my current plan's service plan is a new option for me. I moved on// (date).	ce area, or I recently moved and this
☐ I was released from jail. I was released on// (date).	
I moved back to the United States after living outside the country _ (date).	y. I returned to the U.S. on//_
I recently got lawful presence status in the United States. I got the// (date).	nis status on
I recently had a change in my Medicaid (newly got Medicaid, had assistance, or lost Medicaid) on// (date).	d a change in level of Medicaid
	Continued



Pro	spective member name	Medicare number
	I recently had a change in my Extra Help paying for my drug costs (ne change in the level of Extra Help, or lost Extra Help) on//	
	I dropped my coverage in a PACE (Programs of All-Inclusive Care for// (date).	the Elderly) plan on
	I live in long-term care facility, like a nursing home or rehabilitation ho on// (date).	spital. I moved out of the facility
	I lost other, non-Medicare drug coverage (creditable coverage), or mechanged and is no longer considered creditable coverage. I lost my description of the coverage of the cov	
	I left coverage from my employer or union (including COBRA coverage	e) on// (date).
	I'm in a State Pharmaceutical Assistance Program, or I am losing help Assistance Program.	from a State Pharmaceutical
	I lost my coverage because my plan no longer covers the area that I li Medicare.	ve or it ended its contract with
	I was enrolled in a plan by Medicare (or my state) and I want to choos in that plan started on/ (date).	e a different plan. My enrollment
	I lost my Special Needs Plan (SNP) because I no longer have a conditional disenselled from the SNP on / (date).	on required for that plan. I was
	I was affected by an emergency or major disaster (as declared by the Management Agency, or by a Federal, state or local government entit applied to me, but I was unable to make my enrollment request because	y. One of the other statements
allo a w	one of these statements above apply to you, but you feel you have above you to enroll, you can call us at 1-833-874-8529 (TTY: 711). We're eek, from October 1 to March 31 and 8 AM to 8 PM, Monday through Fill We can help you to determine if you qualify for a Special Election Period	e here 8 AM to 8 PM, seven days riday, from April 1 to September
	erwise, note the reason for your Special Election Period below. Aetna i're eligible.	may contact you to determine if
	Other SEP Reason:	·



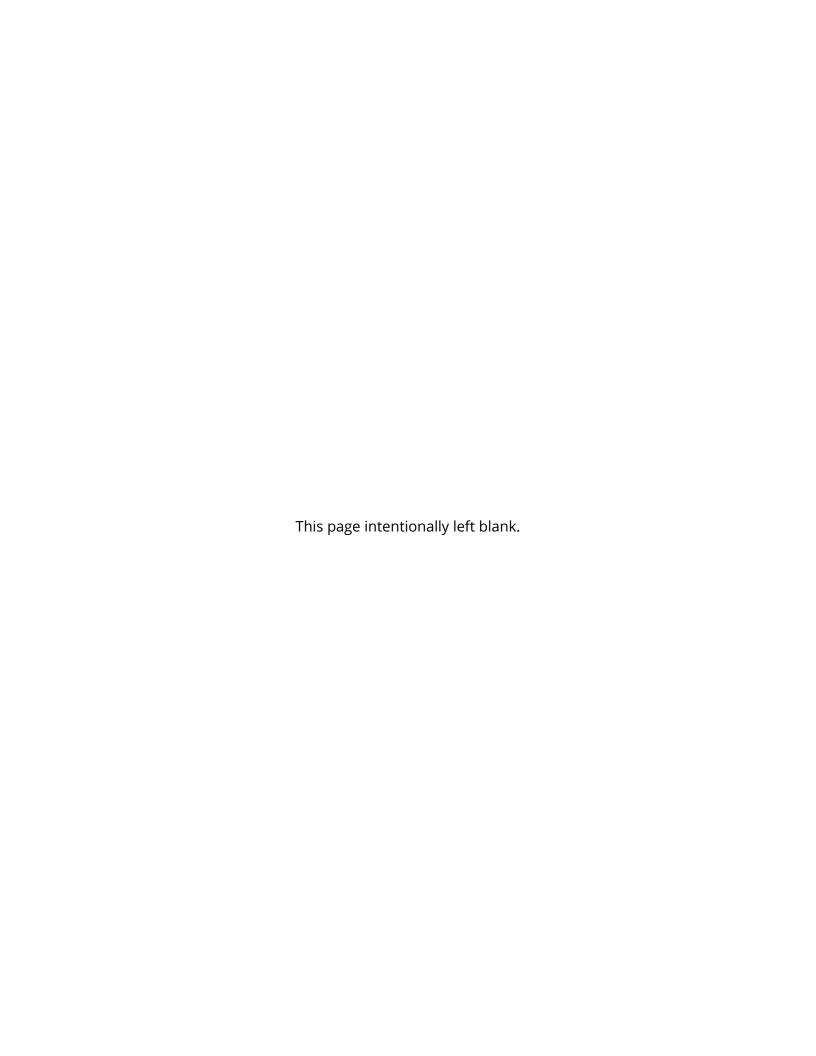
Enrollment Request Form Agent/Producer/Broker Use Only:					
·	Agent/producer/broker name:NPN #:				
	<u> </u>	NFIN #			
To enroll in the Aetna Assure Premie	r Plus P	lan, pl	lease provide t	he follow	ing information
Aetna® Assure Premier Plus (HMO D-SN	P) (H639	9-001)	\$	0.00 per month
Proposed Effective Date of Coverage:	.//				
Effective dates are based on the enrollment Medicaid Services' regulations. Aetna canno honored.					
Last name	First na	me			Middle initial
Birth date// Sex Phone number () F Is this a mobile number? \[\text{Y es } \] No					
Email address (optional)					
Permanent residence street address (a PO	Box is n	ot allo	wed)		
Apt./Suite/Unit (please specify)					
City		Coun	ty	State	ZIP Code
Mailing address (only if different from your parest Address	permane	nt resi	dence street add	ress) State	ZIP Code
Choose a	a Prima	ry Ca	re Provider		
Your plan requires you to choose an in-network we'll choose one for you. You can change you		-	. ,	•	
reason. Be sure to write in your PCP's full name (firs National Provider Identifier (NPI) below. Vi AetnaBetterHealth.com/new-jersey-hmosan in-network PCP and their NPI.	sit our or	nline pi	rovider directory	at	
Please choose an in-network PCP and writ	te their fo	ull nan	ne below	Are you a	current patient?

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NPI (located in the provider directory)

Write the Primary Provider Group Name/Office Address

Yes [

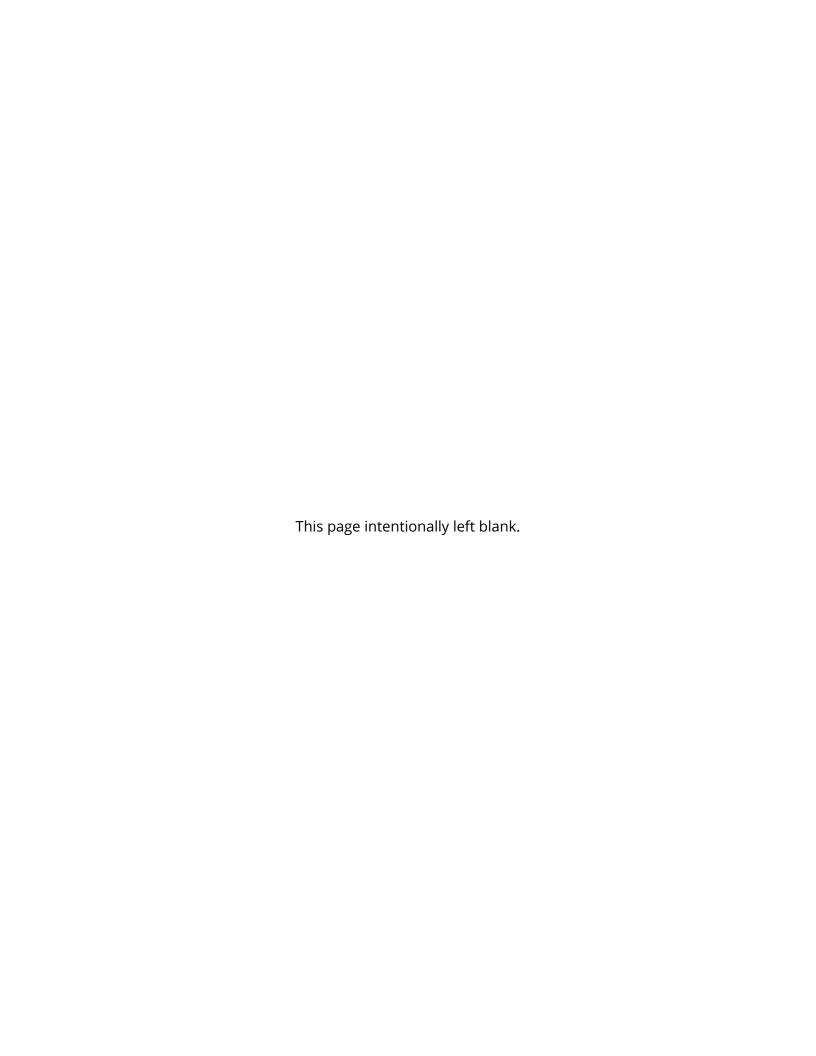


Provide your Medicare insurance information

This information is on your red, white and blue Medicare insurance card You must have Medicare Part A and Part B to join a Medicare Advantage plan

			!	Effective Date:
Medicare Numl	ber:	_ HOSPITAL (I	Part A)	//
		MEDICAL (P	art B)	_//
	Please read and ans	wer these impo	rtant questi	ons
Yes No	1. Will you have other prescripted Premier Plus (HMO D-SNF including other private insucoverage, VA benefits, or still list your other coverage and Name of other coverage: ID # for this coverage:	P)? Some individuals rance, TRICARE, Fe tate pharmaceutical your identification	s may have oth deral employed l assistance pro (ID) numbers	ner drug coverage, ee health benefits rograms. If "Yes," please (s) for this coverage:
Yes No	2. Are you enrolled in your st	tate's Medicaid pro	ogram?	
	If "Yes," write in your Medic	aid number:		
Answering '	these questions is your choice		ied coverage	because you don't fill
Answering these questions is your choice. You can't be denied coverage because you don't fill them out. Are you Hispanic, Latino/a, or Spanish origin? Select all that apply. No, not of Hispanic, Latino/a, or Spanish origin Yes, Puerto Rican Yes, another Hispanic, Latino/a, or Spanish origin Yes, Mexican, Mexican American, Chicano/a Yes, Cuban I choose not to answer. What's your race? Select all that apply. American Indian or Alaska Native Asian Indian Black or African American Chinese Filipino Guamanian or Chamorro Japanese Korean Native Hawaiian Other Asian Other Pacific Islander Samoan Vietnamese White				
Indicate your preferred spoken language (if not English): Spanish Other				
Indicate your pr	eferred written language (if no	ot English):	Spanish 🗌 (Other
Braille Please contact A information in a	Large print Audio CD Aetna® Assure Premier Plus (HN n accessible format other than eek, from October 1 to March 31	10 D-SNP) at 1-833 what is listed above	- 874-8529 (T 7 e. Our office ho	ours are 8 AM to 8 PM,

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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.
- I understand that I can be enrolled in only one MA Plan at a time and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Aetna Assure Premier Plus (HMO D-SNP) coverage begins, I must get all of my medical and prescription drug benefits from Aetna Assure Premier Plus (HMO D-SNP). 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.
- 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 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.

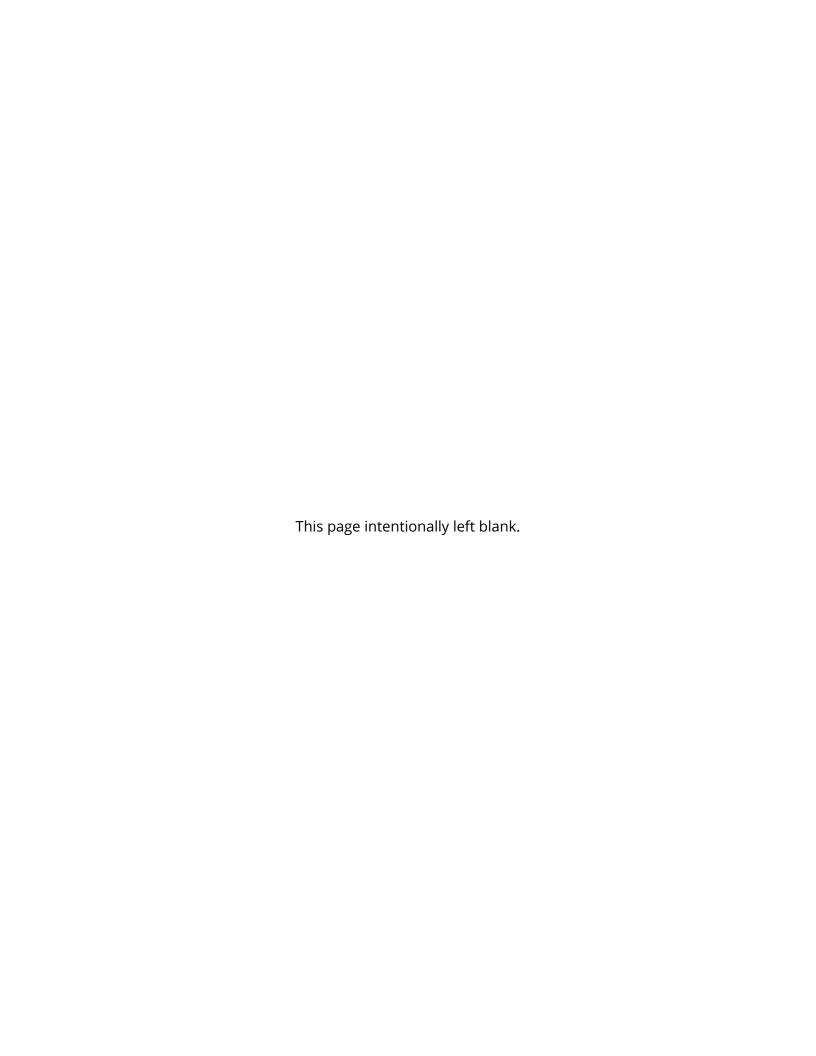
Signature		Today's date
		//
If you're an authorized representative,	you must sign above and provide the foll	owing information.
Name	Address	
Phone number	Relationship to enrollee	
(

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) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 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

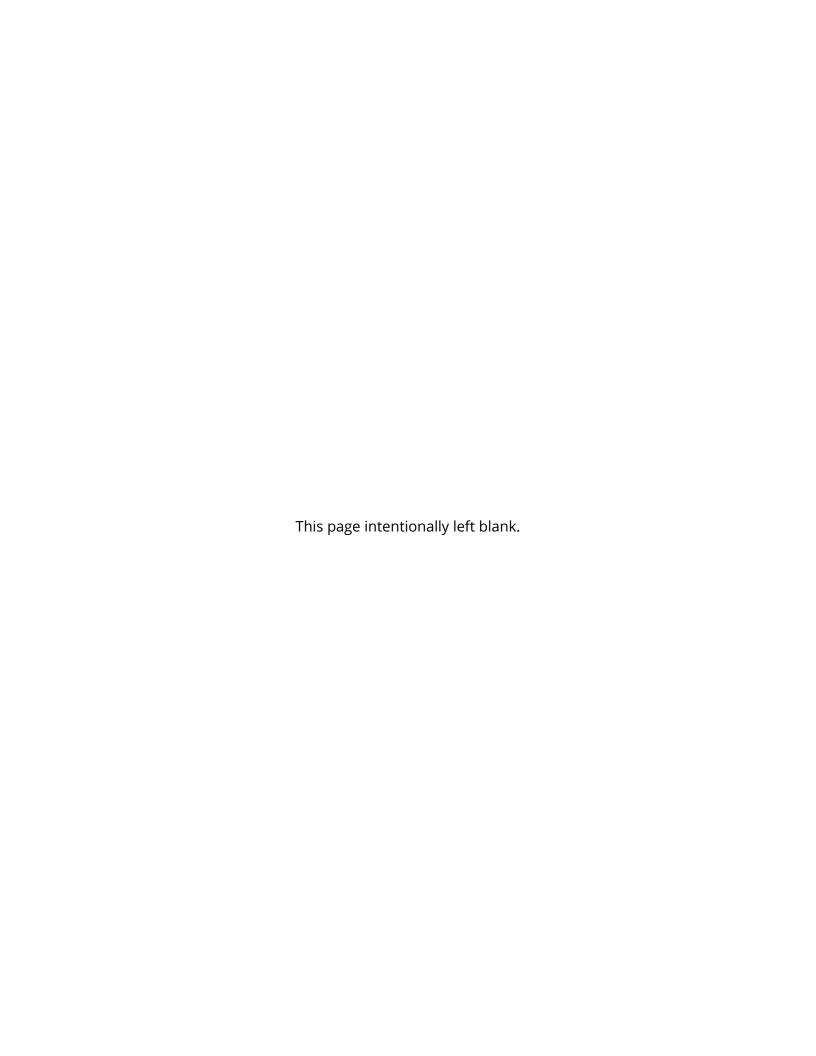
	roker/employed sales representative, you must provide the it it with the completed application.
• • • • • • • • • • • • • • • • • • • •	OA) completed? (The SOA must be agreed to by the Medicare ndividual marketing appointment.)
If "No," why not?	
Was the SOA captured electronic	ally or by telephone? Yes No
If "Yes," please provide the confirm	mation/ID number:
Attach the SOA or indicate why it'	s not available:
Agent/producer/broker/emplo	yed sales representative information
Name of agent/producer/broker/	'sales rep:
Phone number:	National Producer Number (NPN):
a signature and date are REQUIF	oker/employed sales representative takes receipt of this application, RED below. Your signature indicates you understand that this vithin two calendar days of this date.
Signature of agent/producer/bro	ker/sales rep:
Date agent received the Individua	ıl 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





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 an	v auestions:	
	y questions.	
Agent/Broker Name	y questions.	

If you would like a complete copy of your enrollment form, call us at **1-800-562-6315 (TTY: 711)**, 8 AM to 8 PM, seven days a week, from October 1 to March 31 and 8 AM to 8 PM, Monday through Friday, from April 1 to 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 → QS23