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Aetna Medicare Advantage Plan
2022 Individual Enrollment Request Form Instructions

How to enroll

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

Online at	Call us at	Through your agent: Give them the completed form	Fax to:	Mail to:
AetnaBetterHealth.com/Virginia-hmosnp or through Medicare at **www.medicare.gov**	**1-844-934-3324 (TTY: 711)**		Attention: Enrollment Department Fax: **1-844-984-0393**	**Aetna Medicare** PO Box 7083 London, KY 40742

Get ready

Have the following handy:

- Your red, white and blue Medicare insurance card
- Your health insurance information for any other insurance you have (including Medicaid)
- Your primary care physician's information which is available online at AetnaMedicare.com/findprovider

Questions?

Call us at **1-844-934-3324 (TTY: 711)**. We're here 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.

Tips for your enrollment request

1. Each applicant must complete their own enrollment. Please don't photocopy a form for reuse.
2. Print neatly. **Complete all sections.** Don't forget to sign and date the form.
3. If you enroll outside the Annual Enrollment Period (AEP) timeframe, you must confirm your enrollment period (see next page).
4. Make a copy of the application for your records.
5. We recommend you confirm your form was received if you fax or mail it (e.g. send certified mail).

If you need information in another language or accessible format (e.g., large print or braille), contact us at **1-844-934-3324 (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.

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

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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 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 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 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, call us at 1-844-934-3324 (TTY: 711) to see if you can enroll. We're here 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.

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Enrollment Request Form

Agent/Producer/Broker Use Only:
Agent/producer/broker name: _____
NPN #: _____

To Enroll in an Aetna Medicare Plan, Please Provide the Following Information:

Section 1: Choose your plan

Check the plan you want to enroll in.

- ☐ Aetna Better Health of Virginia (HMO D-SNP) (H1610-001) **$0.00** per month
- ☐ Aetna Medicare Assure Premier (HMO D-SNP) (H1610-002) **$0.00** per month
- ☐ Aetna Medicare Assure Value (HMO D-SNP) (H1610-003) **$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. Unless you are new to Medicare or are eligible for a Special Election Period (SEP), your effective date will be January 1. Aetna cannot guarantee the effective date you've requested will be honored.

Section 2: Your information

Last name **First name** **Middle initial**

Birth date ___/___/___ (M M D D Y Y Y Y)

Sex ☐ M ☐ F

Primary phone number (___)___-___

Secondary phone number (___)___-___

Email address

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)

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

Section 3: Tell us your provider

For HMO plans: Write in the **name**, **Provider Group Name/Office Address** and **National Provider Identifier (NPI)** of your primary care physician (PCP) below. If you don't, we may not pay for your care and may assign a PCP to you. Visit our online provider directory at **AetnaBetterHealth.com/virginia-hmosnp/findprovider** or call **1-844-934-3324 (TTY: 711)** to find provider information or a network PCP.

Write the full name of your PCP

Are you a current patient? ☐ Yes ☐ No

Write the Provider Group Name/Office Address

NPI (located in the provider directory ☐☐☐☐☐☐☐☐☐☐

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Section 4: 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.

Section 5: Answer these important questions

☐ Yes ☐ No 1. **Will you have other prescription drug coverage in addition to Aetna Medicare?**
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) 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: (___) _____
Address: _____

☐ Yes ☐ No 3. **Are you enrolled in your state's Medicaid program?** If "Yes," write in your Medicaid number: _____

☐ Yes ☐ No 4. **Have you had creditable coverage since you became eligible for Medicare prescription drug coverage?** Creditable coverage is prescription drug coverage that is at least as good as Medicare prescription drug coverage.
If "Yes," my coverage started on ___/___/_____ (date) and ended on ___/___/_____ (date).
Name of other coverage: _____
Note: If you haven't had creditable coverage, you may have to pay a late enrollment penalty (LEP) if you enroll in Medicare prescription drug coverage in the future. Aetna may ask you to provide evidence of creditable coverage. If you have questions about the LEP, call us at **1-866-246-7981 (TTY: 711)**.

STOP Section 6: Read this important information STOP

If you currently have health coverage from an employer or union, joining Aetna Medicare could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Aetna Medicare. 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 any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

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Section 7: Read and sign below

By completing this enrollment application, I agree to the following:
Aetna Medicare is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B, and continue to pay my Part B premium. I can only be in one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. **For MA-only plans**: I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 – December 7 of every year), or under certain special circumstances.

Aetna Medicare serves a specific service area. If I move out of the area that Aetna Medicare serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Aetna Medicare, 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 Medicare when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan.

For HMO plans: I understand that beginning on the date my Aetna Medicare coverage begins, I must get all of my health care from Aetna Medicare network providers, except for emergency or urgently-needed services or out-of-area dialysis services.

For PPO plans: I understand that beginning on the date my Aetna Medicare coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Aetna Medicare provides refunds for all covered benefits, even if I get services out of network. Out-of-network/non-contracted providers are under no obligation to treat Aetna members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Services authorized by Aetna Medicare and other services contained in my Aetna Medicare Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. **Without authorization**, **NEITHER MEDICARE NOR AETNA MEDICARE WILL PAY FOR THE SERVICES.** I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Aetna Medicare, he/she may be paid based on my enrollment in Aetna Medicare.

I must keep both Hospital (Part A) and Medical (Part B) to stay in Aetna Medicare. By joining this Medicare Advantage plan, I acknowledge that Aetna Medicare 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).

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Section 7: Read and sign below (continued)

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.

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 when my Aetna Medicare coverage begins, I must get all of my medical and prescription drug benefits from Aetna Medicare. Benefits and services provided by Aetna Medicare and contained in my Aetna Medicare "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Aetna Medicare will pay for benefits or services that are not covered.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State 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 from Medicare.

Aetna Medicare is a HMO, PPO plan with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal. Plan features and availability may vary by service area.

Signature	**Today's date** __ __/__ __/__ __ __ __

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

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

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

If you need information in another language or accessible format (e.g., large print or braille), contact us at **1-844-934-3324 (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.

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Section 8: AGENT USE ONLY
Agent/producer/broker/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): _____

☐ Check box if application received at a retail kiosk.

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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Medicare Advantage Plan 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 **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 3 business days for us to process your application. **You'll need to provide your application tracking number, located at the bottom of this page.**

Reminder - Your enrollment request is for a **Medicare Advantage plan (Part C)**. These plans:

- Replace Original Medicare that's provided by the federal government
- Cover all your Part A and Part B benefits
- Don't supplement your Original Medicare coverage like Medicare Supplement or Medigap plans

Aetna Medicare is a HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal. Our SNPs also have contracts with State Medicaid programs. Plan features and availability may vary by service area.

Application Tracking Number → QS22