

### Aetna Medicare 2023 Individual Enrollment Request Form Instructions

#### How to enroll

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

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

### **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 provider's information which is available online at AetnaBetterHealth.com/virginia-hmosnp/find-provider

### **Questions?**

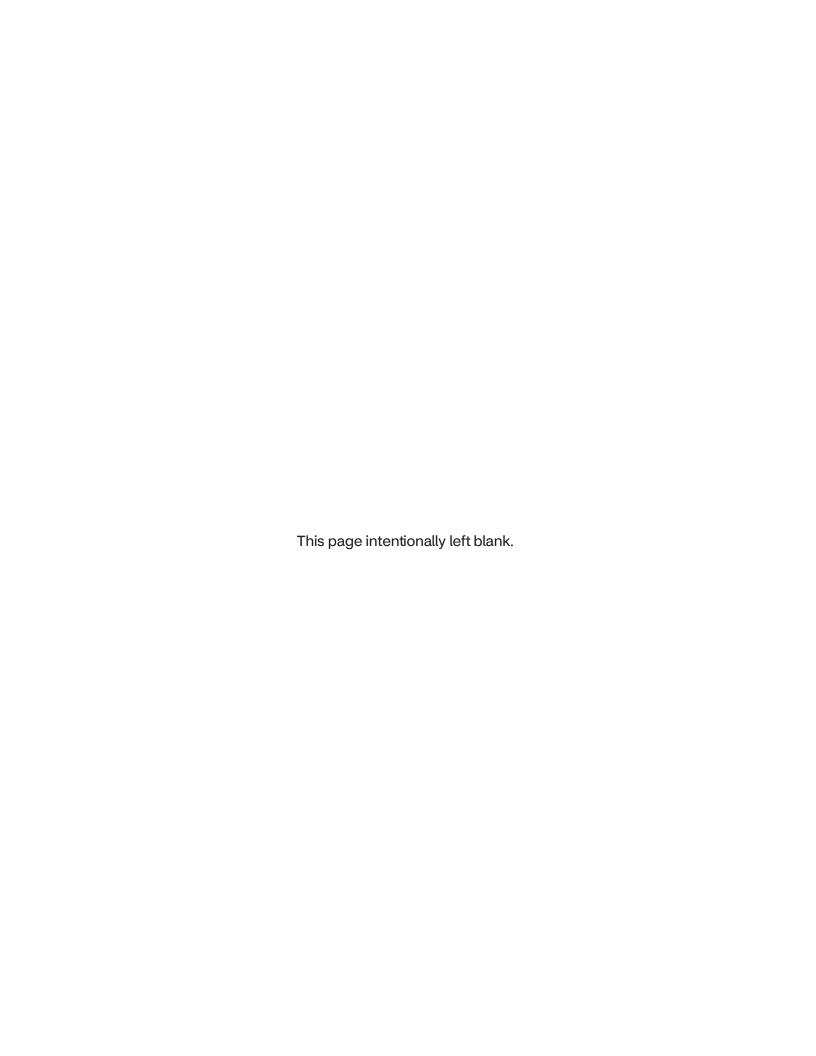
Call us at **1-844-934-3324 (TTY: 711)**. We're here 8 AM to 8 PM, seven days a week, from October 1 to March 31 and 8 AM to 8 PM, Monday through Friday, from April 1 to September 30.

## Tips for your enrollment request

- Each applicant must complete their own enrollment. Please don't photocopy a form for reuse.
- Print neatly. Complete all sections. Don't forget to sign and date the form.
- For 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.
- If you enroll outside the Annual Enrollment Period (AEP) timeframe, you must confirm your enrollment period (see next page).
- 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, call us to confirm receipt or send certified mail).

If you need information in another language or accessible format (for example, 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.



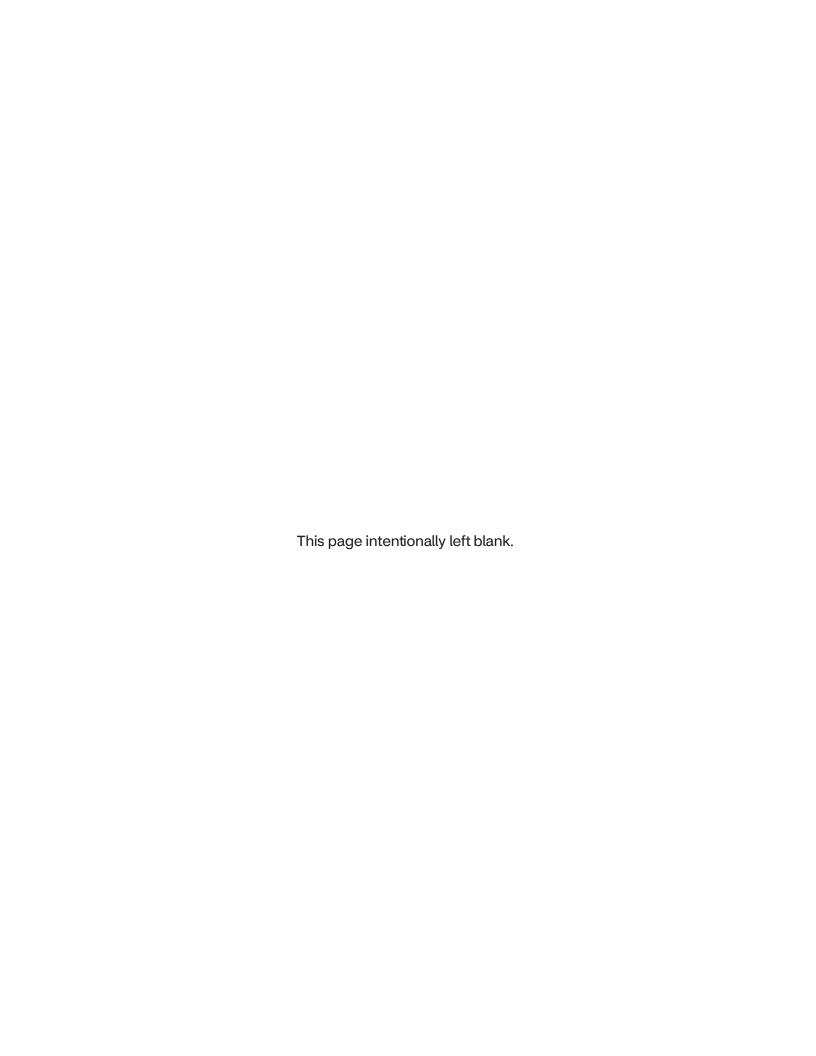


## Confirm your enrollment period

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.

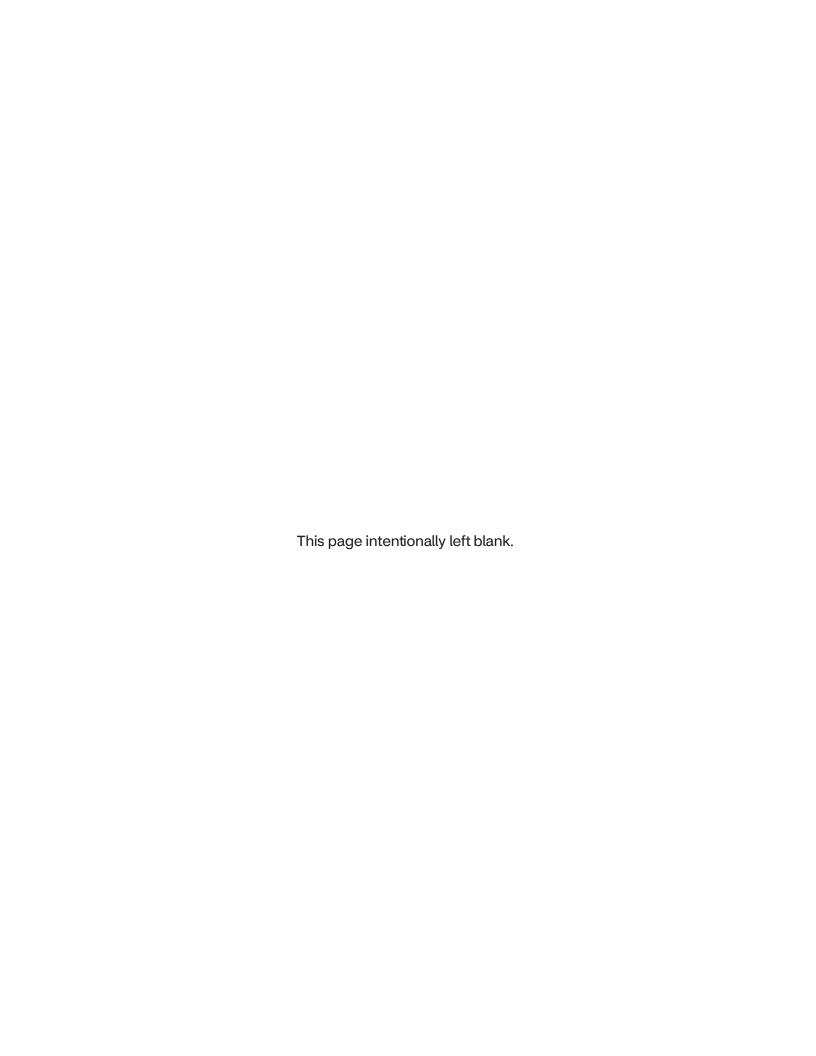
Read the following statements carefully and check the box if the statement applies to you. By checking a box you certify that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

Prospective member name	Medicare Number 
Reason for Annual Enrollment Period Eligibility	
☐ I'm enrolling between 10/15/22-12/7/22 during the	current Annual Enrollment Period.
Reasons for Initial Enrollment Period Eligibility	
☐ I'm new to Medicare.	
☐ I'm new to Medicare, and I was notified about gett coverage started.	ing Medicare after my Part A and/or Part B
☐ I had Medicare prior to now, but I'm now turning 6	5.
Reasons for Open Enrollment Period Eligibility	
Between 1/1/23 and 3/31/23:	
□ I'm in a Medicare Advantage plan and want to make	ke a change.
Between 4/1/23 and 12/31/23:	
☐ I'm in a Medicare Advantage plan and have had M change.	edicare for less than 3 months. I want to make a
Reasons for Special Enrollment Period Eligibility	
☐ I moved to a new address that's outside my current plan is a new option for me. I moved on//	
$\square$ I was released from jail. I was released on $\_\_/\_$	_/ (date).
☐ I moved back to the United States after living outsi / (date).	de the country. I returned to the U.S. on
☐ I recently got lawful presence status in the United	States. I got this status on// (date).
☐ I recently had a change in my Medicaid (newly got assistance, or lost Medicaid) on/ (date = 1.5 cm.)	
☐ I recently had a change in my Extra Help paying fo change in the level of Extra Help, or lost Extra Help	
	(continued on next page)





Prospective member name	Medicare Number
Reasons for Special Enrollment Period Eligibility (continue	ed)
☐ I have both Medicare and Medicaid, my state helps pay for Help paying my Medicare drug coverage.	or my Medicare premiums, or I get Extra
☐ I dropped my coverage in a PACE (Programs of All-Inclus//_ (date).	sive Care for the Elderly) plan on
$\hfill\Box$ I live in a long-term care facility, like a nursing home or a	rehabilitation hospital.
☐ I recently moved out of a long-term care facility, like a nu moved out of the facility on// (date).	rsing home or rehabilitation hospital. I
☐ I lost other, non-Medicare drug coverage (creditable coverage changed and is no longer considered creditable coverage/_ /_ (date).	
$\hfill\Box$ I left coverage from my employer or union (including COI	BRA coverage) on// (date).
☐ I'm in a State Pharmaceutical Assistance Program, or I ar Assistance Program.	m losing help from a State Pharmaceutical
☐ I lost my coverage because my plan no longer covers the Medicare.	area that I live or it ended its contract with
☐ I was enrolled in a plan by Medicare (or my state) and I we enrollment in that plan started on/ (date).	ant to choose a different plan. My
☐ I lost my Special Needs Plan because I no longer have a disenrolled from the plan on/ (date).	condition required for that plan. I was
☐ I was affected by an emergency or major disaster (as dec Management Agency, or by Federal, my state or my local applied to me, but I was unable to make my request beca	government). One of the other statements
If none of these statements above apply to you, but you feel allows you to enroll, you can call us at <b>1-844-934-3324 (TT</b> days a week, from October 1 to March 31 and 8 AM to 8 PM, September 30. We can help you to determine if you qualify	<b>Y: 711)</b> . We're here 8 AM to 8 PM, seven Monday through Friday, from April 1 to
Otherwise, note the reason for your Special Election period if you're eligible.	below. Aetna may contact you to determine
□ Other SEP Reason:	



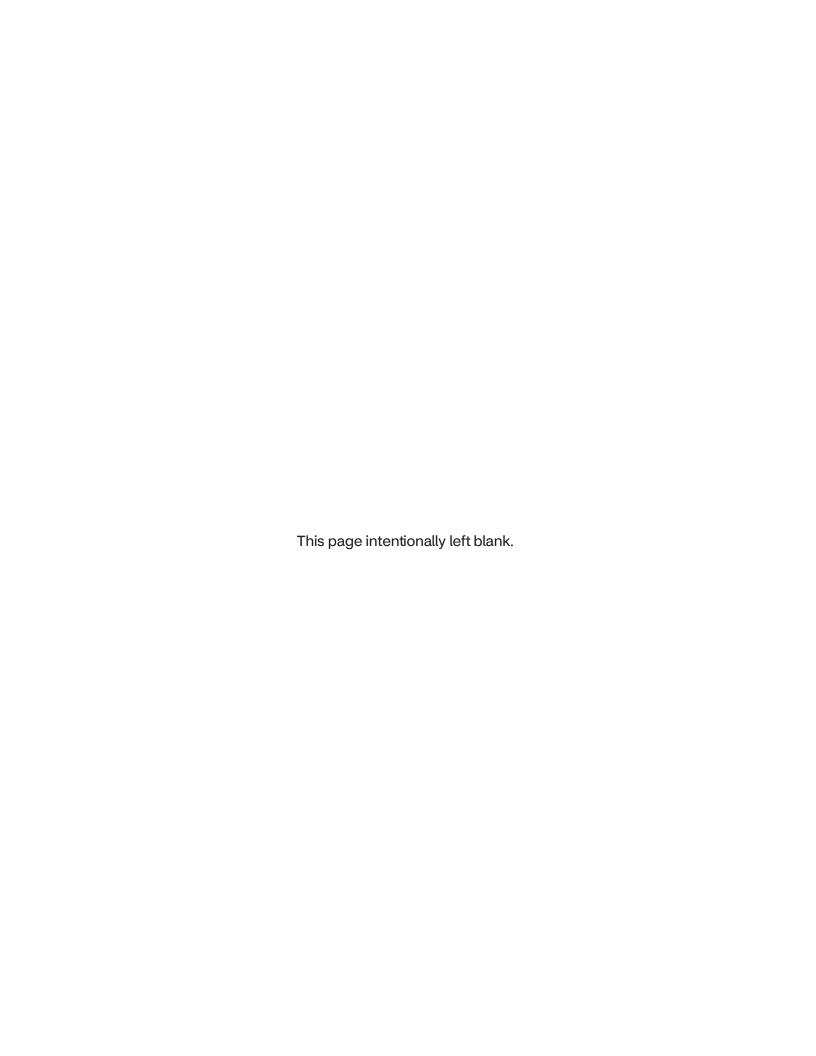


## **Enrollment Request Form**

Agent Use Only:		
Agent Name:		
NPN#:		

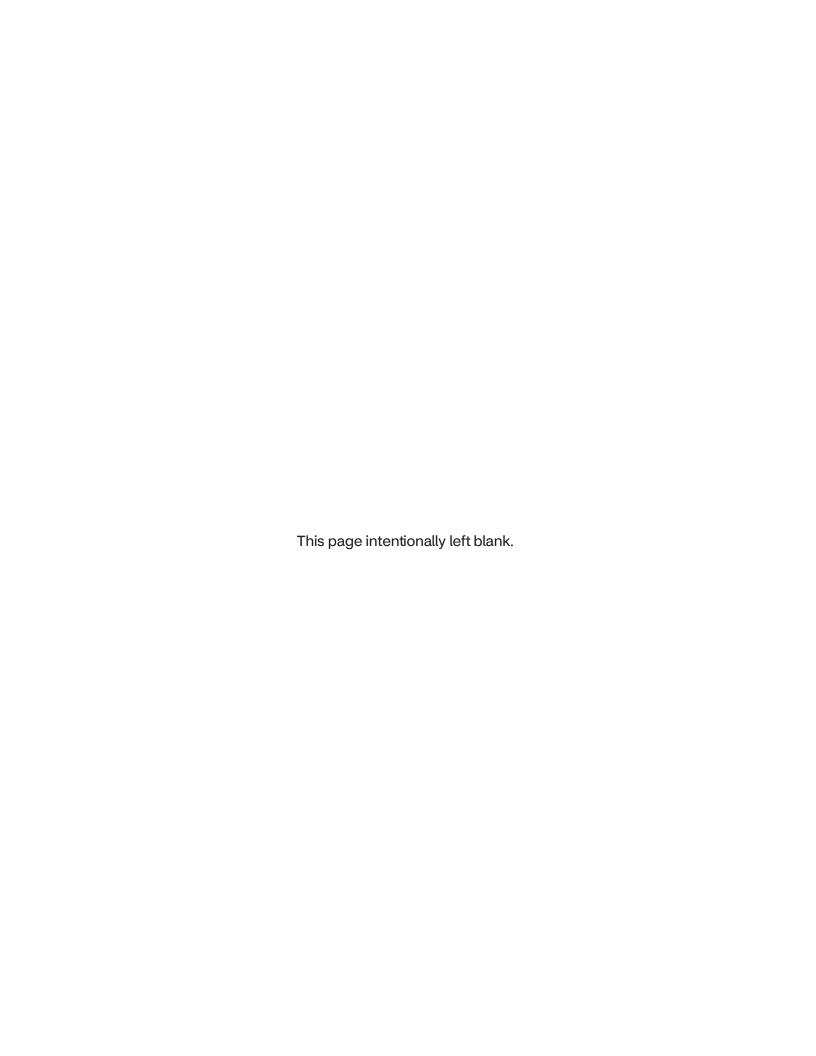
## To enroll in an Aetna plan, please provide the following information:

Choose your plan				
Check the plan you want to enroll in.				
□ *Aetna Better Health of Virginia (HMO D-SNP)	(H1610-001)	<b>\$0.00</b> per month		
□ *Aetna Medicare Assure Premier (HMO D-SNF	P) (H1610-002)	<b>\$0.00</b> per month		
□ *Aetna Medicare Assure Value (HMO D-SNP)	(H1610-003)	<b>\$0.00</b> per month		
Note: Plans with an asterisk (*) next to the plan n See the <b>Choose your Primary Care Provider (PC</b>		Care Provider (PCP) assigned.		
Proposed Effective Date of Coverage:/_ Effective dates are based on the enrollment perion & Medicaid Services' regulations. Unless you are Period (SEP), your effective date will be January requested will be honored.	od you're using to enroll an new to Medicare or are eli 1. Aetna cannot guarantee	gible for a Special Election		
Choose your Primary Care P Some of our plans coordinate your care through (*) next to the plan name (Example: "*Aetna Prinasterisk, and do not choose a PCP, we may not protected that a specialist is not considered a valid	a PCP. We have noted the me Plan (HMO)"). If you sel pay for your care and will a	ected a plan noted with an		
If the plan you have selected does NOT have an asterisk ( * ) next to the plan name, you still have the option to choose a PCP. When we know who your doctor is, we can better support your care.				
Write in the <b>name</b> , <b>Provider Group Name/Office</b> your primary care provider (PCP) below. Visit ou <b>virginia-hmosnp/find-provider</b> or call <b>1-844-9</b> network PCP for your specific plan selection.	r online provider directory	at AetnaBetterHealth.com/		
Full name of your PCP (first and last name)	Are you a current pa	tient?		
	□ Yes □ No			
Provider Group Name/Office Address				
NPI (located in the provider directory)				



# **Your information**

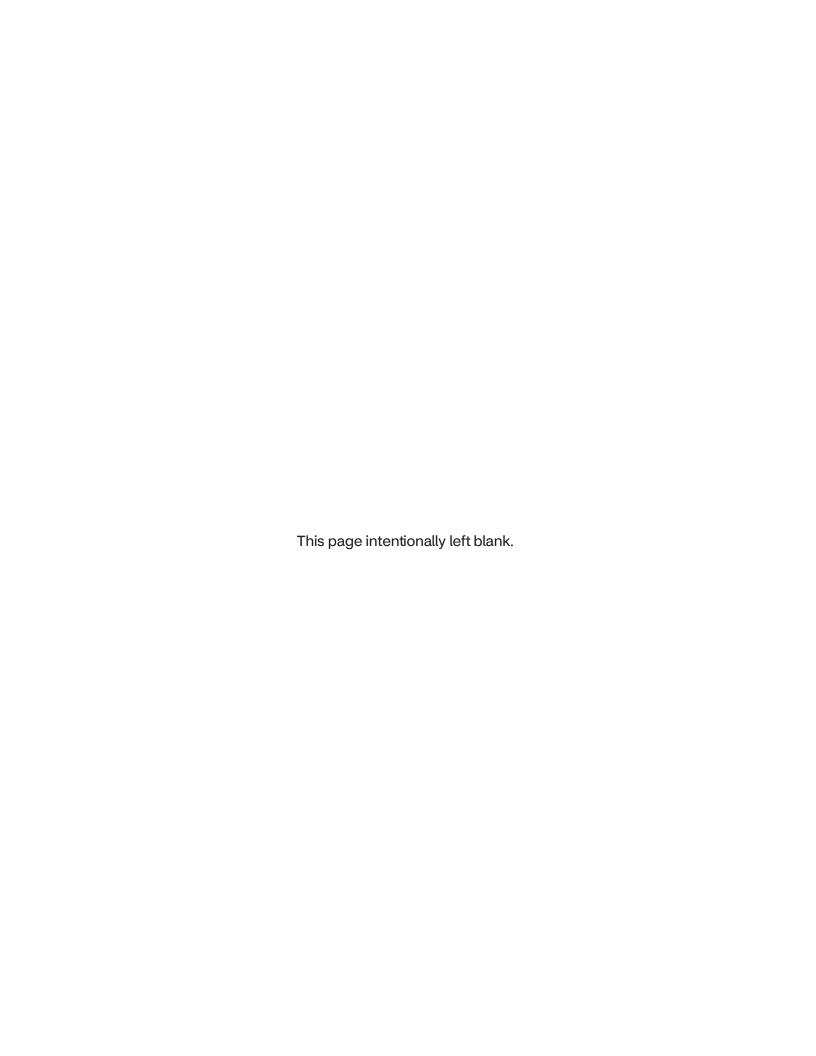
Last name		First Name		Middle initial
Birth date		Sex	Phone number: ( )	
$\overline{M} \overline{M}' \overline{D}$	$\frac{1}{D}$ $\frac{1}{Y}$ $\frac{1}{Y}$ $\frac{1}{Y}$ $\frac{1}{Y}$	□ M □ F	Is this a mobile number? $\ \square$	Yes □ No
Email addres	ss			
Permanent r	esidence street address	- including A	ot/Suite/Unit (a PO Box is no	t allowed)
City		County	State	ZIP code
Mailing addr	ess - including Apt/Suite	e/Unit (if differ	rent from your permanent stre	eet address)
		City	State	ZIP code
	This information is on y	Part A and Par	and blue Medicare insurance t B to join a Medicare Advanta	age plan. ive Date:
Answer the	ese important questio	ns		
□ Yes □ No	Some individuals ma TRICARE, Federal ei	ay have other mployee healt istance progra	drug coverage in addition to drug coverage, including othe h benefits coverage, VA bene ams. If "Yes," please list your of for this coverage:	er private insurance, fits, or state
	Name of other coverage	<b>:</b> :		
	ID # for this coverage:			
	Group # for this coveraç	ge: 		
□ Yes □ No	2. <b>Are you enrolled in</b> If "Yes," write in your Me	-		



# Please tell us a little more about yourself

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 ori		☐ Yes, Mexican, Mexican American, Chicano		n, Mexican American, Chicano/a	
☐ Yes, Puerto Rican		☐ Yes, Cuban			
☐ Yes, another Hispanic, Latino/a, or Spanish origin					
☐ I choose not to answer.					
What's your race? Select all that apply	<i>/</i> .				
☐ American Indian or Alaska Native	☐ Asian India	n		Black or African American	
□ Chinese	□ Filipino			Guamanian or Chamorro	
□ Japanese	□ Korean			Native Hawaiian	
☐ Other Asian	□ Other Pacif	ic Islander		Samoan	
□ Vietnamese	□ White				
□ I choose not to answer.					
Indicate your <b>preferred spoken language</b> (if not English):					
☐ Spanish ☐ Other (please specify):					
Indicate your <b>preferred written language</b> (if not English):					
☐ Spanish ☐ Other (please specify):					
If you need information in another language or accessible format (for example, large print or braille), contact us at <b>1-844-934-3324 (TTY: 711)</b> , 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.					



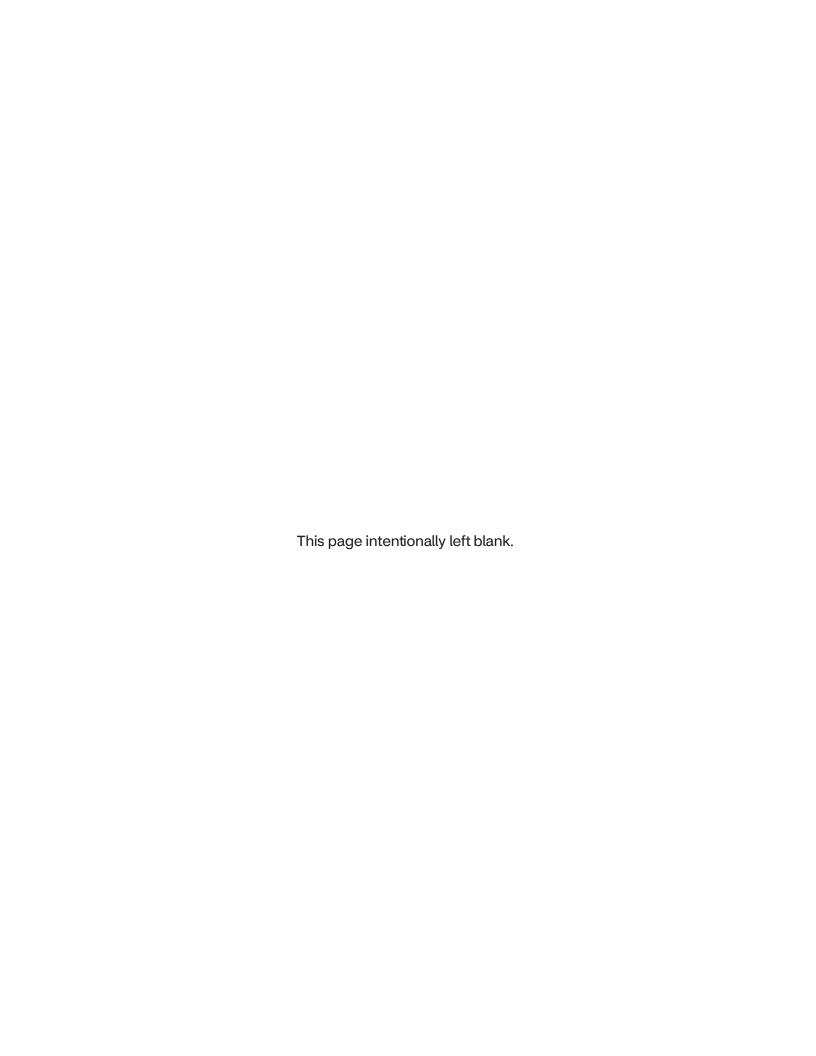
# Read this important information and sign below

- 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.
- 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).

#### **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.
- 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 Private Fee-ForService (PFFS), MA Medical Savings Account (MSA) plans).
- MA-only plans: I understand that when my Aetna Medicare coverage begins, I must get all of my medical benefits from Aetna Medicare. MA-PD plans: I understand that when my Aetna Medicare coverage begins, I must get all of my medical and prescription drug benefits from Aetna Medicare. All plans: 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.
- 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 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.

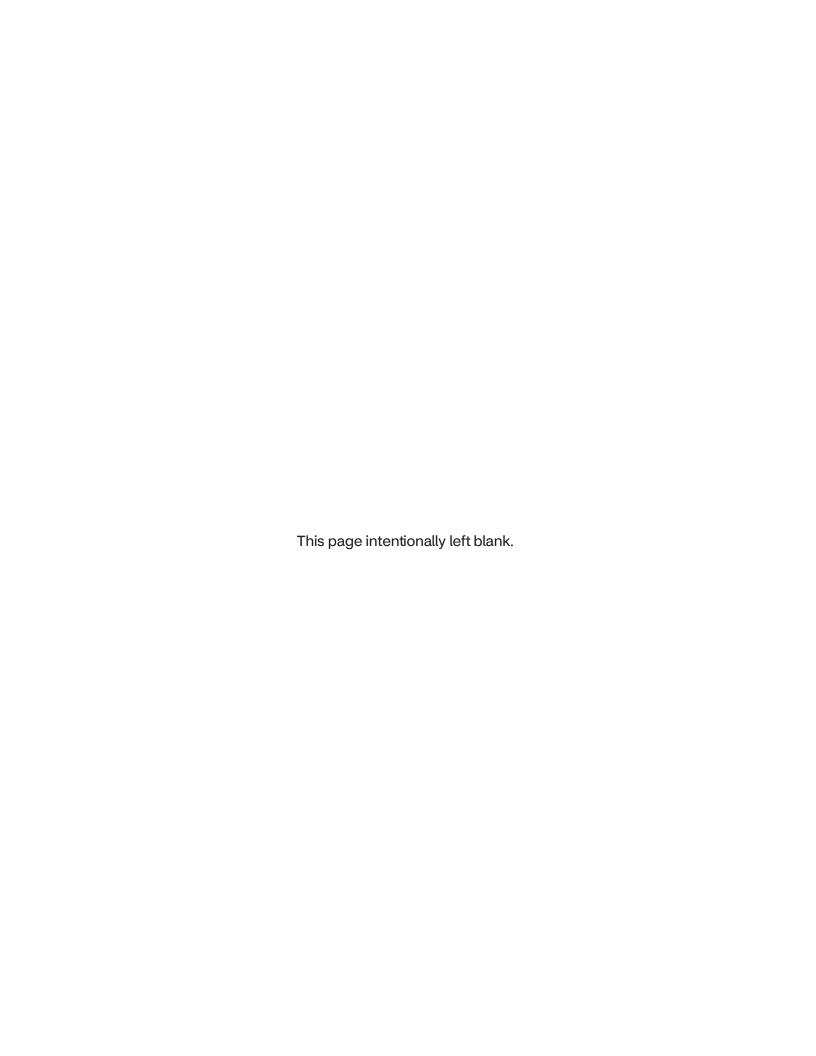
Aetna Medicare is a HMO, PPO plan with a Medicare contract. Our DSNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal. Plan features and availability may vary by service area.



Signature		Today's date	
If you're an authorized representative helping someone fill out this form provide the following information.		ou must sign above and	
Name	Address		
Phone number ()	Relationship to enrollee		

According to the Paperwork Reduction Act (PRA) 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 0938-1378. 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 of this form to send your completed form to the plan.



# **AGENT USE ONLY**

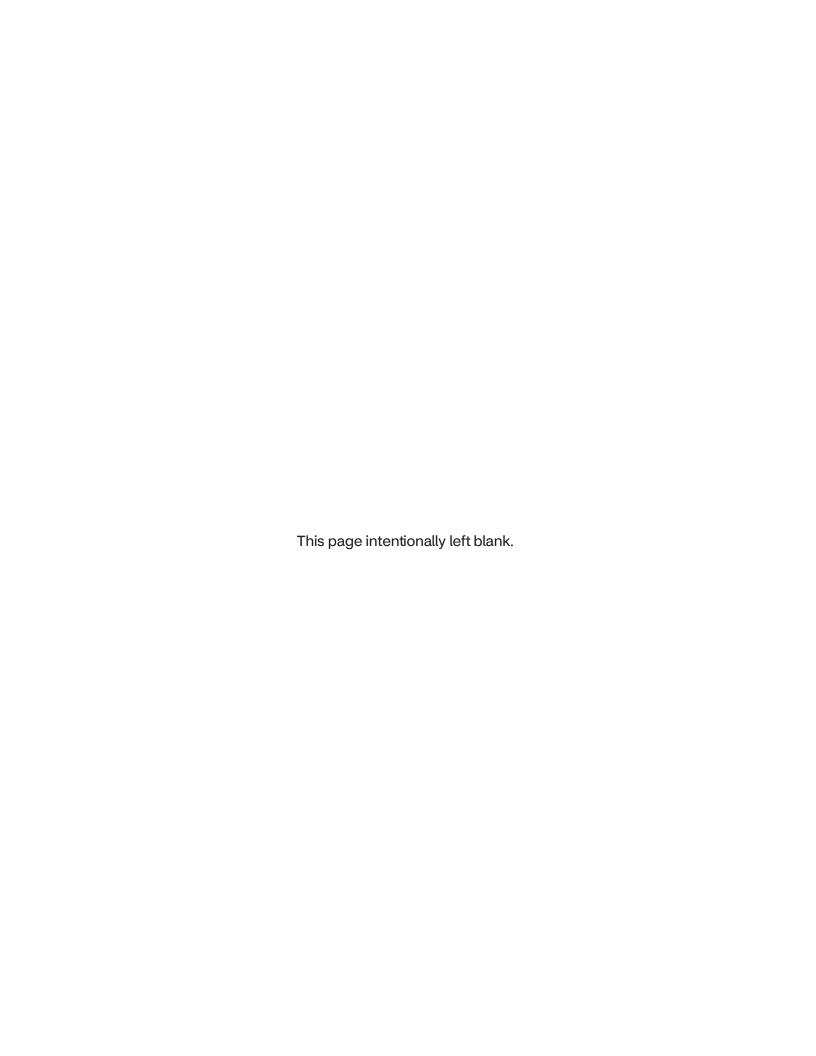
## Agent/producer/broker/representative must complete this section

Applicant's name				
If you are the <u>agent/producer/broker/employed sales representative</u> , you must provide the following information and submit it with the completed application.				
□ Yes □ No	Was the Scope of Appointment (SOA) completed? (The SOA must be agreed to by the Medicare beneficiary prior to any personal individual marketing appointment.)  If "No," why not?:			
□ Yes □ No	Was the SOA captured electronically or by telephone?  If "Yes," please provide the confirmation/ID number:  Attach the SOA or indicate why it's not available:			
Name of age	nt/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 <u>REQUIRED</u> below. Your signature indicates you understand that this application must be submitted within two calendar days of this date.				
		Date agent received the Individual Enrollment Request Form:		

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





## 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 DSNPs also have contracts with State Medicaid programs. Plan features and availability may vary by service area.

**Application Tracking Number:** 

