AETNA BETTER HEALTH Premier Plan MMAI® Membership advisory council membership application form

The Aetna Better Health Member Advisory Council gives you a place to talk to other members, family members or legal guardians of Aetna Better Health members, advocates, community stakeholders and Aetna Better Health staff. The Member Advisory Council gives you the chance to provide input about the program, its operations and ways to improve its quality and value to members.

All interested in applying for the Aetna Better Health Member Advisory Council should complete this form and return it to:

Aetna Better Health Premier Plan MMAI
Attn: Member Services
3200 Highland Avenue F661
Downers Grove, IL 60515
Fax: 1-855-259-2087
E-mail: AetnaBetterHealthIL-MemberServices@AETNA.com

PLEASE TYPE OR PRINT CLEARLY.

FIRST NAME	MI	LAST NAME
ORGANIZATION/EMPLOYER (IF APPLICABLE)		
TELEPHONE		EMAIL ADDRESS
PHYSICAL ADDRESS		
CITY	ILLINOIS ZIP	COUNTY

1) Please tell us about yourself. Please write about your background and participation in other advisory councils. Attach more pages if needed.

2) Please tell us why you want to be on this council. What will your background or interest offer to the team? Limit to one to two paragraphs please. Attach more pages if needed.

CONTINUED ON REVERSE

3) Are you currently a member of other Medicaid or advocacy committees or councils? ☐No ☐Yes (Please list)
Attach more pages if necessary

Race/Ethnicity (optional):

☐ American Indian/Alaska
☐ Native Asian/Pacific Islander
☐ Black
☐ Hispanic
☐ White
☐ Other

Experience with Medicaid

☐ None
☐ Less than 1 year
☐ 1-2 years
☐ 3-5 years
☐ More than 5 years
☐ More than 10 years

What is your membership category? (Check all that apply):

☐Member – you are currently enrolled in Illinois Medicaid
☐Member of Aetna Better Health
☐Other Medicaid Program – Please List:
☐Family member or legal guardian of a member. Name of member:
☐Community organization. Name of community organization:
☐Advocate

Can you attend daytime meetings?

☐Yes – any time ☐Yes – morning only ☐ Yes – afternoon only ☐No

We will provide transportation to these meetings. Do you need transportation or any special accommodations? If so, what?

I certify that the statement made by me on this form are true and correct to the best of my knowledge and belief. I agree to serve on the Aetna Better Health Advisory Council for two years. I will attend and participate in four meetings a year and any other sub-committee meetings as needed. If I am unable to attend, I will notify the Aetna Better Health Member Services Manager prior to the meeting.

SIGNATURE OF APPLICANT DATE

Completion of this form does not make someone a council member. Aetna Better Health will choose members based on geographic diversity and representation of other Medicaid members.

www.aetnabetterhealth.com/illinois
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