

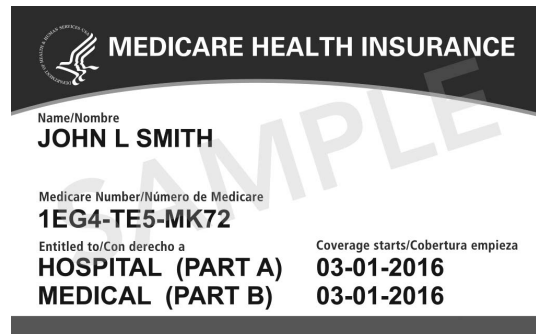
How to enroll

Online at AetnaBetterHealth.com/ virginia-hmosnp or through Medicare at www.medicare.gov	Call us at 1-833-859-6031 (TTY: 711)	Through your agent: Give them the completed form	Fax to: Attention: Enrollment Department Fax: 1-866-756-5514	Mail to: Aetna Medicare PO Box 7405 London, KY 40742
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Get ready

Have the following handy:

- Your red, white and blue Medicare insurance card (see image)
- Your health insurance information for any other insurance you have (including Medicaid)
- Your primary care physician's full name



Questions?

Call us at **1-833-859-6031 (TTY: 711)**. We're here 8 AM to 8 PM, seven days a week, from October 1–March 31 and 8 AM to 8 PM, Monday–Friday, from April 1–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 8 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 **1-833-859-6031 (TTY:711)**, 8 AM to 8 PM, seven days a week, from October 1–March 31 and 8 AM to 8 PM, Monday–Friday, from April 1–September 30.

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

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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 _____-_____-_____
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Reason for Annual Enrollment Period Eligibility

- I am enrolling between 10/15/20 - 12/7/20 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

- | | |
|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP). <input type="checkbox"/> 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). <input type="checkbox"/> I recently was released from incarceration. I was released on ___/___/___ (date). <input type="checkbox"/> I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on ___/___/___ (date). <input type="checkbox"/> I recently obtained lawful presence status in the United States. I got this status on ___/___/___ (date). <input type="checkbox"/> I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on ___/___/___ (date). <input type="checkbox"/> 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). <input type="checkbox"/> 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. <input type="checkbox"/> I recently left a PACE program on ___/___/___ (date). | <ul style="list-style-type: none"> <input type="checkbox"/> 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). <input type="checkbox"/> I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on ___/___/___ (date). <input type="checkbox"/> I will leave or left my employer or union coverage on ___/___/___ (date). <input type="checkbox"/> I belong to a pharmacy assistance program provided by my state. <input type="checkbox"/> My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan. <input type="checkbox"/> 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). <input type="checkbox"/> 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). <input type="checkbox"/> I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster. |
|---|---|

- None of these statements apply to me. Call us at **1-833-859-6031 (TTY: 711)** to see if you can enroll. We're here 8 AM to 8 PM, seven days a week, from October 1-March 31 and 8 AM to 8 PM, Monday-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 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** or **\$28.50** 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**: Tell us the name of your primary care physician (PCP) and their Primary Care ID. If you don't, we may not pay for your care and may assign a PCP to you. Write in the **name** and **Primary Care ID** of your PCP below. Visit our online provider directory at AetnaBetterHealth.com/virginia-hmosnp/find-provider or call **1-833-859-6031 (TTY: 711)** to find provider information or a network PCP.

Write the full name of your PCP

Are you a current patient?

Yes No

Primary Care ID (located in the provider directory)

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Section 4: Provide your Medicare insurance information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

- OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card): _____

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)**.

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Section 6: Plan premium and/or late enrollment penalty (LEP) payment

Let us know how you want to pay your plan premium (and any late enrollment penalty) each month. Please select an option even if your plan has a \$0 premium. If you don't select a payment option, we'll automatically send you an invoice or a coupon book. Check a box below.

I want to pay from my bank account - Electronic Funds Transfer (EFT).

With this option:

- You won't need to remember to send in a check each month.
- The money is automatically taken from your account on the 10th of each month (or the following business day).

Please complete the following:

Account holder name: _____

(Print the name as it appears on the account to be debited.)

Bank name: _____

ROUTING NUMBER

ACCOUNT NUMBER

Account type:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Checking Savings

Signature of account holder: (if different than enrollee) _____

I agree that this authorization will remain in effect until I provide written notification terminating this service.

I want to pay from my Social Security Administration (SSA) or Railroad Retirement Board (RRB) check. (This option can't be selected for \$0 premium plans.)

I get monthly benefits from: Social Security RRB

With this option:

- It can take several months for this option to go into effect after the SSA or RRB approves your request. The first deduction may include all the premiums you owe from when your enrollment starts to the point when we begin taking them out of your check.
- SSA or the RRB determines the date this goes into effect. **You need to pay your premium directly to us for any months the SSA or RRB doesn't cover.**
- Sometimes we're notified that SSA or the RRB did not approve your request. If this happens, you'll likely have to connect with the SSA or the RRB to resolve.
- If Social Security or the RRB does not approve your request, we'll send you an invoice or a coupon book to pay your monthly premium.

I want to pay by invoice or coupon book. With this option:

- You can mail us a check with your payment slip each month.
- You can go online and pay by credit card.
- You can bring your payment slip into any retail CVS location and make a payment with cash, credit card, or debit card. (Note: This service is not available at CVS Pharmacy Target® locations.)

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Section 6: Plan premium and/or late enrollment penalty (LEP) payment (continued)

Additional notes about payment and options:

- Social Security will contact you if you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D IRMAA). You'll have to pay this extra amount as well as your plan premium. You will either have the amount withheld from your Social Security or RRB benefit check, or be billed directly by Medicare or the RRB. **Do not send your Part D IRMAA payment to us.**
- Written EFT terminations must be received before the 1st of the month of the EFT transaction. EFT transactions will occur on the 10th of the month in the amount of the balance due.
- If you owe a late enrollment penalty, you can pay the penalty by EFT, mail or have it taken out of your Social Security or Railroad Retirement Board (RRB) benefit check.
- If your income is limited, you may qualify for the Extra Help program to pay for your prescriptions. If you're eligible, Medicare could pay 75 percent or more of your drug costs, including monthly prescription drug premiums, annual deductibles, and co-insurance. Also, you won't be subject to the coverage gap or a late enrollment penalty. Medicare could pay all or part of your plan premium. If Medicare only pays part of the premium for your prescription drug plan, we will bill you for the remaining amount. For more information, contact your local Social Security office or call Social Security at **1-800-772-1213 (TTY: 1-800-325-0778)**, or go to **www.socialsecurity.gov/prescriptionhelp**.



Section 7: Read this important information



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 8: 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. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

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.

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Section 8: Read and sign below (continued)

Release of Information: By joining this Medicare health plan, I acknowledge that Aetna Medicare will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Aetna Medicare will release my information, (including my prescription drug event data), to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. 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 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 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 **1-833-859-6031 (TTY:711)**, 8 AM to 8 PM, seven days a week, from October 1–March 31 and 8 AM to 8 PM, Monday–Friday, from April 1–September 30.

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Section 9: 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 7405
London, KY 40742
Fax: 1-866-756-5514**

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