



Enrollment instructions

Answer all questions completely. Incomplete or incorrect information may delay the start of your coverage. Below are the instructions for each section of the enrollment form. You can use this form to enroll or submit a plan change if you're already enrolled.

- Effective date:** Your coverage will begin on the first day of the month after you sign this enrollment form, or the date your enrollment is completed. **The effective date can't be earlier than the day you sign this form.**
- Former employer information:** Write the name of the former employer/union/trust offering this health plan (the company you retired from). List the group number and class code if you know it. The group number and class code number are not required. (This information may be pre-filled.)
- Personal information:** This is your name, address, phone number, etc. **Print clearly.**
- Medicare information:** This is your Medicare insurance information, found on your red, white and blue Medicare Card. Complete all the fields to avoid a delay in your coverage.
- Health plan selection:** Check the box next to the plan you want to enroll in. (there may be only one plan available). For more plan details, look at the benefit summary included in your enrollment packet.
- Select a provider:** For Aetna Medicare Plan (HMO): A primary care physician (PCP) is required. Write in the name of your PCP and their office ID number. You'll find this is in our provider directory.
For Aetna Medicare Plan (PPO): A primary care physician is **not** required. But if you choose one you may pay less for care. Write the name of your PCP and office ID number.
- Select a dentist:** **For Aetna Medicare Plan (HMO) only:** If DMO dental benefits are included in your plan, a primary dentist is required. Write the name of your Aetna dentist and their office ID number.
- Medicare-related questions:** Read and answer these Medicare questions.
- Read this important section carefully:** DISCLOSURES
- Signature required:** Sign and date the application in the space provided.
Authorized representatives: Sign the form and write in your information
- Make a copy for yourself and mail original:** Make a copy of the entire application for your records. Then mail your completed original form to the address below. A separate enrollment form must be completed for each Medicare-eligible dependent. Two forms may have been included for your convenience.

Aetna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATTENTION: If you speak a language other than English, free language assistance services are available. Visit our website at www.aetnamedicare.com or call the phone number listed in this material.

ESPAÑOL (SPANISH): ATENCIÓN: Si usted habla español, se encuentran disponibles servicios gratuitos de asistencia de idiomas. Visite nuestro sitio web en www.aetnamedicare.com o llame al número de teléfono que se indica en este material.

繁體中文 (CHINESE): 請注意：如果您說中文，您可以獲得免費的語言協助服務。請造訪我們的網站 www.aetnamedicare.com 或致電本材料中所列的電話號碼。

Call your former employer/union/trust or Aetna Medicare with any questions.

Phone number: **1-800-307-4830 (TTY: 711)**
Hours: Monday – Friday, 7 a.m. – 8 p.m. CT
Mail to: Aetna, PO Box 14088, Lexington, KY 40512-4088
Website: <http://www.aetnaretireplans.com>
Fax Number: **1-888-665-6296**

Effective date: / 01 /

Former employer/union/trust information: Write the name of the former employer/union/trust offering your retiree health plan unless this information is pre-filled.

Name of former employer/union/trust	Group number	Class code
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PERSONAL INFORMATION

Last name	First name	Middle initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
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Birth date (<u> </u> / <u> </u> / <u> </u>) (M M / D D / Y Y Y Y)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Home phone number ()
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Permanent residence street address (PO Box is not allowed)

City	State	ZIP code	County
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Mailing address (only if different from your permanent residence address)	Email address (optional)
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Emergency contact name (optional)	Relationship to you
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Phone number	Cell phone number
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Medicare information

Use your Medicare card to complete this section.

- Fill in these blanks so they match your red, white and blue Medicare card.
- or -
- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.



SAMPLE ONLY

Name _____ Sex ____

Medicare claim number _____ - _____ - _____

Is entitled to _____ Effective date: (MM/YY)

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Health plan selection: Check the box next to the type of plan you want to enroll in. Then write the name of the specific plan on the line provided. (This information may be pre-filled). For more plan details, look at the benefit summary included in your enrollment kit. **Make sure to read the important health plan disclosures on Page 4.**

<input type="checkbox"/> Aetna Medicare HMO (write plan name below)	<input type="checkbox"/> Aetna Medicare PPO (write plan name below)
<input type="checkbox"/> Aetna Medicare HMO with Rx (write plan name below)	<input type="checkbox"/> Aetna Medicare PPO with Rx (write plan name below)

Fill out the following:

I'm currently enrolled in a Medicare Advantage plan issued by (insurance company name) _____. I'd like to change to an Aetna plan. I understand this plan may have different health benefits and monthly payments than my current plan.

Select providers: A primary care physician (PCP) is required for HMO plans and is recommended for PPO plans. (PPO members may pay less by choosing a PCP.) If you choose an HMO plan with DMO dental benefits, you must also choose a dentist. To select a PCP or dentist, look at the Aetna Medicare provider directory or call the phone number on the instruction page.

PCP first and last name	PCP office ID
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Dentist first and last name (for HMO plans with DMO dental benefits)	Dentist office ID (for HMO plans with DMO dental benefits)
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Applicant name: _____ Effective date: / 01 /

MEDICARE-RELATED QUESTIONS

Yes No **Are you an Aetna member?** If Yes, provide your member ID number _____

Yes No **Are you the retiree?** If Yes, provide retirement date (MM/DD/YYYY): ___ / ___ / _____
If No, name of retiree: _____

Yes No **Are you covering a spouse or dependents under this employer, trust or union plan?**
If Yes, name of spouse: _____ Name of dependents: _____

Yes No **Do you or your spouse work?**

Yes No **Do you have end-stage renal disease (ESRD)?** If you've had a successful kidney transplant and/or you don't need regular dialysis any more, **attach a note or records from your doctor** showing you've had a successful kidney transplant or you don't need dialysis. Otherwise, we may need to contact you to obtain additional information.
If Yes, what is the date of your first dialysis treatment? Date: (month) _____ (year) _____

Yes No **Did you become eligible for Medicare because of ESRD and has it been less than 30 months since you became eligible?** If so, Medicare Advantage Coverage will be your secondary coverage for the first 30 months of the coordination period.
If Yes, provide your prior commercial coverage carrier's name: _____
Member number: _____ Effective date ___ / ___ / _____

Yes No **Was your previous policy terminated?** If Yes, provide termination date: ___ / ___ / _____

Yes No **Are you a resident in a long-term care facility, such as a nursing home?**
If Yes, provide the following information:
Name of institution: _____ Phone number: (____) _____
Address: _____ State: _____ ZIP: _____

Yes No **Are you enrolled in your state Medicaid program?** If Yes, provide your Medicaid number: _____

Please choose your preferred language:
 Spanish Other _____
Please contact us at the number below if you need information in another language or format (e.g., large print or braille).
This information is available for free in other languages. Please call our customer service number at **1-888-267-2637 (TTY: 711)**. We're here 8 a.m. to 6 p.m., local time, Monday through Friday.

Other Rx coverage: Complete only if you have other prescription drug coverage.

Yes No Some individuals may have other drug coverage, including other private insurance, workers' compensation, VA benefits or through state pharmaceutical assistance programs.
Will you have other prescription drug coverage in addition to the Aetna Medicare Advantage Rx plan? If Yes, please list your other coverage and identification number(s) for this coverage:
Name of other coverage: _____
ID #: _____ Group #: _____

Yes No **Have you had creditable coverage since you became eligible for Medicare prescription drug coverage?**
If so, from date (MM/DD/YY) _____ to date (MM/DD/YY) _____
Creditable coverage is prescription drug coverage that is at least as good as Medicare prescription drug coverage.
NOTE: If you've not had creditable coverage, you may have to pay a late enrollment penalty. Aetna may ask you to provide evidence of creditable coverage. If you have questions about the late enrollment penalty, call Aetna at the number provided on this form.

