aetna®

Aetna Medicare Rx® (PDP) Plan
2017 Employer Group Enrollment Form
Prescription Drug Plan (PDP)

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 prescription drug plan (the company you retired from). List the group number and class code if you know it. The group number and class code 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.
Prescription drug 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.
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.aetnaretireeplans.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 prescription drug plan, unless this information is pre-filled.

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

PERSONAL INFORMATION

Last name	First name	Middle initial ☐ Mr. ☐ Mrs. ☐ Ms.	
Birth date (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Sex ☐ M ☐ F	Home phone number ( )	
Permanent residence street address (PO Box is not allowed)			
City	State	ZIP code	County
Mailing address (only if different from your permanent residence address)		Email address (optional)	

Emergency contact name (optional)	Relationship to you
Phone number	Cell phone number

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 or Part B (or both) to join a Medicare Rx (PDP) Plan.

SAMPLE ONLY

Name ______________________ Sex ____

Medicare claim number ___ - __ - ____ _

Is entitled to: Effective date (MM/YY)

HOSPITAL (Part A) __________

MEDICAL (Part B) __________

Prescription drug plan selection: Check the box, 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 prescription plan disclosures on Page 4.**

☐ I wish to enroll in the Aetna Medicare Rx (PDP) Plan. Plan name: ______________________

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.

Applicant name:	**Effective date: / 01 /**

MEDICARE-RELATED QUESTIONS

☐ Yes ☐ No **Are you an Aetna member?** If Yes, provide your member ID number: ______________________

☐ Yes ☐ No **Will you have other prescription drug coverage in addition to the Aetna Medicare Rx Plan (PDP)?** 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: 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's 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.

☐ 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: _______________

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 **1-800-594-9390 (TTY: 711)**. We're here 8 a.m. to 6 p.m., local time, Monday through Friday.

EXTRA HELP

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75 percent or more of your drug costs including monthly prescription drug premiums, annual deductibles and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office or call Social Security at **1-800-772-1213 (TTY: 1-800-325-0778)**. You can also apply for extra help online at **www.socialsecurity.gov/prescriptionhelp**.

STOP READ THIS IMPORTANT INFORMATION STOP

If you're a member of a Medicare Advantage plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage plan that will meet your needs. By joining the Aetna Medicare Rx (PDP) plan, your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage, as well as your prescription drug coverage. Read the information your Medicare Advantage plan sends you and if you have questions, contact your Medicare Advantage plan.
If you currently have health coverage from another employer or union, joining Aetna Medicare Rx® (PDP) Plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Aetna Medicare Rx (PDP) Plan. 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 information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Applicant name:	**Effective date: / 01 /**

DISCLOSURES: Read this section carefully

By completing this enrollment application, I agree to the following: Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal. The Aetna Medicare Rx Plan (PDP) is a Medicare drug plan and has a contract with the federal government. I understand this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. It's my responsibility to inform the Aetna Medicare Rx Plan (PDP) of any prescription drug coverage I have or may get in the future. I can only be in one Medicare prescription drug plan at a time – if I am currently in a Medicare prescription drug plan, my enrollment in the Aetna Medicare Rx Plan (PDP) will end that enrollment. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally the Annual Enrollment Period (October 15 – December 7), unless I qualify for certain special circumstances. The Aetna Medicare Rx Plan (PDP) serves a specific service area. If I move out of the area that Aetna Medicare Rx Plan (PDP) serves, I need to notify the plan and my former employer/union/trust so I can disenroll and find a new plan in my new area. I understand I must use network pharmacies except in an emergency when I cannot reasonably use Aetna Medicare Rx Plan (PDP) network pharmacies. Once I am a member of the Aetna Medicare Rx Plan (PDP), 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 when I get it to know which rules I must follow to get coverage. I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future. I understand I must show my membership card and fill my prescriptions at a network pharmacy. I've been advised not to cancel or drop any supplemental insurance I currently have until I receive written notification of my confirmed effective date from Aetna. I may also be disenrolled if I do not pay any applicable plan premiums within the grace period. The effective date of disenrollment is in accordance with federal requirements. I understand if I am getting assistance from a sales agent, broker or other individual employed by or contracted with Aetna's Medicare Advantage plans, he/she may be paid based on my enrollment in the Aetna Medicare Advantage plan. Counseling services may be available in my state to provide advice concerning Medicare Supplement insurance or other Medicare Advantage or prescription drug plan options, medical assistance through the state Medicaid program, and the Medicare Savings program. **Release of information:** By joining this Medicare prescription drug plan, I acknowledge that Aetna will release my information to Medicare and other plans as necessary for treatment, payment and health care operations. I also acknowledge that Aetna 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 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 State law 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 by Medicare.

Signature	**Today's date**

If you're the authorized representative, you must sign above and provide the following information:

Representative's name	Address
Phone number	Relationship to enrollee

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, formulary, pharmacy network, provider network, premium and/or co-payments/co-insurance may change on January 1 of each year. You must be entitled to Medicare Part A and continue to pay your Part B premium and Part A, if applicable. This information is available for free in other languages. Please call our customer service number at **1-800-594-9390 (TTY: 711)**, 8 a.m. to 6 p.m., local time, Monday through Friday.

Esta información está disponible en otros idiomas de manera gratuita. Comuníquese con Servicios al Cliente al **1-800-594-9390 (TTY: 711).** Horario de atención: de 8 a.m. a 6 p.m., hora local, de lunes a viernes.

本資訊也有其他語言的免費版本可供選擇。請致電**1-800-594-9390**　與我們的客戶服務部聯絡以瞭解更多資訊。（聽障人士請致電 **711**）辦公時間為週一至週五、當地時間上午 8 時至晚間 6 時。

Make a copy for yourself and return the original