We want you to know®
Aetna Medicare

Aetna Medicare Rx Plan Group Enrollment Form

Please fill out this form completely by answering all questions. Incomplete or inaccurate information may delay the start date of your coverage. If you have any questions about this application, please contact your former employer or Aetna Medicare at 1-800-307-4830 (TTY/TDD: 1-800-628-3323).

Former Employer Information: *Please tell us about the employer who is providing your retiree health benefits.*

Former Employer Name	Group Number

Personal Information - *Please provide us with some information about you. Please print clearly.*

Last Name	First Name	Middle Initial ☐ Mr. ☐ Mrs. ☐ Ms.

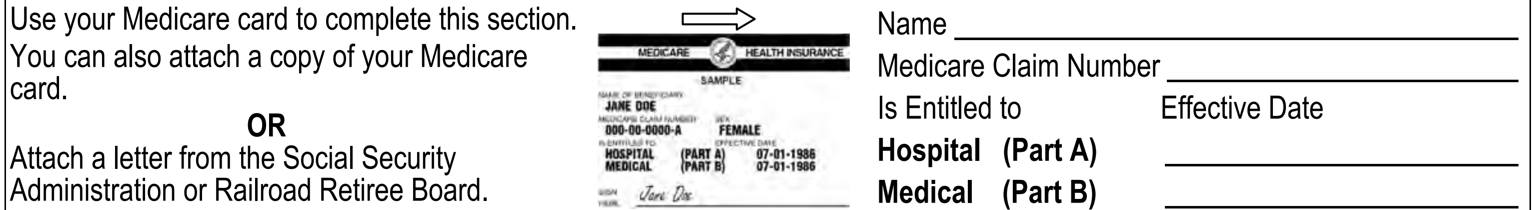
Birth Date (__ __/__ __/__ __ __ __) (M M/D D/Y Y Y Y)	Sex ☐ M ☐ F	Social Security Number (*Optional*)	Home Phone Number ( )

Permanent Residence Street Address

City	State	ZIP Code	County	P.O. Box (Mailing Address)

Race/Ethnicity* ☐ Asian ☐ Black ☐ Hispanic or Latino ☐ White ☐ Other
* Optional – This information cannot be used to deny your application for membership.

Medicare Information – *Complete this section.*



Use your Medicare card to complete this section. You can also attach a copy of your Medicare card.

OR

Attach a letter from the Social Security Administration or Railroad Retiree Board.

Name ____________________
Medicare Claim Number ____________________

Is Entitled to	Effective Date
Hospital (Part A)	________
Medical (Part B)	________

Plan Selection

☐ I wish to enroll in the Aetna Medicare Rx Plan. Option ____________________

Answer the Following Questions to Help Medicare Coordinate Your Benefits

☐ Yes ☐ No **Will you have other prescription drug coverage in addition to the Aetna Medicare Rx Plan?**
Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health coverage, VA benefits or State pharmaceutical assistance programs. If Yes, complete
Name of Coverage ____________ ID # ____________ Group # ____________

☐ Yes ☐ No **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 No, refer to "Creditable Coverage" section on the back of this form.

☐ Yes ☐ No **Are you a resident in a long-term care facility, such as a nursing home?** If Yes, provide the
Institution Name ____________________
Institution Address & Phone Number ____________________

Read This Important Information

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have a prescription drug benefit from your Medicare Advantage plan that will meet your needs. By joining the Aetna Medicare Rx 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 benefits. Read the information that your Medicare Advantage plan sends you; and if you have questions, contact your Medicare Advantage plan.

Please Read Carefully

By completing this enrollment application, I agree to the following:
The Aetna Medicare Rx Plan is a Medicare drug plan and is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare coverage. It is my responsibility to inform the Aetna Medicare Rx Plan of any prescription drug coverage that 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 Aetna Medicare Rx Plan will end that enrollment. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to Aetna Medicare or by calling 1-800-MEDICARE. TTY/TDD users should call 1-877-486-2048, 24 hours per day, 7 days per week. The Aetna Medicare Rx Plan serves a specific service area. If I move out of the area that the Aetna Medicare Rx Plan 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 the Aetna Medicare Rx Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from the Aetna Medicare Rx Plan when I receive it to know which rules I must follow in order to receive coverage with this Medicare prescription drug plan.

Release of Information:
By joining this Medicare prescription drug plan, I acknowledge that Aetna or its affiliates will release my information to Medicare and other plans as is necessary for treatment, payment of claims and health care operations. I also acknowledge that Aetna Medicare Rx Plan will release my information, including my prescription drug event date, 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. If I have any questions about the benefits and services that are provided or excluded from this agreement, I should contact an Aetna Medicare representative before signing this enrollment form. **If a sales representative discussed plan options with me, I understand that this person is acting on behalf of Aetna's Medicare prescription drug plans and may be compensated based upon my enrollment in this plan.**
I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) 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 Aetna or by Medicare.

SIGNATURE ____________________ **TODAY'S DATE** ________

If you are the authorized representative, you must provide the following information:
Name ____________________
Address ____________________
Phone Number ( ) ____________ **Relationship to Enrollee** ____________

Creditable Coverage

If you have not had creditable coverage, you may have to pay a penalty. Aetna may ask you to provide evidence of creditable coverage. If you have any questions about the late enrollment penalty, call 1-800-307-4830. For TTY/TTD call 1-800-628-3323.

Benefits coverage is provided by Aetna Life Insurance Company, a Medicare Prescription Drug Plan sponsor with a Medicare contract.

Customer Service **1-800-307-4830 (TTY/TDD: 1-800-628-3323)**
Monday through Friday – 8:00 a.m. to 6:00 p.m.
PO BOX 963, Blue Bell, PA 19422-9921
www.aetnamedicare.com

For Aetna Internal Use Only

Aetna Medicare Rx Plan

Group # ____________________ Name of Staff Member (if assisted in enrollment) ______________________________________

Effective Date of Coverage _________________ ICEP/IEP _________ OEP __________ AEP __________ SEP __________

Rep Code ___________ Rep Name _____________________________________ Member # ______________________________

Broker/Agent Use Only

Tax ID # ____ Name ____

Phone Number ______________________________ Email ____

☐ By checking this box, I am attesting to the fact that I am part of a larger organization (i.e., General Agency, Field Marketing Organization, Affinity Partner).

Name of Organization ____Tax ID # _________________________________

AGENT/BROKER ONLY - Must submit the completed enrollment form to:
Aetna Medicare Prescription Drug Plans, P.O. Box 935, Blue Bell, PA 19422

Employer Use Only Group # ________________

Employer Name ____

Contact Name ________________________________ Authorized Signature ____

Phone Number ________________________________ Coverage Effective Date _____________________________________