

**Aetna Medicare Open Plan
Private Fee-For-Service Individual Enrollment Form**

Mail your completed form to the address below using the enclosed, postage-paid envelope.

Aetna Medicare Advantage Plans P.O. Box 963 Blue Bell, PA 19422-9921

If you have questions, call **1-800-832-2640** or TTY/TDD **1-800-628-3323**, Monday-Friday 8:00 a.m. – 6:00 p.m.

To enroll in the Aetna Medicare OpenSM Plan, provide the following information.

Check which plan you want to enroll in:

- Aetna Medicare Open Value Plan (Medicare Advantage only)
- Aetna Medicare Open Value Plan with Rx (Medicare Advantage with Rx)
- Aetna Medicare Open Premier Plan (Medicare Advantage only)
- Aetna Medicare Open Premier Plan with Rx (Medicare Advantage with Rx)

LAST NAME	FIRST NAME	MIDDLE INITIAL	
			<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.

Birth Date ____/____/____ M M D D Y Y Y Y	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number (Optional) ____-____-____	Home Phone Number () _____
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Permanent Residence Street Address _____

City _____	State _____	Zip Code _____
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Mailing Address (only if different from your Permanent Residence Address)
Street Address _____ City _____ State _____ Zip Code _____

Emergency Contact (Optional)
Name _____ Phone Number () _____ Relationship to You _____

Email Address (Optional) _____

Provide Your Medicare Insurance Information

Please take out your Medicare Card to complete this section.

- Please 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 the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A or Part B (or both) to join a Medicare Advantage plan.

MEDICARE HEALTH INSURANCE	
SAMPLE ONLY	
Name _____	Sex _____
Medicare Claim Number _____	
Is Entitled To _____	Effective Date _____
HOSPITAL (Part A) _____	
MEDICAL (Part B) _____	

Paying Your Plan Premium

Payment Options include:

- Receiving a monthly bill.
- Automatic deduction from your monthly SSA benefit check. (The SSA deduction may take two or more months to begin. In most cases, the first deduction from your SSA benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)
- Check here if you would like to enroll in automatic deduction from your monthly SSA benefit check.
 - Electronic fund transfer (EFT) from your bank account each month*.
 - One time credit card payment*.

*You must contact 1-888-268-9800 or TTY/TDD 1-800-628-3323, Monday through Friday 8 a.m. to 4:30 p.m. to enroll for EFT payments or to make a one time credit card payment.

If you qualify for extra help with your Medicare prescription drug coverage cost, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover.

If you do not contact us to enroll or check the box for automatic SSA deduction, you will receive a bill each month.

Answer the Following Questions

1. Do you have End Stage Renal Disease (ESRD)? Yes No
 If you answered "Yes" to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, please attach a note or record from your doctor showing you do not need dialysis or have had a successful kidney transplant.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits or State pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to Aetna Medicare Advantage drug plan? Yes No
 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: _____

3. **Are you a resident in a long-term care facility such as a nursing home?** Yes No
 If "Yes", provide the following information:
 Name of Institution _____
 Address & Phone Number of Institution (number and street): _____

4. **Are you enrolled in your State Medicaid program?** Yes No
 If "Yes", provide your Medicaid number _____

5. Do you or your spouse work? Yes No

Check one of the boxes below if you would prefer us to send you information in a language other than English. (Optional)
 Spanish Chinese



Please Read This Important Information

If you currently have health coverage from an employer or union, joining the Aetna Medicare Advantage Plan could affect your employer or union health benefits. If you have health coverage from an employer or union, joining the Aetna Medicare Advantage Plan may change how your current coverage works. 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 is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please read this section and the Acknowledgements on the back, then sign below.

By completing this enrollment application, I agree to the following:

The Aetna Medicare Open Plan is a Medicare Advantage plan and I will need to keep my Part A and B coverage. I understand I must continue to pay my Part B premium and Part A, if applicable. I can only be enrolled in one Medicare Advantage plan at a time. It is my responsibility to inform you of any prescription drug coverage that I might have or may get in the future. If I am enrolling in a Medicare Advantage plan without drug coverage, I understand that I do not 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 in the future. 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 Advantage Plan serves a specific service area. If I move out of the area that the Aetna Medicare Advantage 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 Advantage 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 Advantage Plan when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage Plan. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

Release of Information:

By joining this Medicare health plan, I acknowledge that Aetna or its affiliates will release my information to Medicare and other plans as is necessary for treatment or services, payment of claims and health care operations. 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 a sales representative before signing this enrollment form.**

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, including the ACKNOWLEDGEMENT SECTION on this form. If signed by an authorized individual, this 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 _____

Acknowledgement

1. If a sales representative discussed plan options with me, I understand that this person is acting on behalf of Aetna's Medicare Advantage plans and may be compensated based upon my enrollment in this plan.
2. I understand that I must follow applicable plan guidelines as referenced below:
Aetna Medicare Open Plan® (PFFS): You can receive covered services from any licensed doctor or hospital that is eligible to receive payment from Medicare, agrees to treat you and accepts the Aetna Medicare Open Plan terms and conditions of participation. This product does not require a contracted network and providers are not required to accept Medicare Private Fee-for Service plans.
3. I have been advised not to cancel or drop any supplemental insurance I currently have until I receive written notification or my confirmed effective date from Aetna.
4. If I permanently move or leave my service area for more than six (6) consecutive months, I may be disenrolled from this plan and returned to Original Medical coverage. 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.
5. I understand that I will receive the plan's Evidence of Coverage, which contains a full description of the governing plan provisions, exclusions and limitations of coverage.
6. I understand that the providers are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates.
7. I acknowledge that Aetna will release my information, including prescription drug event date to Medicare, who may release it for research and other purposes which follow all applicable Federal statues and regulations.

Benefits coverage is provided by Aetna Life Insurance Company, a Medicare Advantage organization with a Medicare contract.

For Aetna Internal Use Only

Aetna Medicare Advantage Plan	Date _____
	Plan ID # _____
Name of Aetna Staff Member (if assisted in enrollment) _____	
Email _____	
Effective Date of Coverage _____ IEP _____ AEP _____ SEP (type) _____	
Rep Code _____ Rep Name _____	

Agent/Broker	Date _____
Tax ID # _____ Name _____	
Phone Number _____ Email _____	
<input type="checkbox"/> 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 Advantage Plans, P.O. Box 935, Blue Bell, PA 19422 Fax to: 860-975-1707	

General Agent	Date _____
Tax ID # _____ Name _____	
Phone Number _____ Email _____	

Affinity	Date _____
Company Name _____	

Field Service Representative	Date _____
Aetna ID _____ Name _____	