

You may choose to enroll on-line using our website: aetnamedicare.com. Otherwise, follow these instructions to complete this enrollment form.

Applicant Enrollment Instructions	
Follow these steps to enroll:	
SECTION 1:	Please select the Aetna Medicare Rx [®] Plan (PDP) in which you wish to enroll; include the premium amount of the chosen plan (refer to the Summary of Benefits for detailed benefit information and premium amounts). Please be aware: You can change plans only at certain times during the year*. The general timeframes are: – Annual Enrollment Period: The Annual Enrollment Period is from October 15 through December 7, 2011. During the Annual Enrollment Period anyone with Medicare can select a new Medicare health and/or Medicare prescription drug plan for the following year. * There are exceptions that may allow you to enroll at other times. Refer to Section 6. Contact Aetna at the number listed below for more information on these special enrollment periods.
SECTION 2:	Complete the personal information section (Name, Address, Phone number, etc.). <i>Print clearly.</i>
SECTION 3:	Using your red, white and blue <i>Medicare Card</i> , provide us with your Medicare Insurance information.
SECTION 4:	Check a box for your preferred premium payment method. Do not submit your premium payment with this enrollment form.
SECTION 5:	Please read and answer the questions in this section to help Aetna coordinate your benefits.
SECTION 6:	Complete this section if you are enrolling during a special enrollment period. Check the box(es) that apply to you. A Customer Service Representative may contact you if additional information is required.
SECTION 7:	Read the Important Information in SECTION 7.
SECTION 8:	Sign and date the enrollment form in the space provided at the end of Section 8. <u>If you are a legally authorized representative</u> and assisting the enrollee in completing this enrollment form, sign this form and provide your information under the signature area.
SECTION 9:	Broker/Agent section (if applicable) – Your broker or agent must sign and date the application.

Be sure to complete the entire enrollment form. Missing or inaccurate data will delay enrollment processing.

After you have completed the form, tear out pages marked “Applicant Copy” and keep them for your records.

Mail your completed form (pages marked “Aetna Copy”) to the address below using the enclosed, postage-paid envelope.

**Aetna Medicare
PO Box 14088
Lexington, KY 40512-4088**

If you have questions, call **1-800-213-4599** (TTY/TDD **1-888-760-4748 or 711**), 8:00 a.m. – 8:00 p.m., 7 days a week

You may also enroll in an Aetna Medicare plan through the Centers for Medicare and Medicaid Services Online Enrollment Center at www.medicare.gov or call 1-800-Medicare 1-800-633-4227 (TTY/TDD 1-877-486-2048).

Plans are offered by Aetna Health Inc., Aetna Health of California Inc., and/or Aetna Life Insurance Company (Aetna).
A stand-alone prescription drug plan with a Medicare contract.

Applicant's Name:	Effective Date:
--------------------------	------------------------

Please contact the Aetna Medicare RX[®] Plan if you need information in another language or format (Braille).

Section 1 – To Enroll in the Aetna Medicare Rx[®] Plan (PDP), Please Provide the Following Information:

Please check which plan you want to enroll in:

- Aetna CVS/pharmacy[®] Prescription Drug Plan (PDP) \$ _____ per month
- Aetna Medicare Rx Essentials[®] Plan (PDP) (only available in AK, AR, CO, ID, OR, UT, WA) \$ _____ per month
- Aetna Medicare Rx Premier[®] Plan (PDP) \$ _____ per month

Section 2 – Personal Information

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	Home Phone Number () —
---	---	---

Permanent Residence Street Address (PO Box is not allowed) _____ **Apt./ Suite/Unit** _____

City	State	Zip Code
-------------	--------------	-----------------

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)

Section 3 – Please 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 Social Security or the Railroad Retirement Board.

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

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

Applicant's Name: _____ Effective Date: _____

Section 4 – Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty you may owe) by mail each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security or Railroad Retirement Board benefit check or be billed directly by Medicare. **DO NOT pay the Part D-IRMAA to the Aetna Medicare Rx® Plan (PDP).**

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a 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 users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your Medicare prescription drug coverage costs, 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 doesn't cover. If you don't select a payment option, you will receive a bill each month.

Please select a premium payment option:
 Receive a bill monthly
 Automatic deduction from your monthly Social Security/Railroad Retirement Board benefit check. (The Social Security/Railroad Retirement Board deduction may take two or more months to begin. In most cases, if Social Security/the Railroad Retirement Board accepts your request for automatic deduction, the first deduction from your Social Security/Railroad Retirement Board benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security/the Railroad Retirement Board does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Section 5 – Please Answer the Following Questions

- Yes No 1. 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 the Aetna Medicare Rx® Plan (PDP)? If "Yes," please list your other coverage and your identification 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," please provide the following information:
Name of Institution: _____ Phone number: (____) _____
Address (number & street): _____

Please check the box if you would prefer that we send you information in a language other than English or in another format.

Spanish
Please contact Aetna Medicare Rx® Plan (PDP) at **1-800-213-4599** if you need information in another format or language than what is listed above. TTY users should call: **1-888-760-4748 or 711**. Our office hours are 8:00 a.m. – 8:00 p.m., 7 days a week.

Section 6 – Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Prescription Drug Plan only during the annual enrollment period from October 15 through December 7 of each year. Additionally, there are exceptions that may allow you to enroll in a Medicare Prescription Drug Plan outside of the annual enrollment period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying 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.

- | | |
|--|--|
| <input type="checkbox"/> I am new to Medicare.
<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 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 have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
<input type="checkbox"/> I get extra help paying for Medicare prescription drug coverage.
<input type="checkbox"/> I no longer qualify for extra help paying for my Medicare prescription drug coverage. I stopped receiving extra help on ___/___/___ (date) | <input type="checkbox"/> I live in or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on ___/___/___ (date)
<input type="checkbox"/> I recently left a PACE program on ___/___/___ (date)
<input type="checkbox"/> I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). I lost my drug coverage on ___/___/___ (date)
<input type="checkbox"/> I am leaving 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 am making this enrollment request between January 1 and February 14, and I recently ended my enrollment in a Medicare Advantage plan. I left my Medicare Advantage plan on ___/___/___ (date) |
|--|--|

If none of these statements applies to you or you're not sure, please contact the Aetna Medicare Rx® Plan (PDP) at **1-800-213-4599** to see if you are eligible to enroll. We are open 8:00 a.m. – 8:00 p.m., 7 days a week. TTY users should call **1-888-760-4748 or 711**.

Applicant's Name:	Effective Date:
--------------------------	------------------------

Section 7 – Please Read This Important Information

If you are 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[®] Plan (PDP), 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 that your Medicare Advantage Plan sends you and if you have questions, contact your Medicare Advantage Plan.

If you currently have health coverage from an employer or union, joining the Aetna Medicare Rx[®] Plan (PDP) could affect your employer or union health benefits. You could lose your employer or union health coverage if you join the Aetna Medicare Rx[®] Plan (PDP). 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.

Section 8 – Please Read and Sign Below

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

The Aetna Medicare Rx[®] Plan (PDP) is a Medicare drug plan and has a contract with the Federal government. I understand that 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 is my responsibility to inform the Aetna Medicare Rx[®] Plan (PDP) 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 the Aetna Medicare Rx[®] Plan 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 during 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 the Aetna Medicare Rx[®] Plan (PDP) serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies except in an emergency when I cannot reasonably use the 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 the Aetna Medicare Rx[®] Plan (PDP) 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 that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with the Aetna Medicare Rx[®] Plan (PDP), he/she may be paid based on my enrollment in the Aetna Medicare Rx[®] Plan (PDP).

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 the Aetna Medicare Rx[®] Plan (PDP) will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that the Aetna Medicare Rx[®] Plan (PDP) 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 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 are the authorized representative, you must sign above and provide the following information.

Name	Address
Phone Number	Relationship to Enrollee

Applicant's Name: _____ Effective Date: _____



Section 9 – These Sections Are To Be Completed By A Broker, Agent or Aetna



Is applicant a current Aetna Member? Yes No If "Yes," provide Aetna Member ID #: _____

Check one election type below:

Requested Effective Date of Coverage: _____

ELECTION PERIOD CODES**			ELECTION PERIOD CODES**		
<input type="checkbox"/>	E	(IEP) – Initial Election Period when 1 st elig for Part D	<input type="checkbox"/>	W	(SEP) – U/EGHP (Union or Employer Group Health Plan) ____/____/____ (date, include termination date if applicable)
<input type="checkbox"/>	F	(IEP2) – Second Initial Election Period for Medicare members who are turning 65	<input type="checkbox"/>	A	(AEP) – Annual Election Period
<input type="checkbox"/>	V	(SEP) – Change of Residence ____/____/____ (date circumstance occurred, if applicable)	<input type="checkbox"/>	U	(SEP) – Dual Eligible
<input type="checkbox"/>	S	(SEP) – Provide explanation:			

Field Marketing Organization (FMO) or Affinity Partner Use – (holds a current Aetna-approved FMO/Affinity contract)

Date: ____/____/____ (must be submitted to Aetna within 48 hours of this date)
TIN # _____ Organization Name _____
Phone Number _____ Email _____

Name of Agency or organization receiving commissions * (if different than writing agent)

Date: ____/____/____ (must be submitted to Aetna within 48 hours of this date)
TIN # _____ Organization Name _____
Phone Number _____ Email _____

Selling Agent/Broker Use *

Date: ____/____/____ (Selling agent/broker who completed member application. Must be submitted to Aetna within 48 hours of this date.)
Selling Agent # (SSN/TIN #) _____ Name _____
Phone Number _____ Email _____

Aetna General Agent (GA) Use – (holds a current Aetna-approved General Agency contract)

Date: ____/____/____ (must be submitted to Aetna within 48 hours of this date)
TIN # _____ Organization Name _____
Phone Number _____ Email _____

*** This information must match your approved Aetna Medicare licensing AND commission records**

Aetna Field Sales Representative Use

Date: ____/____/____ (must be submitted to Aetna within 48 hours of this date)
FSR Name _____ Agent ID: _____
Phone Number _____

** Attach documentation if available (not required) to determine if eligible for an SEP (i.e., Proof of LIS, Loss of LIS, Change of Residence, etc.)

IF YOU WORK THROUGH A GA, FMO, OR AFFINITY PARTNER, SUBMIT THE COMPLETED ENROLLMENT FORM TO THEIR OFFICE TO AVOID DELAYS IN APPLICATION AND COMMISSION PROCESSING.

IF YOU DO NOT WORK THROUGH A GA, FMO OR AFFINITY PARTNER, send this completed enrollment form directly to:

Aetna Medicare

PO Box 14088, Lexington, KY 40512-4088 Call: 1-800-213-4599 or fax to: 1-866-441-2341

Failure to complete this form accurately may result in non-payment of commission.