Your enrollment was successfully submitted!

Congratulations!

Thank you for applying to Aetna Medicare Select Plan (HMO) H1109-005.

Your enrollment application was received and will now be processed. It may take up to 10 days before you receive a confirmation letter in the mail.

If you entered your email address earlier, we'll email the confirmation to you.

Confirmation	9877N6043A
Selected Plan	Aetna Medicare Select Plan (HMO) H1109-005
Monthly Premium	$0.00
Application Date	12/02/2017
Contact Information	AETNA HEALTH INC.(GA) 8553387027 TTY: 711 8 a.m.-8 p.m., local time, 7 days a week from 10/1-2/14; 8 a.m.-8 p.m., local time, Monday-Friday from 2/15-9/30 http://www.aetnamedicare.com
Member Name	Nancy Wright
Member Address	115 Tom Chapman Blvd Apt 1504 Warner Robins, GA 31088
Contract/Plan/Segment ID	H1109_005_000
Additional Coverage Premium and Type	$10.00 Dental
Total Monthly Premium	$10.00

Personal Information | Important Questions | Medicare Information | Review | Submit

Personal Information

Use the form below to enroll in a plan. You'll be able to review your information and make changes before you submit your completed form.

Please contact the plan directly if you need information in another language or format (Braille).

Fields marked with an asterisk (*) are required

Special Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this 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 eligib for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

If none of these statements applies to you or you're not sure, please contact AETNA HEALTH INC.(GA) 8553387027 (TTY users should call 711) to see if you are eligible to enroll. We are open 8 a.m.-8 p.m., local time, 7 days a week from 10/1-2/14; 8 a.m.-8 p.m., local time, Monday-Friday from 2/15-9/30.

- ☐ **I am new to Medicare.**
- ☑ **I recently moved outside of the service area for my current plan.** * 11/06/2017
- ☐ **I have both Medicare and Medicaid or my state helps pay for my Medicare Premiums.**
- ☐ **I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or rehabilitation hospital).**
- ☐ **I recently "left" a Programs of All-inclusive Care for the Elderly program.**
- ☐ **I recently involuntarily lost my creditable drug coverage.**
- ☐ **I am losing creditable drug coverage I had from an employer or union.**
- ☐ **I belong to a pharmacy assistance program provided by my state, or I am losing or recently lost participation in such a program.**
- ☐ **I recently returned to the United States after living permanently outside of the U.S.**
- ☐ **I am currently receiving extra help paying for Medicare prescription drug coverage, but do not have Medicaid.**
- ☐ **I am no longer eligible for extra help paying for my Medicare prescription drugs.**
- ☐ **I am being disenrolled from a Medicare special needs plan because I no longer have special needs status.**

☐ I have had Medicare prior to now, but am now turning 65.

Requested Effective Date

Please indicate your proposed effective date of coverage:
01/01/2018

Personal Information

Please enter your personal information in the spaces provided.

Title ○ Mr. ○ Mrs. ○ Ms.

First Name* Nancy

Middle Initial L

Last Name* Wright

Date of Birth (MM/DD/YYYY)* 04/29/1951

Gender* ○ Male ◉ Female

Please enter your 10 digit phone number with no hyphen or spaces (e.g., 212555212).

Home Phone Number 4783339907

Cell Phone Number

Email Address nancy@sawright.net

Providing an email address authorizes us to contact you via email. Your email address will be handled consistent with our Privacy Policy.

Permanent Residence

Please enter your permanent residence address below. (P.O. Box is not allowed.)

Address (Line 1)* 115 Tom Chapman Blvd Apt 1504

Address (Line 2)

City* Warner Robins

State* GA

ZIP Code* 31088

Mailing Address (Optional)

Do you have a separate mailing address where you like to receive correspondence?

○ Yes ◉ No

Physician Selection (Optional)

Some plans require you to choose an in-network primary care physician (PCP). Please give us the name of a PCP. If this PCP is in our network, we'll list this doctor as your PCP. If your plan requires a PCP and you don't select one, then we'll assign you to an in-network doctor.

You will need to enter the PCP name and Primary Office number into the boxes. To get this:

- Select **Find a Physician**
- Select Doctors (Primary Care)
- Copy your Primary Care Physician name and Primary Care ID to your enrollment form

Primary Care Physician

Primary Care ID

Are you an existing patient? ○ Yes ○ No

If "Yes": You'll be assigned to this doctor, even if they're closed to new patients.
If "No": This doctor may be accepting current patients only. If this doctor is not taking new patients we'll assign you to a different in-network doctor.

Important Questions

End Stage Renal Disease

Do you have End Stage Renal Disease, or ESRD?*

○ Yes ◉ No

Prescription Drug Coverage

Some individuals may have additional prescription drug coverage, including other private insurance, TRICARE, federal employee health benefits, VA benefits, or state pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to this plan?

○ **Yes** ◉ **No**

Long Term Care

Are you a resident in a long-term care facility, such as a nursing home?

○ **Yes** ◉ **No**

Medicaid Enrollment

Are you enrolled in your state Medicaid program?

○ **Yes** ◉ **No**

Employment Information

Do you or your spouse work?

◉ **Yes** ○ **No**

Other Language or Format

Please choose your preferred language:

◉ **English**

○ **Spanish**

○ **Other**

Call us at **1-855-338-7027** if you need information in another language or format (e.g., large print or Braille). We're here 8 a.m. to 8 p.m., seven days a week from October 1 – February 14 and 8 a.m. to 8 p.m., Monday – Friday, from February 15 – September 30. **TTY users should call 711.**

Personal Information | Important Questions | Medicare Information | Review | Submit

Medicare Information

Please tell us about your current Medicare coverage and related benefits information.

You can save your progress on this enrollment application if you want to come back and finish it later by using the *Save Enrollment* option at the bottom of this page.

Fields marked with an asterisk (*) are required

Medicare Info

Please take out your red, white and blue Medicare card to complete this section. Fill out this information as it appears on your Medicare card.

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

Medicare Number* 547863932A

Hospital (Part A) Effective Date *(MM/DD/YYYY)* 04/01/2016

Medical (Part B) Effective Date *(MM/DD/YYYY)* 04/01/2016

Paying Your Plan Premium

Let us know how you want to pay your plan premium (and any late enrollment penalty) each month. Please select an option even if your plan has a $0 premium. If you don't select a payment option, we'll automatically send you a coupon book. Check a box below.

○ **I want to pay from my bank account - Electronic Funds Transfer (EFT). With this option:**

- **You won't need to remember to send in a check or coupon slip each month.**
- **The money is automatically taken from your account on the 10th of each month (or the following business day).**

I want to pay by coupon book. With this option:

- **You'll get a coupon book annually, and need to remember to send in a check and a coupon slip each month.**
- **We won't send a monthly bill.**

○

I want to pay from my Social Security Administration (SSA) or Railroad Retirement Board
◉ **(RRB) check. With this option:**

I get monthly benefits from: ◉ **Social Security** ○ **RRB**

- It can take several months for this option to go into effect after the SSA or RRB approves your request. The first deduction may include all the premiums you owe from when your enrollment starts to the point when we begin taking them out of your check.
- SSA or the RRB determines the date this goes into effect. You need to pay your premium directly to us for any months the SSA or RRB doesn't cover.
- Sometimes we're notified that SSA or the RRB did not approve your request. If this happens, you'll likely have to connect with the SSA or the RRB to resolve.
- If Social Security or the RRB does not approve your request, we'll send you a coupon book to pay your monthly premium.
- If you enroll into a Zero Premium plan, you will not be eligible for SSA/RRB deductions unless you have a responsibility above your plan premium. Example: Late Enrollment Penalty, Optional Secondary Benefits (Dental/Vision).

Additional notes about payment and options:

- Social Security will contact you if you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D IRMAA). You'll have to pay this extra amount as well as your plan premium. You can have it taken out of your Social Security or Railroad Retirement Board benefit check or get a bill from Medicare or RRB. Do not send your Part D IRMAA payment to us.
- Written EFT terminations must be received before the 1st of the month of the EFT transaction. EFT transactions will occur on the 10th of the month in the amount of the balance due.
- If you owe a late enrollment penalty, you can pay the penalty by EFT, mail or have it taken out of your Social Security or Railroad Retirement Board (RRB) benefit check.
- If your income is limited, you may qualify for the Extra Help program to pay for your prescriptions. If you're eligible, Medicare could pay 75 percent or more of your drug costs, including monthly prescription drug premiums, annual deductibles, and co-insurance. Also, you won't be subject to the coverage gap or a late enrollment penalty. Medicare could pay all or part of your plan premium. If Medicare only pays part of the premium for your prescription drug plan, we will bill you for the remaining amount. For more information, contact your local Social Security office or call Social Security at **1-800-772-1213 (TTY: 1-800-325-0778)**, or go to **www.socialsecurity.gov/prescriptionhelp**.

Personal Information | Important Questions | Medicare Information | Review | Submit

Review

Please review the information that you entered. Click *Continue* to review the next page in the form. If you need to make a change, choose *Edit* at the bottom of the Review section. Once you have verified that your information is correct then select *Complete Review*.

You can save your progress on this enrollment application if you want to come back and finish it later by using the *Save Enrollment* option at the bottom of this page.

Personal Information | Important Questions | Medicare Information | Review | Submit

SUBMIT

Read This Important Information

Please read the legal information. After you review, identify who is completing this form. Then check the box to confirm you read the disclosures. Select *Submit Enrollment* to send us your enrollment form.

You can save your progress on this enrollment application if you want to come back and finish it later by using the *Save Enrollment* option at the bottom of this page.

If you currently have health coverage from an employer or union, joining the Aetna Medicare Select Plan (HMO) H1109-005 could affect your employer or union health benefits. You could lose your employer or union health coverage if you join the Aetna Medicare Select Plan (HMO) H1109-005. 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 any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

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

The Aetna Medicare Select Plan (HMO) H1109-005 is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B, and continue to pay my Part B premium. I can only be in one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare

health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. (For MA-only plans) I understand that if I don't 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 coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 - December 7 of every year), or under certain special circumstances. The Aetna Medicare Select Plan (HMO) H1109-005 serves a specific service area. If I move out of the area that the Aetna Medicare Select Plan (HMO) H1109-005 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 Select Plan (HMO) H1109-005, 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 Select Plan (HMO) H1109-005 when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border. {For HMO plans} [I understand that beginning on the date the Aetna Medicare Select Plan (HMO) H1109-005 coverage begins, I must get all of my health care from the Aetna Medicare Select Plan (HMO) H1109-005, except for emergency or urgently-needed services or out-of-area dialysis services.] {For PPO plans} [I understand that beginning on the date the Aetna Medicare Select Plan (HMO) H1109-005 coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, the Aetna Medicare Select Plan (HMO) H1109-005 provides refunds for all covered benefits, even if I get services out of network. Out-of-network/non-contracted providers are under no obligation to treat Aetna members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.] Services authorized by the Aetna Medicare Select Plan (HMO) H1109-005 and other services contained in my Aetna Medicare Select Plan (HMO) H1109-005 Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR Aetna Medicare Select Plan (HMO) H1109-005 WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with the Aetna Medicare Select Plan (HMO) H1109-005, he/she may be paid based on my enrollment in the Aetna Medicare Select Plan (HMO) H1109-005.

Release of Information:

By joining this Medicare health plan, I acknowledge that the Aetna Medicare Select Plan (HMO) H1109-005 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 Select Plan (HMO) H1109-005 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 the laws of the State 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 from Medicare.

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. 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, premium and/or copayments/coinsurance may change on January 1 of each year.

Please select the statement below that best describes your relationship to the person with Medicare listed on this enrollment form:*

- (●) **I am the person listed on this enrollment form or I am simply helping to complete this enrollment form.**
- ( ) **I am the person authorized to act on behalf of the individual listed on this enrollment form under the laws of the State where the individual resides.**

*

- [x] **I understand that my submission (or submission of the person authorized to act on my behalf under the laws of the State where I live) of this application means that I have read and understand the contents of this application, and that I confirm that the information I have provided is accurate. If submitted by an authorized individual (as described above), this submission 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.**