Aetna Medicare Core Plan (PPO) H5521-419

Confirmation Number	7993N9844A
Selected Plan	Aetna Medicare Core Plan (PPO) H5521-419
Monthly Premium	$0.00
Total Monthly Premium	$0.00
Application Date	08/01/2024
Contact Information	Aetna Medicare , http://AetnaMedicare.com
Business Phone	8338596031
Member Name	DRXTEST DRXTEST
Member Address	DRXTEST Los Angeles, CA 90010
Contract / Plan / SegmentID	H5521_419_000
Broker Information	Sri Anumolu sanumolu@connecture.com (232) 323-2323

- Contact Information: Step 1 of 5. Current step.
  - Benefit Information: Step 2 of 5.
  - Other Information: Step 3 of 5.
  - Agent Information: Step 4 of 5.
  - Review and Submit: Step 5 of 5.

Personal Information

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

* Indicates Required Fields

Special Enrollment Period

Typically, you may enroll in a Medicare Advantage or Prescription Drug 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 or Prescription Drug 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 eligible 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 Medicare at 8338596031 (TTY users should call 711) to see if you are eligible to enroll. We are open 8 AM to 8 PM, local time, 7 days a week from 10/1 to 3/31; 8 AM to 8 PM, local time, Monday to Friday from 4/01 to 9/30.

*

☑ Other

Please Explain:* DRX

Requested Effective Date

Please indicate your proposed effective date of coverage:

09/01/2024

Effective dates are based on the enrollment period you're using to enroll and the Centers for Medicare & Medicaid Services' regulations. Aetna cannot guarantee the effective date you've requested will be honored.

Personal Information

*First Name	DRXTEST
Middle Initial	
*Last Name	DRXTEST
*Date of Birth	01/01/1950
*Gender	◉ Male ○ Female
Phone Number	
Is this a mobile number?	○ Yes ○ No
Email Address	

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

Permanent Residence

*Address (Line 1) DRXTEST

Address (Line 2)

*City Los Angeles

*State CA

*ZIP Code 90010

Mailing Address (Optional)

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

○ Yes ○ No

Physician Selection

Your plan may require a primary care physician (PCP). Please provide the Provider ID and Primary Care ID to ensure you get the correct PCP. If you do not provide this information, we will assign an in-network doctor to you. For plans that require a PCP, if one is not selected or ID numbers are not accurate, or we cannot locate the provider based on data entered, a provider will be selected for you by the plan.

To locate these IDs:

- Select Find a Physician
- Search and select your PCP

Primary Care Physician

Medical Group/IPA

Provider ID

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.

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Important Questions

* Indicates Required Fields

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

Please tell us a little more about yourself

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish Origin? Select all that apply.

- ☐ No, not of Hispanic Latino/a or Spanish origin
- ☐ Yes, Puerto Rican
- ☐ Yes, another Hispanic, Latino or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban
- ☐ I choose not to answer

What is your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ I choose not to answer

Medicaid Enrollment

*Are you enrolled in your state Medicaid program?

- ○ Yes ◉ No

Other Language or Format

Please choose your preferred spoken language:

- ○ English
- ○ Spanish
- ○ Chinese
- ○ Other

Please choose your preferred written language:

- ○ English
- ○ Spanish
- ○ Chinese
- ○ Other

Select one if you want us to send you information in an accessible format:

- ○ Braille
- ○ Large Print
- ○ Audio CD

Call us at **1-833-859-6031** if you need information an accessible format other than what is listed above. We are here seven days a week, 8 AM to 8 PM from 10/01-3/31 and Monday - Friday, 8 AM to 8 PM from 4/1-9/30. **TTY users should call 711.**

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Medicare Information

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

Fields marked with an asterisk (*) are required

Medicare Information

Image of an example Medicare Health Insurance Card.

*Medicare Number: 1AA1AA1AA11

Hospital (Part A) Effective Date
(MM/DD/YYYY)

Medical (Part B) Effective Date
(MM/DD/YYYY)

Paying Your Plan Premium

Let us know how you want to pay your monthly plan premium (including any Part D late enrollment penalty you may owe). 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 an invoice each month.

○ **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).
- We will withdraw the total amount due on your account. This includes your current monthly premium payment, as well as any past due payments at the time of the monthly draft.

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

- Do not select this option if another program (such as an Employer Group or State Pharmaceutical Assistance Program (SPAP) is paying part of your premium.
- Do not select this option if you are enrolling in a plan with a $0 premium and you do not owe a late enrollment penalty.
- Do not select this option if you are enrolling in a Dual Special Needs Plan (DSNP) or an Institutional Special Needs Plan (ISNP).
- SSA/RRB will tell us when your premium deduction will start coming out of your SSA/RRB check (this could take up to 3 months). While we wait for your request to process, we'll send you an invoice to pay your premium.
- Sometimes SSA/RRB may not accept the request for deductions from your SSA/RRBcheck. If they don't accept the deduction request, we'll send you an invoice to pay your monthly premium.

◉ **I want to pay by invoice. With this option:**

- You can mail us a check with your payment slip each month.
- You can go online and pay by debit or credit card after your enrollment in the plan is active.
- You can bring your invoice to any retail CVS Pharmacy® and pay with cash, credit card, or debit card. (Note: This service is not available at CVS Pharmacy Target® or Schnucks Pharmacy locations.)

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**.

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Agent Information

Review the Agent information below and signify your acceptance of this attestation to continue.

Agent Name: Sri Anumolu

NPN Number 303756

Please attest that you, as the writing agent or sales representative, received a completed scope of appointment (SOA) for the beneficiary name listed in the application:

In the text box enter **Yes** (for a paper SOA), **Scope of Appointment ID Number**, or **No**
*

Y

Aetna reserves the right to request a copy of the SOA.

As the writing agent, I hereby attest that:

1. I am appropriately licensed to sell this product and appointed by the carrier to do so.
2. I have provided the applicant with the information necessary to make a sound, informed voluntary decision to enroll in this plan, understanding the implications of enrollment in areas including but not limited to benefit coverage, potential out-of-pocket costs, availability of specific medications on formulary, and network pharmacies.
3. The applicant has read this statement in person or I have read the statement aloud to the applicant and the applicant grants me permission to submit the application on his/her behalf.

* ☑ **I agree with the above statements.**

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Review and Submit

Review your application

Please read the legal information. After you complete your review, check the acknowledgment that you read the disclosures. Click *Submit* to send us your enrollment form.

Aetna and SilverScript CMS and Legal Disclaimers

Read this important information and sign below

If you currently have health coverage from an employer or union, joining Aetna Medicare Core Plan (PPO) H5521-419 could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Aetna Medicare Core Plan (PPO) H5521-419. 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.

I must keep both Hospital (Part A) and Medical (Part B) to stay in Aetna Medicare Core Plan (PPO) H5521-419.

By joining this Medicare Advantage plan, I acknowledge that Aetna Medicare Core Plan (PPO) H5521-419 will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)," System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

- I understand that I can be enrolled in only one MA Plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- **MA-only plans**: I understand that when my Aetna Medicare Core Plan (PPO) H5521-419 coverage begins, I must get all of my medical benefits from Aetna Medicare Core Plan (PPO) H5521-419. **MA-PD plans**: I understand that when my Aetna Medicare Core Plan (PPO) H5521-419 coverage begins, I must get all of my medical and prescription drug benefits from Aetna Medicare Core Plan (PPO) H5521-419. **All plans**: Benefits and services provided by Aetna Medicare Core Plan (PPO) H5521-419 and contained in my Aetna Medicare Core Plan (PPO) H5521-419 "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Aetna Medicare Core Plan (PPO) H5521-419 will pay for benefits or services that are not covered.
- 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 legally 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 HMO, PPO plan with a Medicare contract. Our DSNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal. Plan features and availability may vary by service area.

***What is your relationship to the person enrolling in this plan?**

◉ I am (or am helping) the person enrolling
○ I am an agent or authorized person

*

☑ **I understand** that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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.

Additional information

Below is additional information provided for this application....