SUBMISSION INSTRUCTIONS – MEDICARE ADVANTAGE PLANS

Please submit your completed form(s) to DCRB.

Please include a copy of your Medicare Card.

All materials must be postmarked or received no later than the close of business on December 14, 2020.

Members can submit their materials to DCRB in a variety of ways:

- Call our Member Service Center at 202-343-3272 or 1-866-456-3272 to request a secure upload link

- Fax us at (202) 566-5001

- Send United States Postal Service mail to us at:
  District of Columbia Retirement Board
  Attn: Member Services Center (Open Enrollment)
  900 7th Street NW, 2nd floor
  Washington, DC 20001

aetna™ medicare solutions

Aetna Medicare Advantage Plan 2021 Employer Group Enrollment Form

Aetna Medicare[SM] Plan (HMO) Aetna Medicare[SM] Plan (PPO)

Enrollment instructions	
Answer all questions completely. Incomplete or incorrect information may delay the start of your coverage. Below are the instructions for each section of the enrollment form. You can use this form to enroll or submit a plan change if you're already enrolled.	
Effective date:	Your coverage will begin on the first day of the month after you sign this enrollment form, or the date your enrollment is completed. **The effective date can't be earlier than the day you sign this form.**
Former employer information:	Write the name of the former employer/union/trust offering this health plan (the company you retired from). List the group number and class code if you know it. The group number and class code number are not required. (This information may be pre-filled.)
Personal information:	This is your name, address, phone number, etc. **Print clearly.**
Medicare information:	This is your Medicare insurance information, found on your red, white and blue Medicare Card. Complete all the fields to avoid a delay in your coverage.
Health plan selection:	Check the box next to the plan you want to enroll in. (There may be only one plan available). For more plan details, look at the benefit summary included in your enrollment packet.
Select a provider:	For Aetna Medicare Plan (HMO): You're required to have a primary care physician (PCP) on file with us. This means you need to tell us who your doctor is. Write in the name of your PCP and their Primary Care ID number. You'll find this information in our Provider Directory. For Aetna Medicare Plan (PPO): You have the option to choose an Aetna network PCP. But when we know your doctor we can better coordinate your care. Write in the name of your Aetna Network PCP and their Primary Care ID number. You'll find this information in our Provider Directory.
Select a dentist:	**For Aetna Medicare Plan (HMO) only:** If DMO dental benefits are included in your plan, a primary dentist is required. Write the name of your Aetna dentist and their office ID number.
Medicare-related questions:	Read and answer these Medicare questions.
Read this important section carefully:	DISCLOSURES
Signature required:	Sign and date the application in the space provided. **Authorized representatives**: Sign the form and write in your information
Make a copy for yourself and mail original:	Make a copy of the entire application for your records. Then mail your completed original form to the address below. A separate enrollment form must be completed for each Medicare-eligible dependent. Two forms may have been included for your convenience.

Call your former employer/union/trust or Aetna Medicare with any questions.

Phone number:	(202)442-7627
Hours:	8:30 a.m. to 5:00 p.m. EST
Mail to:	District of Columbia Retirement Board Attn: Member Services Center (Open Enrollment) 900 7th Street NW, 2nd floor Washington, DC 20001
Fax:	(202) 566-5001

Make a copy for yourself and return the original

Effective date
/ 01 /

Gov of DC - Employee Number:

Group number	Class code
AE467167	n/a

Personal Information			
Last name	First name	Middle initial ☐ Mr. ☐ Mrs. ☐ Ms.	
Birth date (M M / D D / Y Y Y Y)	Sex ☐ M ☐ F	Home phone number ( )	
Permanent residence street address (PO Box is not allowed)			
City	State	ZIP code	County
Mailing address (only if different from your permanent residence address)		Email address (optional)	

Emergency contact name (optional)	Relationship to you
Phone number	Cell phone number

Medicare Information	
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. -OR- • Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.	Name (as it appears on your Medicare card): _____ Medicare Number: _____ Is Entitled To: Effective Date: HOSPITAL (Part A) _____ MEDICAL (Part B) _____ You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Health plan selection: Check the box next to the type of plan you want to enroll in. Then write the name of the specific plan on the line provided. (This information may be pre-filled). For more plan details, look at the benefit summary included in your enrollment kit. **Make sure to read the important health plan disclosures on Page 4.**

☐ Aetna Medicare PPO ESA Rx P01 Custom Rx

Fill out the following:

I'm currently enrolled in a Medicare Advantage plan issued by (insurance company name) _____.
I'd like to change to an Aetna plan. I understand this plan may have different health benefits and monthly payments than my current plan.

Select providers: A primary care physician (PCP) is required for HMO plans and is recommended for PPO plans. If you choose an HMO plan with DMO dental benefits, you must also choose a dentist. To select a PCP or dentist, look at the Aetna Medicare provider directory or call the phone number on the instruction page.

PCP first and last name	PCP office ID
Dentist first and last name (for HMO plans with DMO dental benefits)	Dentist office ID (for HMO plans with DMO dental benefits)

Applicant name:	**Effective date:** / 01 /

Medicare-Related Questions

☐ Yes ☐ No **Are you an Aetna member?** If Yes, provide your member ID number _____

☐ Yes ☐ No **Are you the retiree?** If Yes, provide retirement date (MM/DD/YYYY): __ __ / __ __ / __ __ __ __

If No, name of retiree: _____

☐ Yes ☐ No **Are you covering a spouse or dependents under this employer, trust or union plan?**

If Yes, name of spouse: _____ Name of dependents: _____

☐ Yes ☐ No **Do you or your spouse work?**

☐ Yes ☐ No **Do you have end-stage renal disease (ESRD)?** If you've had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a letter or records from your doctor** showing you've had a successful kidney transplant or you don't need dialysis. Otherwise, we may need to contact you to obtain additional information.

If Yes, what is the date of your first dialysis treatment? Date: (month) _____ (year) _____

☐ Yes ☐ No **Did you become eligible for Medicare because of ESRD *and* has it been less than 30 months since you became eligible?** If so, Medicare Advantage Coverage will be your secondary coverage for the first 30 months of the coordination period.

If Yes, provide your prior commercial coverage carrier's name: _____

Member number: _____ Effective date ____ / ____ / _____

☐ Yes ☐ No **Was your previous policy terminated?** If Yes, provide termination date: ___ / _____ / ____

☐ Yes ☐ No **Are you a resident in a long-term care facility, such as a nursing home?**

If Yes, provide the following information:

Name of institution: _____ Phone number: (____) _____

Address: _____ State: _____ ZIP: _____

☐ Yes ☐ No **Are you enrolled in your state Medicaid program?** If Yes, provide your Medicaid number:

_____

Please check one of the boxes below if you would prefer that we send you information in a language other than English or in an accessible format: ☐ Spanish Other _____

Please contact us at **1-888-267-2637** if you need information in an accessible format or language other than what is listed above. Our office hours are 8 a.m. to 6 p.m., local time, Monday through Friday. TTY users should call 711.

Other Rx coverage: Complete only if you have other prescription drug coverage.

☐ Yes ☐ No 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 Advantage Rx plan? If Yes, please list your other coverage and identification number(s) for this coverage:

Name of other coverage: _____

ID #: _____ Group #: _____

☐ Yes ☐ No **Have you had creditable coverage since you became eligible for Medicare prescription drug coverage?**

If so, from date (MM/DD/YY) _____ to date (MM/DD/YY) _____

Creditable coverage is prescription drug coverage that is at least as good as Medicare prescription drug coverage.

NOTE: If you've not had creditable coverage, you may have to pay a late enrollment penalty. Aetna may ask you to provide evidence of creditable coverage. If you have questions about the late enrollment penalty, call Aetna at the number provided on this form.

Applicant name:	**Effective date:** / 01 /

Disclosures – Read this section carefully.

By completing this enrollment application, I agree to the following: Aetna Medicare is a HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal. I will need to keep my Medicare Parts A and B coverage. 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. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. If I'm enrolling in a Medicare Advantage plan without prescription drug coverage (medical benefits only), 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 if an enrollment period is available or under certain special circumstances. The Aetna Medicare Advantage plan serves a specific service area. If I move out of the area that Aetna Medicare dvantage plan serves, I need to notify the plan and my former employer/union/trust so I can disenroll and find a new plan in my new area. Once I'm 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 Aetna 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. 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. **HMO plans -** I understand that beginning on the date Aetna Medicare Advantage plan coverage begins, I must get all my health care from the Aetna Medicare Advantage plan, except for emergency or urgently needed services or out of area dialysis services. Services authorized by the Aetna Medicare Advantage plan and other services contained in my Aetna Medicare Advantage plan Evidence of Coverage document (also known as the member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR THE AETNA MEDICARE ADVANTAGE PLAN WILL PAY FOR THE SERVICES**. **PPO plans:** I understand that beginning on the date Aetna Medicare Advantage plan 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. I understand I can go to doctors, specialists or hospitals in or out of network. I understand that providers must be licensed and eligible to receive payment under the federal Medicare program and agree to accept the PPO plan. I also understand I may have to pay more for services I receive out of network. Services authorized by the Aetna Medicare Advantage plan and other services contained in my Aetna Medicare Advantage plan Evidence of Coverage document (also known as the member contract or subscriber agreement) will be covered. Without authorization when required by the plan, **NEITHER MEDICARE NOR THE AETNA MEDICARE ADVANTAGE PLAN WILL PAY FOR THE SERVICES**. I've been advised not to cancel or drop any supplemental insurance I currently have until I receive written notification of my confirmed effective date from Aetna. I understand the providers in the Aetna network are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. I understand if I'm getting assistance from a sales agent, broker, or other individual employed by or contracted with Aetna's Medicare Advantage plans, he/she may be paid based on my enrollment in the Aetna Medicare Advantage plan. **Release of information:** By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Aetna Medicare 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 if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand 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 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.

Signature:	**Today's date**:

If you're the authorized representative, you must sign above and provide the following information:

Representative's name:	Address:
Phone number:	Relationship to enrollee:

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.