SUBMISSION INSTRUCTIONS – MEDICARE ADVANTAGE PLANS

Please make sure you submit both a copy of the DC Health Form along with any separate Medicare Advantage Plan required form.

Please include a copy of your Medicare Card.

All materials must be postmarked or received no later than the close of business on December 13, 2021.

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

- 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
2022 Employer Group Enrollment Form
Aetna Medicare℠ Plan (HMO)
Aetna Medicare℠ Plan (PPO)

OMB No. 0938-1378 Expires 7/31/2023

Employer Group Enrollment Form Instructions

Answer all questions completely. Incomplete or incorrect information may delay the start of your coverage. The instructions for each section of this enrollment form are below. You can use this form to enroll or to 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. **Please print clearly.**
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, their Provider ID and their Primary Care ID. You'll find this information in your 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, their Provider ID and their Primary Care ID. You'll find this information in your Provider Directory.
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.
Disclosures:	Read this information carefully.
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 return the original:	Make a copy of this entire application for your records. Then return your completed original form to the address below. A separate enrollment form must be completed for each Medicare-eligible dependent. Two forms may be included for your convenience.

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

Phone number:	202-343-3272
Hours:	Mon - Fri 8:30a.m. to 5p.m. ET
Mail to:	Member Services Center (Health Plan Enrollment) 900 7th Street NW, 2nd floor Washington, DC 20001
Fax:	(202) 566-5001

Make a copy for yourself and return the original

EG22

Effective date: / 01 /

Former employer/union/trust information: Write the name of the former employer/union/trust offering your retiree health plan unless this information is pre-filled.

Name of former employer/union/trust employee ID:	Group number AE467167	Class code

Your information

Last name **First name** **Middle initial**

Birth date (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Sex ☐ M ☐ F	**Primary phone number** (_ _ _) _ _ _ - _ _ _ _ **Secondary phone number** (_ _ _) _ _ _ - _ _ _ _

Email address

Permanent residence street address (a PO Box is not allowed)

Apt./Suite/Unit (please specify)

City	County	State	ZIP Code

Mailing address (only if different from your permanent residence street address)

City	State	ZIP Code

Health plan selection

Check the box next to the 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 the last page of this form.**

☐ Aetna Medicare HMO (write plan name below)

☐ Aetna Medicare PPO (write plan name below)

☐ Aetna Medicare HMO with Rx (write plan name below)

☑ Aetna Medicare PPO with Rx (write plan name below)

Are you enrolled in another Medicare Advantage plan? If yes, fill in the following:

I'm currently enrolled in a Medicare Advantage plan issued by:

Name of insurance company _____

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.

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

Tell us your provider

A primary care physician (PCP) is required for HMO plans and is recommended for PPO plans. To select a PCP visit our online provider directory at **AetnaMedicare.com/findprovider** or call the phone number on the instructions page of this enrollment form.

Write the full name of your PCP

Are you a current patient? ☐ Yes ☐ No

Provider ID (if applicable) (located in the provider directory): ☐☐☐☐☐☐☐

Primary Care ID (located in the provider directory): ☐☐☐☐☐☐

Provide your Medicare insurance information

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.

Answer these important questions

☐ Yes ☐ No 1. **Are you an Aetna member?**
If "Yes," provide your member ID number _____

☐ Yes ☐ No 2. **Are you the retiree?** If "Yes," provide retirement date: __ __ / __ __ / __ __ __ __
If No, name of retiree: _____

☐ Yes ☐ No 3. **Are you covering a spouse or dependents under this employer, trust or union plan?**
If "Yes," name of spouse: _____
Name(s) of dependent(s): _____

☐ Yes ☐ No 4. **Was your previous policy terminated?**
If "Yes," provide termination date: __ __ / __ __ / __ __ __ __

☐ Yes ☐ No 5. **Are you a resident in a long-term care facility, such as a nursing home?**
If "Yes," provide the following information:
Name of facility: _____ Phone number: (__ __ __) __ __ __ - __ __ __ __
Address: _____ State: _____ ZIP: _____

☐ Yes ☐ No 6. **Are you enrolled in your state's Medicaid program?**
If "Yes," write in your Medicaid number: _____

☐ Yes ☐ No 7. **Will you have other prescription drug coverage in addition to the Aetna Medicare plan?** Some individuals may have other drug coverage, including other private insurance, worker's compensation, TRICARE, Federal employee health benefits coverage, VA benefits or state pharmaceutical assistance programs.
If "Yes," please list your other coverage and identification number(s) for this coverage.
Name of other coverage: _____
ID #: _____ Group #: _____

☐ Yes ☐ No 8. **Have you had creditable coverage since you became eligible for Medicare prescription drug coverage?** Creditable coverage is prescription drug coverage that is at least as good as Medicare prescription drug coverage.
If "Yes," my coverage started on __ __ / __ __ / __ __ __ __ (date) and ended on __ __ / __ __ / __ __ __ __ (date).
Name of other 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 /**

Indicate your preferred spoken language (if not English): ☐ Spanish ☐ Other _____

Indicate your preferred written language (if not English): ☐ Spanish ☐ Other _____

If you need information in another language or accessible format (e.g. large print or braille), contact us at **1-888-267-2637 (TTY: 711)** 8 AM to 6 PM, local time, Monday through Friday.

DISCLOSURES – Read this section carefully and sign below

By completing this enrollment application, I agree to the following: Aetna Medicare is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can only be in one Medicare 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. 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 (Example: Annual Enrollment Period from October 15 – December 7), or under certain special circumstances.

The Aetna Medicare plan serves a specific service area. If I move out of the area that Aetna Medicare 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 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 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.

HMO plans: I understand that beginning on the date Aetna Medicare 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 plan and other services contained in my Aetna Medicare 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 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 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 PLAN WILL PAY FOR THE SERVICES**.

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 Advantage plan, I acknowledge that the Aetna 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 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 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. Enrollment in our plans depends on contract renewal. Plan features and availability may vary by service area.

Signature	**Today's date** _ _ / _ _ / _ _ _ _

If you're the authorized representative helping someone fill out this form, you must sign above and provide the following information.

Representative's name	Address
Phone number (_ _ _) _ _ _ - _ _ _ _	Relationship to enrollee