aetna™
medicare solutions

Aetna Medicare
2022 Medicare Prescription Drug Plan (Part D)
Individual Enrollment Form

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

Confirm your enrollment eligibility

Typically, you may enroll in a Medicare Prescription Drug Plan only during the Annual Enrollment Period (AEP) from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare 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 that reason, which will help us to determine your enrollment period. If we later determine that this information is incorrect, you may be disenrolled.

Reasons for Annual Enrollment Period Eligibility

☐ I am enrolling between 10/15/21 – 12/7/21 during the current Annual Enrollment Period.

Reasons for Initial Enrollment Period Eligibility

☐ I am new to Medicare. ☐ I previously had Medicare but am now turning 65.

Reasons for Special Enrollment Period Eligibility (Select reason and enter date if applicable)

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

☐ 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).

☐ I recently was released from incarceration. I was released on __ __/__ __/__ __ (date).

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on __ __/__ __/__ __ (date).

☐ I recently obtained lawful presence status in the United States. I got this status on __ __/__ __/__ __ (date).

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on __ __/__ __/__ __ (date).

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on __ __/__ __/__ __ (date).

☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.

☐ 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).

☐ I recently left a PACE program on __ __/__ __/__ __ (date).

☐ I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). I lost my drug coverage on __ __/__ __/__ __ (date).

☐ I am leaving employer or union coverage on __ __/__ __/__ __ (date).

☐ I belong to a pharmacy assistance program provided by my state.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on __ __/__ __/__ __ (date).

☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the natural disaster.

If none of these statements applies to you, call us at 1-833-526-2210 (TTY: 711) to see if you can enroll. We're here 8 AM to 8 PM, seven days a week, from October 1 to March 31 and 8 AM to 8 PM, Monday through Friday, from April 1 to September 30.

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Section 1: Choose your plan

Please check the plan you want to enroll in:

- ☐ SilverScript SmartRx (PDP)
- ☐ SilverScript Choice (PDP)
- ☐ SilverScript Plus (PDP)

Proposed effective date of coverage:

__ __ /__ __ /__ __ __ __
M M / D D / Y Y Y Y

The effective date for enrollees in their Initial Enrollment Period will either be the first of the month following enrollment submission or the first of the month the enrollee is eligible for Part D, whichever is later.

Section 2: Your information

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

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

Permanent residence / long-term care facility address (a PO Box is not allowed)
Street number Street name

Apt./Suite/Unit (please specify)

City	**County**	**State**	**ZIP Code**

Long-term care facility name

Mailing address (only if different from your permanent residence address)
Street number Street name

Apt./Suite/Unit (please specify)

City	**County**	**State**	**ZIP Code**

Email address

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Section 3: Provide your Medicare insurance information

Medicare Number: _ _ _ _ - _ _ _ - _ _ _ _

Is Entitled To:	Effective Date:
HOSPITAL (Part A)	_ _/_ _/_ _ _ _
MEDICAL (Part B)	_ _/_ _/_ _ _ _

You must have either Medicare Part A or Part B (or both) to join a Medicare Prescription Drug (Part D) Plan.

Section 4: Please read and answer these important questions

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 Aetna Prescription Drug Plan (Aetna PDP) during the 2022 calendar year?

☐ Yes ☐ No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: _____

Member number: _____ Group number: _____

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

If you need information in an alternate language or accessible format, such as Braille, audio tape, or large print, please contact us at **1-855-771-9286 (TTY: 711)**, 24 hours a day, 7 days a week.

Would you like to receive paperless Explanation of Benefit (EOB) statements?

We'll send you a monthly email letting you know how to access and view your secure EOB statement. You will need to provide us with your email address. You can opt out at any time.

☐ Yes, I want to receive my EOB statements electronically.
Please be sure to include your email address in Section 2.

☐ No, I want to receive my EOB statements in the mail.

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Section 5: Paying your plan premium

You can pay your monthly plan premium (including any Part D late enrollment penalty you may owe) by Electronic Funds Transfer (EFT), automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check, monthly payment by invoice, credit card, or by mail.

Please select a premium payment option. If you don't select a payment option, we'll automatically send you an invoice each month.

☐ **Electronic Funds Transfer from Checking or Savings account**

- You won't need to remember to send in a check each month.
- The money is automatically taken from your account on or around the 9th of each month.
- 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.
- To sign up, please include a VOIDED check or savings account direct deposit form from your bank with your enrollment form.

Signature of account holder: (if different than enrollee) _____

I agree that this authorization will remain in effect until I provide written notification terminating this service.

☐ **Automatic deduction from Social Security or Railroad Retirement Board (RRB) benefit check**

I get monthly benefits from: ☐ **Social Security** ☐ **RRB**

- We will deduct your monthly premium from your Social Security check (or RRB for those who qualify) automatically. Your request for automatic deduction will be submitted for the next available payment cycle.
- It can take several months for this option to begin once approved by Centers for Medicare & Medicaid Services, and it will not cover any premiums for which we have already sent you an invoice, so please continue to pay your premium as long as you receive an invoice.
- Do not select this option if another entity (such as an Employer Group or State Pharmaceutical Assistance Program) is paying part of your premium.
- If Social Security or the RRB does not approve your request for automatic deduction, we will send you an invoice to pay your monthly premium.

☐ **Monthly payments by invoice**

- You can mail us a check with your payment slip each month.
- You can pay using a 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. (This service is not available at CVS Pharmacy Target® or Schnucks Pharmacy locations.)

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Section 5: Paying your plan premium (continued)

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75 percent or more of your drug costs, including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify won't have a coverage gap or a Part D 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: 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 does not cover.

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 will either have the amount withheld from your Social Security or RRB benefit check, or be billed directly by Medicare or the RRB. **Do not send your Part D IRMAA payment to us**.

STOP Section 6: Please read this important information STOP

If you are a member of a Medicare Advantage Plan (such as an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage Plan that will meet your needs.

By joining Aetna 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 Aetna PDP could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Aetna 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 7: Please read terms and sign below

By completing this enrollment application, I agree to the following: Aetna 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 to stay in Aetna PDP. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I can only be enrolled in one Medicare Prescription Drug Plan at a time – if I am currently enrolled in a Medicare Prescription Drug Plan, my enrollment in Aetna PDP 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.

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Section 7: Please read terms and sign below (continued)

Aetna serves a specific service area. If I move out of the area that Aetna 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 Aetna network pharmacies. Once I am a member of Aetna, 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.

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 Part D 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 Aetna, he or she may be paid based on my enrollment in Aetna.

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 Aetna PDP will release my information to Medicare, who may use it to track beneficiary enrollment, for payment and other purposes applicable to Federal statutes 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) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 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.

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 people with Medicare are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

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.

SilverScript is a Prescription Drug Plan with a Medicare contract marketed through Aetna Medicare. Enrollment in SilverScript depends on contract renewal.

Signature	**Today's date**
	__ __/__ __/__ __ __ __

Print name *(please print)*

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Section 8: Power of Attorney / Authorized Representative

If you're an authorized representative helping someone fill out this form, you must sign the previous page and provide the following information (not for agent use).

Name _____

Address _____

City _____ **State** _____ **ZIP Code** _____

Phone number ____ - ____ - _____

Relationship to enrollee ☐ child ☐ friend ☐ spouse ☐ other _____

When you've completed this Enrollment Form, sign, date, and mail it in the enclosed postage-paid envelope. If you do not use the postage-paid envelope, include the proper postage and mail to:

SilverScript Insurance Company
PO Box 30001
Pittsburgh, PA 15222-0330

Note: This mailing address is not applicable for agent-submitted applications.

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STOP To be completed by Agent / Prescription Drug Plan only STOP

AGENT INSTRUCTIONS

Complete Steps 1 and 2 below for successful enrollment:

Step 1: You must enter the enrollment application into the agent portal within 24 hours of receiving the application from the beneficiary. **Instructions on how to enter enrollments are located in the Reference Materials section of the agent portal. Failure to complete this step can result in your enrollment not being processed.**

Step 2: Please send all pages of the signed, completed application and the Scope of Appointment to SilverScript Insurance Company within 24 hours of portal entry. Choose one of the following options:

- ☐ **Upload:** Upload a scanned copy of the documents via the agent portal secure mailroom
- ☐ **Email:** **enrollmentverification@CVScaremark.com**
- ☐ **Fax:** **1-866-552-6205**
- ☐ **Mail:** **SilverScript Insurance Company**
  Attn: Agent Processing
  PO Box 30002
  Pittsburgh, PA 15222-0330

Application received date __ __/__ __/__ __ __ __

Agent ID number _____

Agent name *(please print)* _____

Agent signature _____

Agent portal application confirmation number _____

Scope of Appointment (you must check one)

- ☐ A Scope of Appointment is included with this enrollment form.
- ☐ Scope of Appointment was NOT completed because the agent did not have an individual or one-on-one marketing appointment (whether in person, telephonically, or otherwise) with the applicant.

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