Aetna Medicare Advantage Plan
2027 Employer Group Enrollment Form
Aetna Medicare℠ Plan (HMO)
Aetna Medicare℠ Plan (PPO)
OMB No. 0938-1378 Expires 12/31/2027

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/ union/trust information	Write the name of the former employer/union/trust offering this health plan (the company you retired from). List the Class Code if you know it. (This information may be pre-filled.)
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.
Tell us your provider	**For Aetna Medicare Plan (HMO):** You're required to have a Primary Care Provider (PCP) on file with us. Write in the full name of your PCP, their Provider ID and their Primary Care ID. You'll find this information in our online provider directory at **AetnaMedicare.com/findprovider. Please note that a specialist is not considered a valid PCP.** **For Aetna Medicare Plan (PPO):** You have the option to choose a Primary Care Provider (PCP). When we know who your doctor is, we can better support your care. Write in the full name of your PCP, their Provider ID and their Primary Care ID. You'll find this information in our online provider directory at **AetnaMedicare.com/findprovider. Please note that a specialist is not considered a valid PCP**.
Your information	This is your name, address, phone number, etc. **Please 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.
Tell us more about yourself	Answering these questions is your choice. You can't be denied coverage because you don't fill them out.
Important information	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 the completed 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:	1-800-307-4830 (TTY: 711),
Hours:	Monday through Friday, 8 AM to 6 PM ET
Mail to:	ATT Aetna: City of New York - Mail Code F314, PO Box 818013 Cleveland, OH 44181
Website:	www.aetnamedicare.com/cony
Fax Number:	860-907-3010

Prospective member name	Effective date: / 01 /

Former employer/union/trust information

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

Name of former employer/union/trust	Class Code
City of New York	☐ ☐ ☐ ☐

Health plan selection

Check the box next to the plan you want to enroll in. 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.**

	Plan Type	Master Plan ID	Plan Name	
☐	MA ESA PPO - NO RX			HIDE
☐	MA ESA PPO - WITH RX			HIDE
☐				HIDE
☐				HIDE
☐				HIDE
☐				HIDE

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.

Tell us your provider

A Primary Care Provider (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. **Please note that a specialist is not considered a valid PCP.**

Full name of your PCP (first and last name)	Are you a current patient? Yes No

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

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

Your information

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

Birth date
(_ _ /_ _ /_ _ _ _)
(MM /DD/YYYY)

Sex
☐ **Male** ☐ **Female**

Phone number (_ _ _) _ _ _ - _ _ _ _
Is this a mobile number? ☐ Yes ☐ No

Email address

Enter your permanent residence street address below – including Apt/Suite/Unit (Don't enter a PO Box unless you are experiencing homelessness.
☐ Check here if you are currently experiencing homelessness

Permanent residence address

Street address – including Apt/Suite/Unit

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

Mailing address (if different from your permanent street address)

Street address – including Apt/Suite/Unit

City | **State** | **ZIP Code**

Your Medicare Information

This information is on your red, white and blue Medicare insurance card.
You must have Medicare Part A and Part B to join a Medicare Prescription Drug Plan.

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

Effective Date:
Hospital (Part A) (_ _ /_ _ /_ _ _ _)
Hospital (Part B) (_ _ /_ _ /_ _ _ _)

Please read and answer these important questions

☐ Yes ☐ No

1. Are you the retiree? If "Yes," retirement date _ _ /_ _ /_ _ _ _
If "No," name of retiree: _____

☐ Yes ☐ No

2. 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

3. 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 # for this coverage: _____
Group # for this coverage: _____

Prospective member name	Effective date:
	/ /

All questions below are optional

Indicate your preferred **spoken language** (if not English):

☐ Spanish ☐ Chinese ☐ Other (please specify): _____

Indicate your preferred **written language** (if not English):

☐ Spanish ☐ Chinese ☐ Other (please specify): _____

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

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please call us at **1-800-307-4830 (TTY: 711)** if you need information in an accessible format other than what's listed above. We're here 8 AM to 8 PM, 7 days a week, from October 1 to March 31 and 8 AM to 8 PM, Monday through Friday, from April 1 to September 30.

Continued on the next page

Prospective member name:	Effective date: / 01 /

Please 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.

Prospective member name:	Effective date: / 01 /

Please read this section carefully and sign below

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 (such as a power of attorney)** filling out this form on behalf of the enrollee, you must sign above and provide the following information.

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

For individuals helping an enrollee with completing this form

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping someone fill out this form (but not authorized to make decisions on behalf of the enrollee).

Name	Relationship to enrollee
Signature	National Producer Number (NPN) (Agents/Brokers only)