Quality health plans & benefits
Healthier living
Financial well-being
Intelligent solutions

Enrollment Instructions for Aetna Medicare Advantage Products

Follow these steps to submit enrollment applications for Aetna Medicare Advantage Products (MA, MAPD, PDP). Incomplete, inaccurate, or illegible enrollment information will cause delays in enrollment and compensation.

Enrollment Checklist

For timely processing and accurate submission, make sure:

- Every application has a valid requested effective date that corresponds with an election period
- The application is received by Aetna within 48 hours of receipt by the producer
- All information is complete and legible.
- On paper applications, use blue or black ink and write in print versus script.
- The following required fields are complete. Missing information will delay enrollment processing and may also result in a denial if the required information is not obtained within the time frame specified by CMS.
  - Plan Selection
  - Beneficiary Name
  - Beneficiary Date of Birth
  - Beneficiary Sex
  - Permanent Residence Address
  - Response to the ESRD Question
  - Beneficiary signature or Authorized representative signature
  - Special Election Period, effective date (when applicable)
  - Heath Insurance Claim Number (HICN)
- You use long enrollment forms for:
  - New enrollees in PDP
  - New enrollees in MAPD
  - Current members switching from PDP to MAPD (or vice versa)
  - Current members switching from HMO to PPO (or vice versa)
- You use short enrollment forms for:
  - Current members making a plan change to their existing Aetna PDP plan
  - Current members making a plan change to their existing Aetna MAPD plan
- You submit Loss of Creditable Coverage when applicable
- Complete section 9 entirely
- Complete the Selling Agent/Broker Use fields with the writing agent's National Producer Number (NPN) or SSN/TIN and other information. To look up your NPN, go to https://pdb.nipr.com/html/PacNpnSearch.html.
- If you work with a FMO/GA or Affinity partner, forward the completed application to them so they can complete their section as appropriate.

Submit enrollments accurately and on time

- Please see page 5 for online enrollment options.
- Submit paper enrollment applications to:
  - Fax: 1-866-441-2341
  - Mail: Aetna Medicare Broker Enrollment Team
    P.O. Box 14088
    Lexington, KY 40512-4088
  - Email: MedicareEnrollmentTransactions@aetna.com
  - Please see page 5 for instructions on providing the Scope of Appointment to Aetna.
- If you work with a FMO/GA or Affinity partner, please follow their instructions for submitting completed enrollment forms to them to ensure timely processing and accurate commission payments.

Questions? We're happy to help! Please contact your Aetna Medicare Broker Sales Representative or the Aetna Medicare Broker Support Unit at 1-888-247-1050 or e-mail BrokerService-MedicareTeam@Aetna.com.

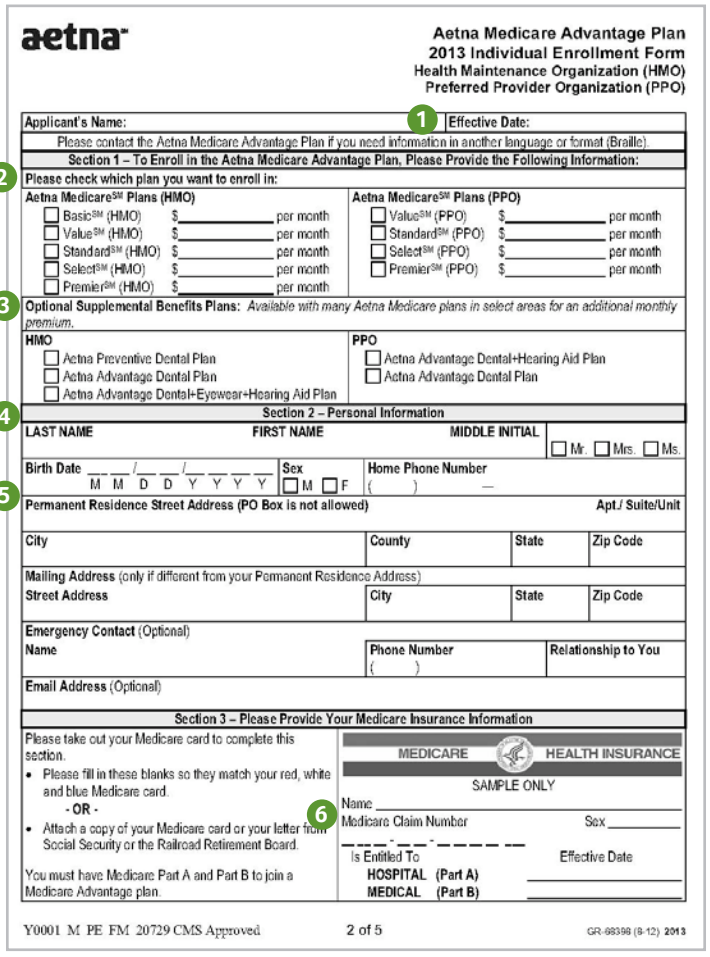
18.02.015.1 D (11/12)

Step-by-Step Instructions for Completing Paper Enrollment Applications (MA, MAPD, PDP)

Page 2

1. Choose a valid effective date on every application.
2. Choose a plan.
3. Include the optional supplemental benefit selection, if applicable (HMO/PPO application only).
4. Enter all applicant's personal data.
5. Don't forget to list complete address information, including the applicant's permanent residential address. The county is used to assign the member's monthly premium payment.
6. Include the Medicare Claim number (also called HICN) exactly as it appears on the red, white and blue Medicare Card. Include all letters and numbers as they appear.

2013 HMO/PPO Enrollment Form



aetna

Aetna Medicare Advantage Plan
2013 Individual Enrollment Form
Health Maintenance Organization (HMO)
Preferred Provider Organization (PPO)

Applicant's Name: | 1 Effective Date:

Please contact the Aetna Medicare Advantage Plan if you need information in another language or format (Braille).

Section 1 – To Enroll in the Aetna Medicare Advantage Plan, Please Provide the Following Information:

2 Please check which plan you want to enroll in:

Aetna Medicare℠ Plans (HMO)	Aetna Medicare℠ Plans (PPO)
☐ Basic℠ (HMO) $_____ per month	☐ Value℠ (PPO) $_____ per month
☐ Value℠ (HMO) $_____ per month	☐ Standard℠ (PPO) $_____ per month
☐ Standard℠ (HMO) $_____ per month	☐ Select℠ (PPO) $_____ per month
☐ Select℠ (HMO) $_____ per month	☐ Premier℠ (PPO) $_____ per month
☐ Premier℠ (HMO) $_____ per month	

3 **Optional Supplemental Benefits Plans:** *Available with many Aetna Medicare plans in select areas for an additional monthly premium.*

HMO	PPO
☐ Aetna Preventive Dental Plan	☐ Aetna Advantage Dental+Hearing Aid Plan
☐ Aetna Advantage Dental Plan	☐ Aetna Advantage Dental Plan
☐ Aetna Advantage Dental+Eyewear+Hearing Aid Plan	

4 **Section 2 – 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 ( ) —

5 Permanent Residence Street Address (PO Box is not allowed) | Apt./ Suite/Unit

City | County | State | Zip Code

Mailing Address (only if different from your Permanent Residence Address)

Street Address | City | State | Zip Code

Emergency Contact (Optional)

Name | Phone Number ( ) | Relationship to You

Email Address (Optional)

Section 3 – Please Provide Your Medicare Insurance Information

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card.
  - OR -
- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name _____

6 Medicare Claim Number _____ Sex _____

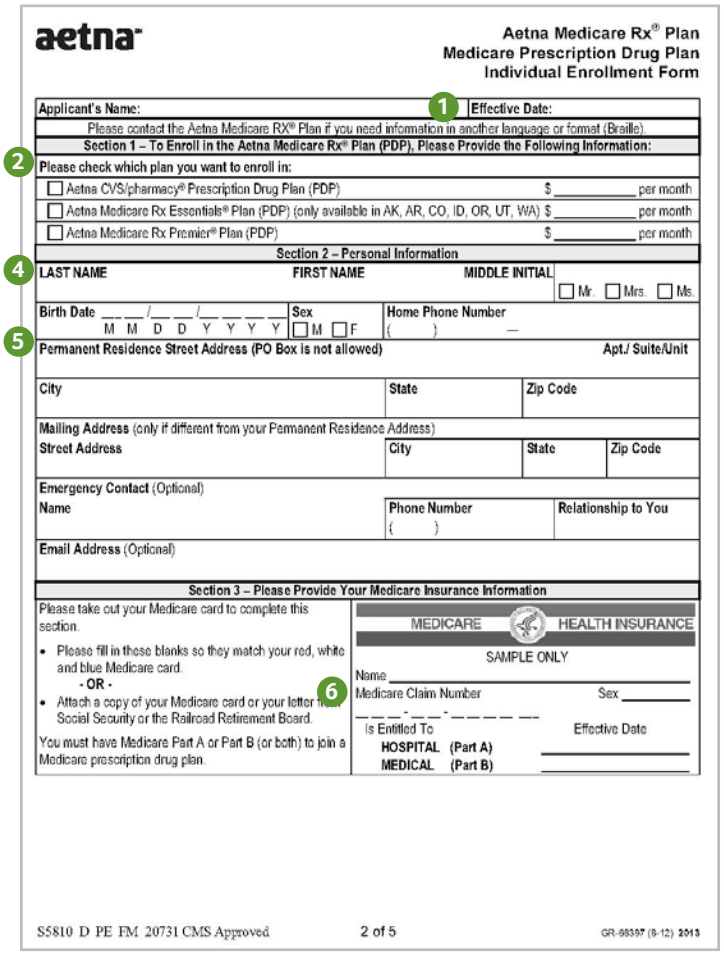
Is Entitled To | Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Y0001 M PE FM 20729 CMS Approved 2 of 5 GR-68398 (8-12) 2013

2013 PDP Enrollment Form



aetna

Aetna Medicare Rx® Plan
Medicare Prescription Drug Plan
Individual Enrollment Form

Applicant's Name: | 1 Effective Date:

Please contact the Aetna Medicare RX® Plan if you need information in another language or format (Braille).

Section 1 – To Enroll in the Aetna Medicare Rx® Plan (PDP), Please Provide the Following Information:

2 Please check which plan you want to enroll in:

- ☐ Aetna CVS/pharmacy® Prescription Drug Plan (PDP) $_____ per month
- ☐ Aetna Medicare Rx Essentials® Plan (PDP) (only available in AK, AR, CO, ID, OR, UT, WA) $_____ per month
- ☐ Aetna Medicare Rx Premier® Plan (PDP) $_____ per month

Section 2 – Personal Information

4 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 ( ) —

5 Permanent Residence Street Address (PO Box is not allowed) | Apt./ Suite/Unit

City | State | Zip Code

Mailing Address (only if different from your Permanent Residence Address)

Street Address | City | State | Zip Code

Emergency Contact (Optional)

Name | Phone Number ( ) | Relationship to You

Email Address (Optional)

Section 3 – Please Provide Your Medicare Insurance Information

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card.
  - OR -
- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name _____

6 Medicare Claim Number _____ Sex _____

Is Entitled To | Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

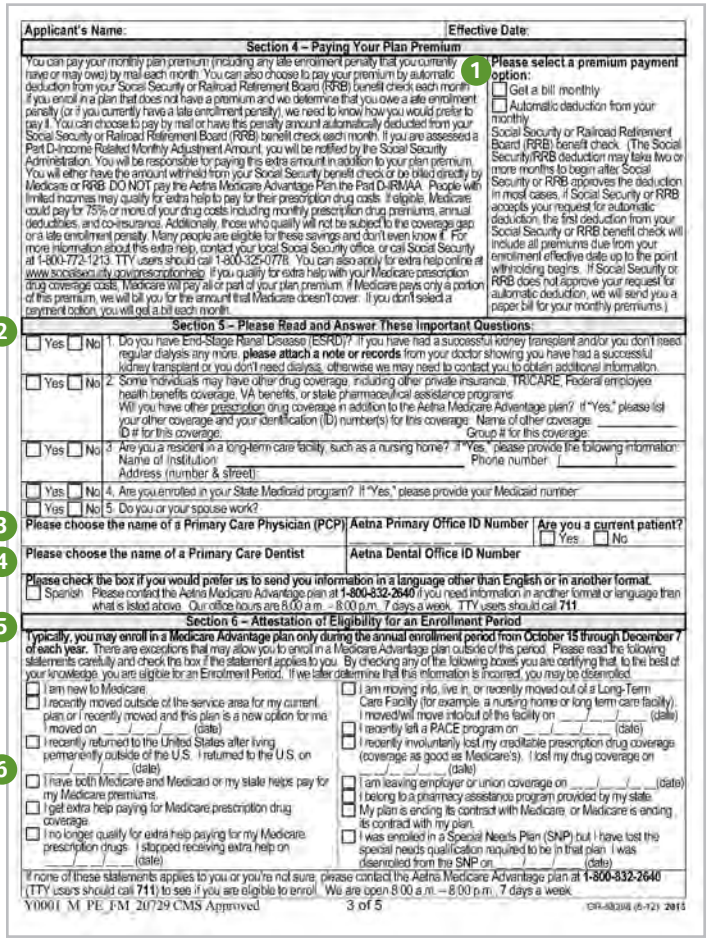
S5810 D PE FM 20731 CMS Approved 2 of 5 GR-68397 (8-12) 2013

Step-by-Step Instructions for Completing Paper Enrollment Applications (MA, MAPD, PDP)

Page 3

1. Select a Premium Payment Option. If left blank, beneficiary will receive monthly premium statements.
2. Complete Section 5 (either Yes or No). If left blank, processing delays will occur.
3. Choose a Primary Care Physician (required for HMO plans). The Aetna Primary Office ID Number is listed in DocFind®. On DocFind, perform a general search and select a physician. The six-digit code is shown on the Provider Details page.
4. If the beneficiary elects an optional supplemental benefit plan, he or she should select a Primary Care Dentist.
5. Determine and select the correct enrollment period. Attach supporting documentation used to determine member's eligibility for special enrollment periods or exceptions.
6. Provide the effective date for a specific special enrollment period, if applicable.

2013 HMO/PPO Enrollment Form



Applicant's Name: Effective Date:

Section 4 – Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you enroll in a plan that does not have a premium and we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can choose to pay by mail or have this penalty amount automatically deducted from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT pay the Aetna Medicare Advantage Plan the Part D-IRMAA. People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a 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 users should call 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 doesn't cover. If you don't select a payment option, you will get a bill each month.

1 **Please select a premium payment option:**
- ☐ Get a bill monthly
- ☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Section 5 – Please Read and Answer These Important Questions:

2
- ☐ Yes ☐ No 1. Do you have End-Stage Renal Disease (ESRD)? If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.
- ☐ Yes ☐ No 2. 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 plan? If "Yes," please list your other coverage and your identification (ID) number(s) for this coverage: Name of other coverage: _____ ID # for this coverage: _____ Group # for this coverage: _____
- ☐ Yes ☐ No 3. Are you a resident in a long-term care facility, such as a nursing home? If "Yes," please provide the following information: Name of Institution: _____ Phone number: (___) ___-____ Address (number & street): _____
- ☐ Yes ☐ No 4. Are you enrolled in your State Medicaid program? If "Yes," please provide your Medicaid number: _____
- ☐ Yes ☐ No 5. Do you or your spouse work?

3 **Please choose the name of a Primary Care Physician (PCP):** _____ **Aetna Primary Office ID Number:** _____ **Are you a current patient?** ☐ Yes ☐ No

4 **Please choose the name of a Primary Care Dentist:** _____ **Aetna Dental Office ID Number:** _____

Please check the box if you would prefer us to send you information in a language other than English or in another format.
☐ Spanish Please contact the Aetna Medicare Advantage plan at **1-800-832-2640** if you need information in another format or language than what is listed above. Our office hours are 8:00 a.m. – 8:00 p.m., 7 days a week. TTY users should call **711**.

5 **Section 6 – Attestation of Eligibility for an Enrollment Period**

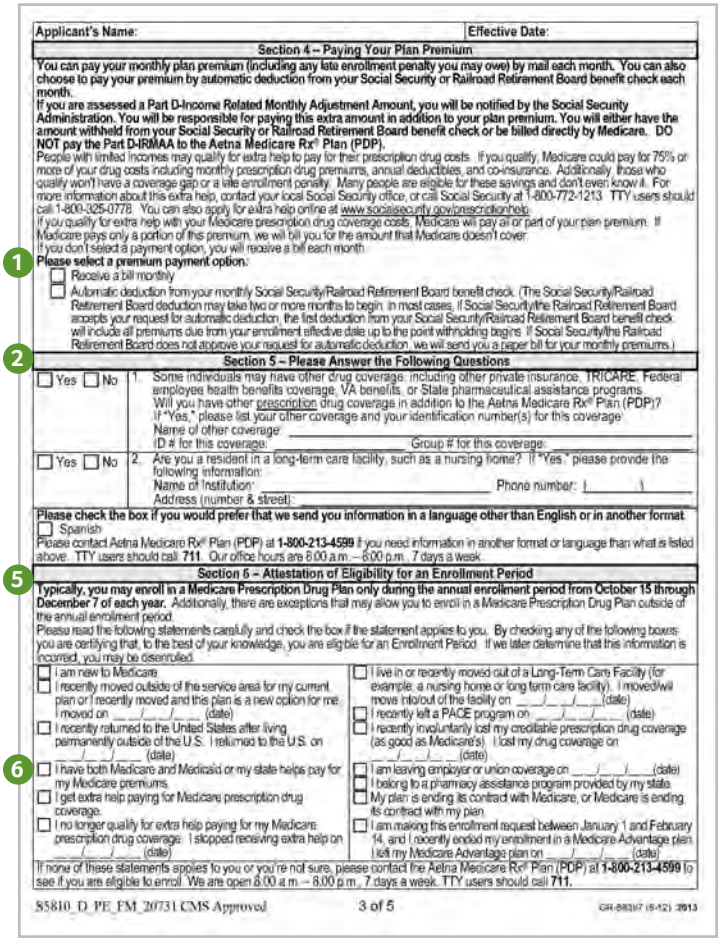
Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period. Please read the following statements carefully and check 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.

6
- ☐ I am new to Medicare.
- ☐ 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 returned to the United States after living permanently outside of the U.S. I returned to the U.S. on ___/___/___ (date)
- ☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- ☐ I get extra help paying for Medicare prescription drug coverage.
- ☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on ___/___/___ (date)
- ☐ I am moving into, 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 this facility on ___/___/___ (date)
- ☐ I recently left a PACE program on ___/___/___ (date)
- ☐ I recently involuntarily lost my creditable prescription drug coverage (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 Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on ___/___/___ (date)

If none of these statements applies to you or you're not sure, please contact the Aetna Medicare Advantage plan at **1-800-832-2640** (TTY users should call **711**) to see if you are eligible to enroll. We are open 8:00 a.m. – 8:00 p.m., 7 days a week.

Y0001_M_PE_FM_20729 CMS Approved 3 of 5 GR-68398 (6-12) 2013

2013 PDP Enrollment Form



Applicant's Name: Effective Date:

Section 4 – Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty you may owe) by mail each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check each month.
If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security or Railroad Retirement Board benefit check or be billed directly by Medicare. DO NOT pay the Part D-IRMAA to the Aetna Medicare Rx® Plan (PDP).
People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a 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 users should call 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 doesn't cover.
If you don't select a payment option, you will receive a bill each month.

1 **Please select a premium payment option:**
- ☐ Receive a bill monthly
- ☐ Automatic deduction from your monthly Social Security/Railroad Retirement Board benefit check. (The Social Security/Railroad Retirement Board deduction may take two or more months to begin. In most cases, if Social Security/the Railroad Retirement Board accepts your request for automatic deduction, the first deduction from your Social Security/Railroad Retirement Board benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security/the Railroad Retirement Board does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Section 5 – Please Answer the Following Questions

2
- ☐ Yes ☐ No 1. 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 Rx® Plan (PDP)? If "Yes," please list your other coverage and your identification number(s) for this coverage: Name of other coverage: _____ ID # for this coverage: _____ Group # for this coverage: _____
- ☐ Yes ☐ No 2. Are you a resident in a long-term care facility, such as a nursing home? If "Yes," please provide the following information: Name of Institution: _____ Phone number: (___) ___-____ Address (number & street): _____

Please check the box if you would prefer that we send you information in a language other than English or in another format.
☐ Spanish
Please contact Aetna Medicare Rx® Plan (PDP) at **1-800-213-4599** if you need information in another format or language than what is listed above. TTY users should call **711**. Our office hours are 8:00 a.m. – 8:00 p.m., 7 days a week.

5 **Section 6 – Attestation of Eligibility for an Enrollment Period**

Typically, you may enroll in a Medicare Prescription Drug Plan only during the annual enrollment period from October 15 through December 7 of each year. Additionally, there are exceptions that may allow you to enroll in a Medicare Prescription Drug Plan outside of the annual enrollment 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.

6
- ☐ I am new to Medicare.
- ☐ 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 returned to the United States after living permanently outside of the U.S. I returned to the U.S. on ___/___/___ (date)
- ☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- ☐ I get extra help paying for Medicare prescription drug coverage.
- ☐ I no longer qualify for extra help paying for my Medicare prescription drug coverage. I stopped receiving extra help on ___/___/___ (date)
- ☐ 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 am making this enrollment request between January 1 and February 14, and I recently ended my enrollment in a Medicare Advantage plan. I left my Medicare Advantage plan on ___/___/___ (date)

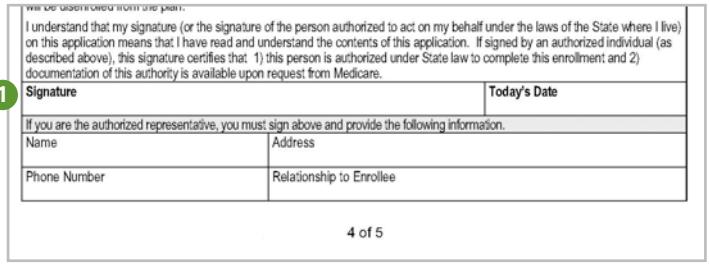
If none of these statements applies to you or you're not sure, please contact the Aetna Medicare Rx® Plan (PDP) at **1-800-213-4599** to see if you are eligible to enroll. We are open 8:00 a.m. – 8:00 p.m., 7 days a week. TTY users should call **711**.

S5810_D_PE_FM_20731 CMS Approved 3 of 5 GR-68317 (5-12) 2013

Step-by-Step Instructions for Completing Paper Enrollment Applications (MA, MAPD, PDP)

Page 4

1. The applicant, or the person acting as Power of Attorney or Legal Representative, must sign and date the application. **Be sure the application is received by Aetna within 48 hours of completing it with the beneficiary.**



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 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.

1 Signature	Today's Date

If you are the authorized representative, you must sign above and provide the following information.

Name	Address
Phone Number	Relationship to Enrollee

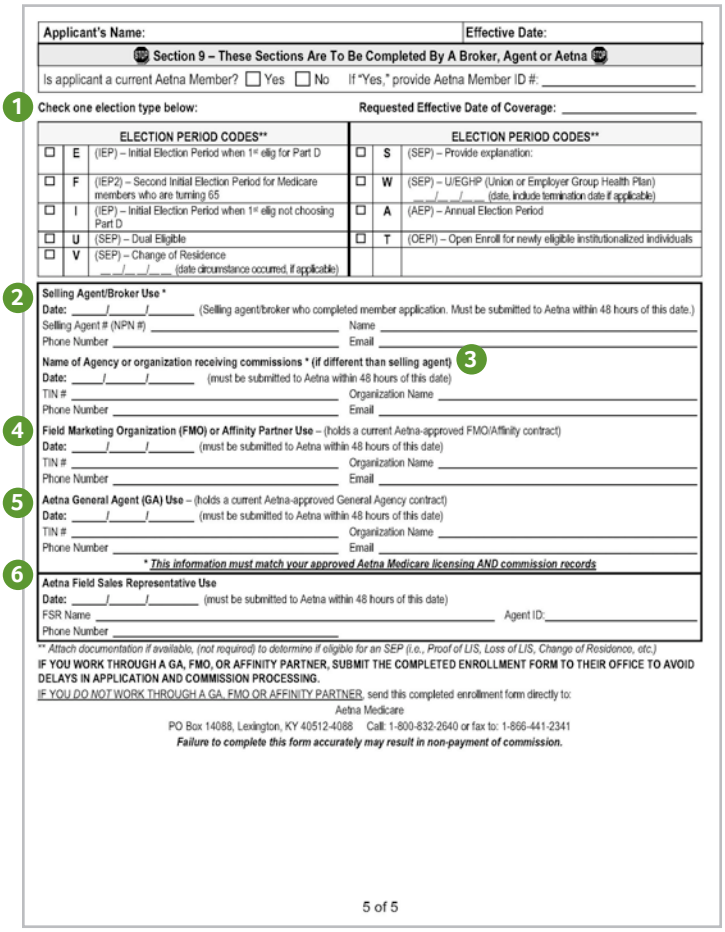
4 of 5

Page 5

1. Select the applicable election period. **Enrollment forms submitted outside of the Annual Enrollment Period must include an SEP reason code and a requested effective date of coverage.**
2. These are mandatory fields on all enrollment forms. Must be completed with individual writing agent name and your NPN or SSN.

   Agent assisted enrollments must be reported to CMS as part of the Medicare Part C and D reporting requirements. Incomplete or inaccurate information may result in non-payment of commissions. Information not reflecting the actual writing agent may result in disciplinary action.

   This information must match the approved broker information on our files. Remember: you must be licensed and registered with Aetna to sell in the state where the beneficiary resides.
3. Complete with full agency or firm name.
4. Complete when there is a Field Marketing Organization (FMO) with an active executed Medicare FMO contract only (this is not the same as the producer agreement found on Producer World).
5. Complete when there is a general agency (GA) with an active executed Medicare GA contract only (this is not the same as the producer agreement found on Producer World).
6. Complete if you are an AETNA EMPLOYEE ONLY.



Applicant's Name: | Effective Date:

Section 9 – These Sections Are To Be Completed By A Broker, Agent or Aetna

Is applicant a current Aetna Member? ☐ Yes ☐ No If "Yes," provide Aetna Member ID #: _____

1 **Check one election type below:** **Requested Effective Date of Coverage:** _____

ELECTION PERIOD CODES**			ELECTION PERIOD CODES**		
☐	E	(IEP) – Initial Election Period when 1st elig for Part D	☐	S	(SEP) – Provide explanation:
☐	F	(IEP2) – Second Initial Election Period for Medicare members who are turning 65	☐	W	(SEP) – U/EGHP (Union or Employer Group Health Plan) __/__/__ (date, include termination date if applicable)
☐	I	(IEP) – Initial Election Period when 1st elig not choosing Part D	☐	A	(AEP) – Annual Election Period
☐	U	(SEP) – Dual Eligible	☐	T	(OEPI) – Open Enroll for newly eligible institutionalized individuals
☐	V	(SEP) – Change of Residence __/__/__/__ (date circumstance occurred, if applicable)			

2 **Selling Agent/Broker Use ***
Date: ____/____/____ (Selling agent/broker who completed member application. Must be submitted to Aetna within 48 hours of this date.)
Selling Agent # (NPN #) _____ Name _____
Phone Number _____ Email _____

3 **Name of Agency or organization receiving commissions * (if different than selling agent)**
Date: ____/____/____ (must be submitted to Aetna within 48 hours of this date)
TIN # _____ Organization Name _____
Phone Number _____ Email _____

4 **Field Marketing Organization (FMO) or Affinity Partner Use** – (holds a current Aetna-approved FMO/Affinity contract)
Date: ____/____/____ (must be submitted to Aetna within 48 hours of this date)
TIN # _____ Organization Name _____
Phone Number _____ Email _____

5 **Aetna General Agent (GA) Use** – (holds a current Aetna-approved General Agency contract)
Date: ____/____/____ (must be submitted to Aetna within 48 hours of this date)
TIN # _____ Organization Name _____
Phone Number _____ Email _____

* *This information must match your approved Aetna Medicare licensing AND commission records*

6 **Aetna Field Sales Representative Use**
Date: ____/____/____ (must be submitted to Aetna within 48 hours of this date)
FSR Name _____ Agent ID: _____
Phone Number _____

** *Attach documentation if available, (not required) to determine if eligible for an SEP (i.e., Proof of LIS, Loss of LIS, Change of Residence, etc.)*

IF YOU WORK THROUGH A GA, FMO, OR AFFINITY PARTNER, SUBMIT THE COMPLETED ENROLLMENT FORM TO THEIR OFFICE TO AVOID DELAYS IN APPLICATION AND COMMISSION PROCESSING.

IF YOU DO NOT WORK THROUGH A GA, FMO OR AFFINITY PARTNER, send this completed enrollment form directly to:
Aetna Medicare
PO Box 14088, Lexington, KY 40512-4088 Call: 1-800-832-2640 or fax to: 1-866-441-2341

Failure to complete this form accurately may result in non-payment of commission.

5 of 5

Frequently asked questions and useful information:

Where do I submit completed enrollment forms?

By fax: 1-866-441-2341

By mail: Aetna Medicare Broker Enrollment Team
P.O. Box 14088
Lexington, KY 40512-4088

By email: MedicareEnrollmentTransactions@aetna.com. Email attachments must be in an approved format and must not exceed 7 pages.

Online: through the new iPad mobile enrollment app. Contact your Broker Sales Rep or the Aetna Medicare Broker Support Unit for downloading instructions.

Online: through Aetna's Producer Online Enrollment Tool (POET). Register through Producer World or by contacting your Broker Sales Rep or the Aetna Medicare Broker Support Unit. Usernames and passwords will be sent via email within 5-7 business days, accompanied by a link to the POET website. Note: If using POET, you must obtain a signed Online Enrollment Authorization Form and provide a signed hard copy to the beneficiary and to Aetna. Download the form from Producer World.

When and how should I submit the Scope of Appointment?

If you meet with a beneficiary one-on-one or during personal/individual appointment (i.e., not in a formal group setting such as an advertised meeting), you must capture a Scope of Appointment (SOA) prior to the appointment. If the beneficiary chooses to enroll, you must submit the SOA to Aetna along with the application as per the directions below. (**Exception**: If WEST captures an SOA for a personal/individual appointment, you do not need to obtain another SOA prior to the appointment or submit the SOA to Aetna with the application.)

- **When using paper applications:** Write the HICN in the "Plan Use Only" field of the SOA prior to submitting the enrollment and SOA to Aetna. Beneficiaries are not permitted to fill in the HICN on their own. If using Voice Vault: Obtain the Voice Vault Transaction ID (9-digit number) from the SOA Confirmation email and write that Transaction ID number next to the Broker/Agent Use Name on the paper enrollment application.
- **When using the iPad mobile enrollment app or POET:** Obtain a paper SOA. Write the HICN in the "Plan Use Only" field of the SOA before submitting the SOA to Aetna. Beneficiaries are not permitted to fill in the HICN on their own. Fax the SOA directly to Aetna at 800-441-2341. If using Voice Vault: Obtain the Voice Vault Transaction ID and enter it in the Voice Vault ID field in the iPad app or in POET. This will automatically tie the telephonic SOA captured in Voice Vault with the enrollment.

Who can I contact for assistance?

Contact the Aetna Medicare Broker Support Unit

By phone: 1-888-247-1050

By e-mail: BrokerService-MedicareTeam@Aetna.com

Hours: Monday-Friday, 8:30 a.m. to 5:00 p.m., local time

How can I order enrollment kits?

Complete the online order form on Producer World. Visit the Individual Medicare page of Producer World and access the order form under Enrollment Materials.

Who can I contact if I need assistance with commissions?

By phone: 1-888-622-3435, Monday-Friday, 8:00 a.m. to 4:30 p.m., ET

By e-mail: BrokerComm@Aetna.com

When can I expect to see my commission from this application?

Once the application is completed by Aetna and approved by CMS, the member's information will be included in our compensation file.

The member enrollment will then be reviewed for commission eligibility in the next scheduled commission processing run. Upon validation of all licensing, appointment, registration and certification requirements related to the parties involved in the sales process, the member enrollment will be eligible for commission payment.

Commission checks are printed/issued weekly, approximately 10 days after the enrollment is submitted. For example, enrollments in active membership and approved by CMS on 1/2/13 will be paid on 1/12/13.

Where I can find information about Aetna's plans or Medicare Advantage plans in general?

- Producer World
- AetnaMedicare.com
- Centers for Medicare and Medicaid Services (CMS): cms.gov

www.aetna.com

18.02.015.1 D (11/12)