Aetna Medicare Rx offered by SilverScript

2021 Employer Group Prescription Drug Plan (PDP) Enrollment Form

Enrollment Instructions	
Follow the instructions below to complete your enrollment into **Aetna Medicare Rx offered by SilverScript (PDP). Answer all questions completely as incomplete or incorrect information may delay the start of your coverage.**	
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. **Your effective date cannot be earlier than the day you sign this form.**
Former Employer Information	Write the name of the former employer/union/trust offering this prescription drug plan (the company you retired from). List the group number and class code, if you know it. The group number and class code are not required.
Personal 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 of the fields to avoid a delay in your coverage.
Plan Selection	Check the box next to the plan you wish to enroll in. (There may only be one option available.) For more plan details, review the benefit summary included in your enrollment packet.
Medicare Information	Read and answer the Medicare questions.
Important Information	DISCLOSURES
Signature Required	Sign and date the application in the space provided. If you are the **Authorized Representative**, sign the form and include your information.
Make a Copy	Make a copy of the entire application for your records. 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 with any questions

Phone Number:
Hours of Operation:
Mail to:

Website:
Fax Number:

Make a copy for yourself and return the original.

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Please Read This Important Information

Typically, you may enroll in a Medicare Prescription Drug Plan during the Medicare Annual Enrollment Period between October 15 and December 7, or your former employer/union/trust annual Open Enrollment Period. Please check with your former employer group, union, or trust regarding their designated enrollment period as it may be tied to other retiree benefits. 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 determine your enrollment period. If we later determine that this information is incorrect, you may be disenrolled.

Reason for Eligibility

Annual Enrollment Period Eligibility

- ☐ I am enrolling during the Medicare Annual Enrollment Period (October 15 through December 7)
- ☐ I am enrolling during my (former) employer group, union, or trust designated enrollment period

Initial Enrollment Period Eligibility

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

If none of these statements apply to you, please contact your employer group, union, or trust for assistance.

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 ______________.
- ☐ I recently was released from incarceration. I was released on ______________.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on ______________.
- ☐ I recently obtained lawful presence status in the United States. I got this status on ______________.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on ______________.
- ☐ 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 ______________.
- ☐ 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 ______________.
- ☐ I recently left a PACE program on ____________.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). I lost my drug coverage on ______________.
- ☐ I am leaving employer or union coverage on ______________.
- ☐ 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 ____________.
- ☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

To Enroll in Aetna Medicare Rx offered by SilverScript, Provide the Following Information

Please check the SilverScript plan in which you wish to enroll.

☐ I wish to enroll in **Aetna Medicare Rx offered by SilverScript**

Employer/Union/Trust Information

Group Name: ____________________

Group ID: ____________________

Class Code: ____________________

Coverage Effective Date: ____________________

Power of Attorney / Authorized Representative

If you are legally authorized to represent the enrollee, you must provide the following information (not for agent use)

Name ____________________

Address ____________________

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

Phone Number ____________________

Relationship to Enrollee ☐ **Child** ☐ **Friend** ☐ **Spouse** ☐ **Other** ____________________

Signature ____________________ **Today's Date** ____________________

☐ **Please check if authorized representative should receive duplicate copy of plan materials.**

Complete the Information Below Exactly as it Appears on Your Medicare Card

Use 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.

Entitled To:

Hospital Insurance (Part A) ____________________

Medical Insurance (Part B) ____________________

Prefix ____________________

First Name ____________________

MI _____

Last Name ____________________

Suffix ____________________

Medicare Number

____

Please Provide the Following Personal Information

Birth Date ____________ MM/DD/YYYY

Sex ☐ M ☐ F

Primary Phone Number ____________

Cell Phone Number ____________

Permanent Residence / Long-term Care Facility Address (P.O. Box is not allowed)

Street Number ________ Street Name ____________

Apt/Suite/Unit ____________

City ____________

County ____________ **State** ________ **ZIP Code** ____________

Long-term Care Facility Name ____________

Mailing Street Address

Street Number ________ Street Name ____________

Apt/Suite/Unit ____________

City ____________

County ____________ **State** ________ **ZIP Code** ____________

Email Address (optional) ____________

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 Medicare Rx offered by SilverScript?

☐ Yes ☐ No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage.
The shaded line shows how this may appear on your card.

Plan Name	Effective Date	Term Date	RxBin	RxPCN	RxGroup	RxID#
ABC Insurance	10/01/2009	12/31/2018	123456	0049876912	ABC1234	123456789

¿Le gustaría recibir esta información en español? ☐ Yes (Sí) ☐ No

If you need information in an alternate language or accessible format, such as braille, audio tape or large print, please contact Aetna Medicare Rx offered by SilverScript at 1-888-665-6296 (TTY: 711).

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

We will send you a monthly email alert to view your statement. You can print it if you need to.

☐ Yes, I want to receive my EOB statements electronically and have noted my email address on this form

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

The Explanation of Benefits (EOB) is a record of your prescription claims that have been processed for the month. The EOB statement shows each prescription's cost, the amount your plan has paid toward its cost, and the amount for which you're responsible. You can change your preference on Caremark.com at any time.

If you choose to receive paperless Explanation of Benefit statements, you will need to create an account on Caremark.com. In addition to viewing your EOB statements online, Caremark.com will give you the ability to track your prescription costs and order mail service prescriptions.

STOP! 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 SilverScript Employer 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 another employer or union, joining SilverScript Employer PDP could affect your other employer or union health benefits. You could lose your employer or union health coverage if you join SilverScript Employer 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.

Please Read Terms and Sign

By completing this enrollment form, I agree to the following:

SilverScript Employer 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. It is my responsibility to inform SilverScript of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare Prescription Drug Plan at a time – if I am currently in a Medicare Prescription Drug Plan, my enrollment in SilverScript 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, **between October 15 and December 7, or during my former employer/union/trust annual Open Enrollment Period,** unless I qualify for certain special circumstances.

Aetna Medicare Rx offered by SilverScript serves a specific service area. If I move out of the service area, 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 Medicare Rx offered by SilverScript network pharmacies. Once I am a member of Aetna Medicare Rx offered by SilverScript, 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 Medicare Rx offered by SilverScript 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 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 Medicare Rx offered by SilverScript, he or she may be paid based on my enrollment in Aetna Medicare Rx offered by SilverScript.

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 Medicare Rx offered by SilverScript 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 Rx offered by SilverScript 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 that 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 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.

Applicant's Signature	
Your Signature	**Today's Date**
Print Name *(please print)*	

SilverScript Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Aetna Medicare Rx offered by SilverScript is a group standalone Medicare Prescription Drug Plan (PDP). This Plan is offered by SilverScript Insurance Company, which has a Medicare contract. SilverScript Insurance Company and Aetna are affiliated companies. Enrollment in the Plan depends on Medicare contract renewal.