Aetna Medicare Advantage Plan
2025 Employer Group Enrollment Form
Aetna Medicare℠ Plan (HMO)
Aetna Medicare℠ Plan (PPO)

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 9 PM ET
Mail to: City of New York - Mail Code F314, PO Box 818013, Cleveland,OH, 44181

Website: https://cityofny.aetnamedicare.com/
Fax Number: 1-860-907-3010
Contact Name:

Prospective member name	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	Class Code ☐ ☐ ☐ ☐
Plan Sponsor Name	

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
☐ Plan selection	Master Plan ID	MA ESA PPO - NO RX
☐ Plan selection	Master Plan ID	MA ESA PPO - WITH RX
☐		
☐		
☐		
☐		

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	**Sex**	**Phone number**
__ __/__ __/__ __ __ __ M M/ D D/ Y Y Y Y	☐ M ☐ F	(_ _ _) _ _ _ - _ _ _ _ Is this a mobile number? ☐ Yes ☐ No

Email address

Permanent residence street address – including Apt/Suite/Unit (**Don't enter a PO Box.**
Note: For individuals experiencing homelessness, a PO Box may be considered your permanent address.):

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

Mailing address – including Apt/Suite/Unit (if different from your permanent street address)

	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 Advantage Plan

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

Effective Date:

HOSPITAL (Part A) _ _/_ _/_ _ _ _

MEDICAL (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 <u>prescription</u> 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: / 01 /

Please tell us a litte more about yourself

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you of Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban
- ☐ **I choose not to answer.**

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ **I choose not to answer.**

What is your gender? Select one.

- ☐ Woman
- ☐ Man
- ☐ Non-binary
- ☐ I use a different term: _____
- ☐ **I choose not to answer.**

Which of the following best represents how you think of yourself? Select one.

- ☐ Lesbian or gay
- ☐ Straight, that is, not gay or lesbian
- ☐ Bisexual
- ☐ I use a different term: _____
- ☐ I don't know
- ☐ **I choose not to answer.**

Continued on the next page

Prospective member name	**Effective date:** **/ 01 /**

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, 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.

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)