SilverScript®

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Aetna Medicare Rx offered by SilverScript
2024 Employer Group Prescription Drug Plan (PDP) Enrollment Form

OMB No. 0938-1378 Expires 7/31/2024

Employer Group Prescription Drug Plan (PDP) 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 prescription drug plan (the company you retired from). List the Group ID number and Class Code if you know it. The Group ID number and Class Code are not required. (This information may be pre-filled.)
Choose your prescription drug plan	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.
Your information	This is your name, address, phone number, etc. **Please print neatly.** **For individuals experiencing homelessness**: If you want to join a plan but have no permanent residence, a Post Office Box, the address of a shelter or clinic, or the address where you receive mail (for example, Social Security checks) may be considered your permanent resident address.
Your 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 important 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:
Hours:
Mail to:

Website:
Fax Number:

Confirm your enrollment period

Typically, you may enroll in a Medicare Prescription Drug Plan only during the Annual Enrollment Period (AEP) from October 15 through 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. 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.

Prospective member name	**Medicare number:**
	__ __ __ __ - __ __ __ - __ __ __ __

Reason for Annual Enrollment Period Eligibility

☐ I'm enrolling between 10/15/23-12/7/23 during the current Annual Enrollment Period.

Reasons for Initial Enrollment Period Eligibility

☐ I'm new to Medicare.

☐ I'm new to Medicare, and I was notified about getting Medicare after my Part A and/or Part B coverage started. I was notified on __ __/__ __/__ __ (date).

☐ I had Medicare prior to now, but I'm now turning 65

Reasons for Open Enrollment Period Eligibility

Between 1/1/24 and 3/31/24:

☐ I'm in a Medicare Advantage plan and want to make a change.

Between 4/1/24 and 12/31/24:

☐ I'm in a Medicare Advantage plan and have had Medicare for less than 3 months. I want to make a change.

Reasons for Special Enrollment Period (SEP) Eligibility

☐ I moved to a new address that's outside my current plan's service area, or I recently moved and this plan is a new option for me. I moved on __ __/__ __/__ __ (date).

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

☐ I moved back to the United States after living outside the country. I returned to the U.S. on __ __/__ __/__ __ (date).

☐ I recently got 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 my drug costs (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, my state helps pay for my Medicare premiums, or I get Extra Help paying my Medicare drug coverage.

☐ I dropped my coverage in a PACE (Programs of All-Inclusive Care for the Elderly) plan on __ __/__ __/__ __ (date).

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Prospective member name	**Medicare number:**
	__ __ __ __ - __ __ __ - __ __ __ __

- ☐ I live in a long-term care facility, like a nursing home or a rehabilitation hospital.
- ☐ I recently moved out of a long-term care facility, like a nursing home or rehabilitation hospital. I moved out of the facility on __ __/__ __/__ __ (date).
- ☐ I lost other, non-Medicare drug coverage (creditable coverage), or my other non-Medicare coverage changed and is no longer considered creditable coverage. I lost my drug coverage on __ __/__ __/__ __ (date).
- ☐ I left coverage from my employer or union (including COBRA coverage) on __ __/__ __/__ __ (date).
- ☐ I'm in a State Pharmaceutical Assistance Program, or I am losing help from a State Pharmaceutical Assistance Program.
- ☐ I lost my coverage because my plan no longer covers the area that I live or it ended its contract with Medicare.
- ☐ 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 lost my Special Needs Plan because I no longer have a condition required for that plan. I was disenrolled from the plan on __ __/__ __/__ __ (date).
- ☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency, or by Federal, my state or my local government). One of the other statements applied to me, but I was unable to make my request because of the disaster.

If none of these statements above apply to you, but you feel you have a special circumstance which allows you to enroll, please contact your employer group, union, or trust, or Aetna Medicare at **1-800-307-4830 (TTY: 711**). We're here 7 AM to 8 PM, Monday through Friday. We can help you to determine if you qualify for a Special Election Period.

Prospective member name	Effective date: / /

Former employer/union/trust information: Write the name of the former employer/union/trust offering your retiree prescription drug plan unless this information is pre-filled.

Name of former employer/union/trust	Group ID number	Class code

Choose your prescription drug plan

Check the box next to the plan you want to enroll in (there may only be one option). 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.**

☐ **Aetna Medicare Rx offered by SilverScript**

Your information

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

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

Email address

Permanent residence street address – including Apt/Suite/Unit (a PO Box is not allowed)

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 or Part B (or both) to join a Medicare Prescription Drug Plan.

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

Effective Date:

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

MEDICAL (Part B) _ _/_ _/_ _ _ _

Please answer this important question

☐ Yes ☐ No

1. **Will you have other <u>prescription</u> drug coverage in addition to the Aetna Medicare Rx offered by SilverScript 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:** / /

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.**

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

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

☐ Braille ☐ Large print ☐ Audio 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.

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.

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.

Prospective member name:	Effective date: / /

Please read this section carefully

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 Medicare Rx offered by SilverScript, 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 Aetna Medicare Rx offered by SilverScript. 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.

By completing this enrollment application, I agree to the following: Aetna Medicare Rx offered by SilverScript is a Medicare prescription drug plan and has a contract with the Federal government. I must keep Medicare Part A or Part B to stay in Aetna Medicare Rx offered by SilverScript.

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.

By joining this Medicare Prescription Drug Plan, I acknowledge that Aetna Medicare Rx offered by SilverScript 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.

Release of Information
By joining this Prescription Drug Plan, I acknowledge that the Prescription Drug 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 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 Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Aetna Medicare Rx offered by SilverScript coverage begins, I must get all of my prescription drug services from Aetna Medicare Rx offered by SilverScript. Prescription drugs authorized by Aetna Medicare Rx offered by SilverScript and contained in my Aetna Medicare Rx offered by SilverScript Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR Aetna Medicare Rx offered by SilverScript WILL PAY FOR THE SERVICES.**

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Prospective member name:	Effective date: / /

Please read this section carefully and sign below

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where the individual resides) 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.

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

Print name *(please print)*

If you're the authorized representative helping someone fill out this form, you must sign above and provide the following information.

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

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. Aetna® and CVS Pharmacy® are a part of the CVS Health® family of companies. Plan features and availability may vary by service area.