Retireefirst™

Enrollment Form:

aetna®

Medicare Advantage Prescription Drug Plan (MAPD)

First Name	
Middle Initial	
Last Name	
Birth Date	_____/_____/_____
Group Name	**Acton Health Insurance Trust (School)**
Social Security Number	
Gender	
Phone Number	( ) -
Permanent Residence Address (P.O. box not allowed)	
City	
State	
Zip Code	
Mailing Address (Only if different from your permanent residence address) (P.O. box allowed for mailing only)	
City	
State	
ZIP	
Effective Date of Coverage	
Medicare Claim Number	
Part A Effective Date	
Part B Effective Date	
End Stage Renal Disease (ESRD) Please circle Y or N	Y N
Email Address	

Enrollment Form Continued:

Medicare Advantage Prescription Drug Plan (MAPD)

PLEASE READ: By completing this Retiree Healthcare Information Sheet, I agree to the following:

I understand that this prescription drug coverage and/or medical coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A and Part B coverage. I can only be in one Medicare Part D prescription drug plan at a time. If I am currently in a Medicare Part D prescription drug plan, my enrollment into Aetna MAPD will end that enrollment. Once I enroll, I may leave this plan only at a certain time of the year, or under certain special circumstances, by sending a request to Retiree First. I understand that the Medicare Advantage Plan will only pay on Medicare approved charges. I understand that if I leave this plan and do not have Medicare prescription drug coverage or any other creditable coverage for a prescription plan; 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 he/she may be paid based on my enrollment in this plan. Counseling services may be available in my state to provide advice concerning Medicare Supplement, Medicare Advantage, or Prescription Drug plan options, medical assistance through the state Medicaid program and the Medicare savings program. 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 drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify would not have a coverage gap or a Late Enrollment Penalty. Many people are eligible for these savings. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213.

RELEASE INFORMATION: The information on this form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be dis-enrolled from the plan. I understand that my signature (or the signature of the person authorized to act on my behalf under the state law where I live) on this application means that I have read and understand the contents of this application.

Enrollee Signature: _____ Date: _____