STATE OF MAINE MEDICARE ADVANTAGE PLAN ENROLLMENT

2021 AETNA MEDICARE SOLUTIONS ADMINISTRATOR
Office of Employee Health and Wellness
61 State House Station
Augusta, ME 04333-0061
Hours: Monday through Friday 8 AM to 4:30 PM, EST

Enrollment Instructions

Answer all questions completely. Incomplete or incorrect information may delay the start of your coverage. Below are the instructions for each section of this enrollment form.

Personal Information: This is your legal name, address, phone number, etc. **Please print clearly.**

Medicare Information: This is your Medicare insurance information found on your Medicare card (red, white & blue identification card). **You must be enrolled in and maintain Medicare Part B, at a minimum, to enroll in the State of Maine Medicare Advantage Plan. If you refuse Medicare Part B coverage, you may lose your State of Maine retiree health insurance.**

Physician Information: Write the first and last name of your Primary Care Physician. You are not required provide information; however, Aetna can better handle claims with knowledge of your primary care physician

Enrollment Related Questions & Disclosures: Read and answer all questions and disclosures carefully.

Signature/Date required: Sign and date this enrollment form. Authorized Representatives: Sign and date this enrollment form and complete the additional section provided. Authorized Representatives are those who are designated through the court system to make health related decisions for another person. A copy of legal court documents is required to be sent to our office, if not already on file.

Documentation for your file: Please make a copy of this completed enrollment form for yourself and mail the original to the address listed above in the self-addressed envelope provided (if applicable).

Effective Date: Your coverage under this plan will normally start on the day your Medicare B coverage begins if your completed application is received prior to this date. If we are unable to process your enrollment, your effective date may be later than expected. **The effective date can't be earlier than the day you signed this enrollment form.**

PLEASE NOTE: Once your Aetna Medicare Advantage Plan becomes effective, put your MEDICARE (red, white and blue) identification card in a safe place, **DO NOT** present it to medical or pharmacy providers. Give all providers your Aetna identification card.

Our Aetna Medicare Advantage plan is designed to work with your Medicare coverage. Aetna pays your claims up and collects from Medicare the portion they are responsible. This is an advantage to all providers as they don't have to bill two separate companies. It's also an advantage to you as you don't have to call two separate companies for claims related issues, if applicable.

Once you are enrolled, if you have a change of address or telephone number, please contact Aetna directly to inform them of your changes. You do not need to call our office to update this information.

Questions?

If you have questions related to the State of Maine's requirements for enrollment or need additional assistance completing this form, please call the numbers listed below. If you have questions related to providers, coverage, coverage areas, claims OR need this enrollment form supplied in another language or accessible format (braille, larger print, etc.), please call Aetna's customer service at 1-888-267-2637 (TTY: 711).
Hours of operation are Monday through Friday 8 am to 6 pm ET.
Website: https://www.aetnamedicare.com/state-of-maine

Personal Information			Page 2
Last Name	First Name	Middle Initial	
Birth Date __ __ / __ __ / __ __ __ __ M M D D Y Y Y Y	Sex ☐ M ☐ F	Phone Number (Home or Cell) ( )	
Physical Residence Address (PO Box is not allowed)			
City	State	Zip Code	County
Mailing Address (if same as Physical Address, leave blank)			
Alternate Name of individual to contact if we cannot reach you via phone (optional)	Relationship to You	Phone Number	

Medicare Information

Fill out the below information exactly as it is written on your Medicare (red, white and blue) identification card. **PLEASE SUBMIT A COPY OF YOUR MEDICARE CARD WITH THIS APPLICATION TO OUR OFFICE. You must enroll in Medicare Part B to maintain your State of Maine retiree health insurance coverage. Failure to enroll may jeopardize your coverage.**

Name as written on Medicare card: _____

Medicare Number as written on Medicare card: _____

Medicare Part A (HOSPITAL COVERAGE) Effective Date, if applicable: _____

Medicare Part B (PHYSICIAN COVERAGE) Effective Date, **required**: _____

Physician Information

Full Name of Primary Care Physician: _____

City and State of Practice: _____

Continue to next page

OFFICE USE ONLY

☐ PPO ☐ ESA Effective Date: _____ /_____ /_____

Group Number: AE _____ Class Code: _____ PCP Office ID: _____

Retiree Billing ID Number: _____ Dependent Billing ID Number: _____

Aetna ID Number: _____ Specialist Initials: _____

Are you currently enrolled in or already applied to enroll in a Medicare Advantage Plan other than this plan we are offering you? ☐ Yes* ☐ No

***Please note:** Centers for Medicare and Medicaid Services also known as CMS will only approve enrollment into one Medicare Advantage Plan per person. This means if you answered "yes" to this question, enrollment into our plan may cancel your current plan.

Are you the Retiree? ☐ Yes ☐ No If no, name of Retiree: _____

Are you currently covering an eligible dependent on the State of Maine's Aetna Medicare Advantage Plan?
☐ Yes ☐ No
If yes, please provide name of spouse/domestic partner/child(ren): _____

Are you a resident in a long-term care facility (nursing home, assisted living, etc.)? ☐ Yes* ☐ No
* Name of Facility: _____ Facility Phone Number: _( )_____

Address of Facility: _____ State: _____ Zip Code: _____

Do you have End-Stage Renal Diagnosis (ESRD)? ☐ Yes* ☐ No
*If you answered "yes" to this question, Aetna may contact you directly to obtain additional information pertaining to your treatment/diagnosis only to determine whether specific claims would be solely covered by Medicare as primary payer rather than the State of Maine Medicare Advantage Plan.

Did your End-Stage Renal Diagnosis (ESRD) qualify you for Medicare **AND** has it been less than 30 months since you became eligible? ☐ Yes* ☐ No ☐ N/A
*If you answered "yes" to this question, you are ineligible for this plan. You will remain on the State of Maine non-Medicare plan until we can move you to our Medicare Advantage plan effective the first of the month once you reach your 31st month after your qualification for Medicare due to ESRD.

Disclosures – Please read this section carefully

By submitting this enrollment application to the State of Maine Employee Health and Wellness office, I agree to the following: The State of Maine's Medicare Advantage Plan is a plan contracted with Medicare. I understand I am required to maintain my Medicare Part B coverage to remain on this plan. If Medicare cancels my Medicare Part B coverage, my State of Maine retiree health insurance coverage will also be cancelled. Cancellation of this plan may also occur if I fail to pay my monthly premium to be on this plan (does not apply if the State of Maine pays my monthly premium). Re-enrollment into the State of Maine retiree health insurance plan may not be available. I can only enroll in one Medicare Advantage plan at a time. If I'm already enrolled in a Medicare Advantage Plan or have a pending enrollment with another Medicare Advantage Plan at the time the State of Maine submits this enrollment, I understand the State of Maine enrollment will override any previous or pending enrollment with another plan.

I understand if I want to make enrollment changes (adding or removing dependents or cancelling entire policy), I must call Employee Health and Wellness for the appropriate paperwork to be sent to me.

I understand I'm responsible for reading the Evidence of Coverage documents Aetna will mail to me after enrollment to know the plan rules, plan benefits, exclusions, limitations and conditions of coverage. Once I'm enrolled on the State of Maine's Medicare Advantage plan, I have the right to appeal plan decisions about payment or services if I disagree. I understand if I want to appeal, I need to contact Aetna directly.

I understand in network services can cost less than out of network services (excluding services covered at the same level). I understand payment for services under this plan is subject to providers being licensed, who accept this plan and eligible to receive payment under the federal Medicare program.
I understand I'm responsible for paying the annual deductible and any coinsurance applicable for services rendered under this plan. Services outlined in the Evidence of Coverage document are covered under this plan. Any services not covered under this plan will not be covered by Medicare or the State of Maine Medicare Advantage plan. Costs

for these services will be the member's responsibility.

Release of Information: By enrolling in the State of Maine Medicare Advantage plan, I understand Aetna will release my information to Medicare and/or other plans as necessary for coordination of my treatment and/or payment for services rendered. I also understand Aetna may release my information to include prescription drug data to Medicare and in turn Medicare may release the same data for research and other purposes in accordance with federal statutes and regulations.

Signature & Date Acknowledgement

Information I provide 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 this plan. I understand my signature or the signature of my legal authorized representative below means I have read and understand the contents of this application and information provided.

_____ _____

Signature **Today's date**

If you're the authorized legal representative for the person requesting enrollment in the State of Maine Medicare Advantage plan, your signature on behalf of this individual means you have read and understand the contents of this application and information provided. You also understand if false information was provided on this enrollment form, the individual's enrollment will be cancelled.

_____ _____

Legal Representative Signature **Today's date**

Contact Phone Number: (_____)_____

***Please also provide a copy of your legal court documentation to the State of Maine along with this enrollment form. Once the individual is enrolled, Aetna may also request this documentation from you for their files.**

I consent to receive e-mails from the Office of Employee Health & Wellness that are serviced by Constant Contact which contain important benefit information. I understand I may revoke my consent to receive e-mails via the Constant Contact service at any time by using the SafeUnsubscribe® link found at the bottom of every e-mail.

_____ **OR** _____

Signature **Legal Representative Signature**

_____ _____

Today's date **Email Address**

Revised: 12/23/2020