SouthernJersey FUND

SOUTHERN NEW JERSEY REGIONAL EMPLOYEE BENEFITS FUND

Medicare Advantage Plan Enrollment Form

Fill out this form completely by answering all the questions. Incomplete or inaccurate information may delay the start date of your coverage. Below are the instructions for each section of the form.

Effective date:	The effective date will be on the first day of the month following the date you sign this enrollment form or on the effective date of your group health plan and the date your enrollment is deemed complete. The effective date cannot be earlier than the signature date.
Personal information:	Complete the personal information section (name, address, phone number, etc.). **Print clearly.**
Medicare information:	Using your red, white and blue Medicare Card, provide us with your Medicare insurance information. ***Also please attach a copy of your Medicare card***. Failure to provide this information accurately may delay your enrollment.
Medicare-related questions:	Please read and answer the questions in this section to help Aetna coordinate your benefits.
Read the following information carefully:	DISCLOSURES
Signature required:	Sign and date the application in the space provided on this form. If you are a legally authorized representative and assisting the enrollee in completing this enrollment form, sign this form and provide your information under the signature area.

Make a copy of the entire application for your records. Then mail the ORIGINAL form (completed and signed) to the address listed below ("Mail to"). A separate enrollment form must be completed for EACH Medicare enrollee***. If you have dependents that are under your current plan and are under age 65, they will stay enrolled in their current plan. An additional enrollment form is not required.*** If you have any questions about your benefits under the Medicare Advantage plan, please contact ***Aetna at 1-888-267-2637***.

Mail Completed Enrollment Form to:

PERMA Enrollment Department
PO BOX 99106
Camden, NJ 08101

PLEASE COMPLETE A FORM FOR EACH MEDICARE ENROLLEE.

Effective Date:	**Employer Group Name:**

Last name	First name	Middle initial Mr. Mrs. Ms.

Birth date (_ _ / _ _ / _ _ _ _) M M / D D / Y Y Y Y	Sex ☐ M ☐ F	Home phone number ( )

Permanent residence street address (PO Box is not allowed)			
City	State	ZIP code	County

Mailing address (only if different from your permanent residence)	Social Security Number

Medicare Information

Please Attach a copy of your Medicare card or you letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Sample Medicare Card

Plan Selection – Select the Aetna Medicare Advantage plan.
Please read important health plan DISCLOSURES.

☐ **Plan Name: Aetna Medicare Advantage w/ Rx**

For Internal Use Only	
BA System Entry Date:	**Effective Date:**
File Date:	**Effective Date:**

Applicant Name:	Effective Date:

Answer the following questions to help coordinate your benefits

Circle One: Yes No	Are you an ☐ Aetna member? Please provide your current member ID number: _____
Circle One: Yes No	Are you the Retiree? If Yes, retirement date (mm/dd/yyyy): __ __ / __ __ / __ __ __ __ If No, name of retiree: _____
Circle One: Yes No	If you are the Retiree, are you covering a spouse or dependents under your employer plan? If Yes, name of spouse**:** _____ Name of dependents: _____
Circle One: Yes No	Are you or your spouse currently employed or does your spouse have retiree coverage through a prior employer? If yes, please advise details below. _____
Circle One: Yes No	Do you have End-Stage Renal Disease (ESRD)? If you have had a successful kidney transplant and/or you don't need regular dialysis any more, please attach a note or records from your doctor showing you have had a successful kidney transplant or that you do not need dialysis, otherwise we may need to contact you to obtain additional information. If Yes, what is the date of your first dialysis treatment? Date: (month) _____ (year)_____
Circle One: Yes No	Did you become eligible for Medicare because of ESRD and has it been less than 30 months since you became eligible? If so, Medicare Advantage coverage will be your secondary coverage for the first 30 months of coordination period. If Yes, please provide prior commercial coverage: Carrier's name _____ Member number _____ Effective date __ __ / __ __ / __ __ __ __
Circle One: Yes No	Is your policy terminated? If Yes, provide termination date __ __ / __ __ / __ __ __ __
Circle One: Yes No	Are you a resident in a long-term care facility, such as a nursing home? If Yes, provide the following information: Name of institution _____ Phone number: _____ Address: _____State:_____ ZIP: _____
Circle One: Yes No	Are you enrolled in your state Medicaid program? If Yes, provide your Medicaid number:__ __ __ / __ __ / __ __ __ __

Applicant Name:	Date:

DISCLOSURES – Read this section carefully.

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

The Aetna Medicare Advantage Plan (PPO) is a PPO plan with a Medicare contract. I will need to keep my Medicare Parts A and B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. If I am enrolling in a Medicare Advantage plan without prescription drug coverage (medical benefits only), I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.

Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available or under certain special circumstances.

Once I am a member of the Aetna Medicare Advantage plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage (EOC) document from Aetna when I receive it to know which rules I must follow to get coverage through this Medicare Advantage plan. I may also be disenrolled if I do not pay any applicable plan premiums within the grace period. The effective date of disenrollment is in accordance with Federal requirements.

I understand that beginning on the date Aetna Medicare Advantage plan coverage begins, I understand that providers must be licensed and approved under the Federal Medicare program. Services authorized by the Aetna Medicare Advantage plan and other services contained in my Aetna Medicare Advantage plan Evidence of Coverage (EOC) document (also known as the member contract or subscriber agreement) will be covered. Without authorization, when required by the plan, NEITHER MEDICARE NOR THE AETNA MEDICARE ADVANTAGE PLAN WILL PAY FOR THE SERVICES.

I have been advised not to cancel or drop any supplemental insurance I currently have until I receive written notification of my confirmed effective date from Aetna.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Aetna's Medicare Advantage plans, he/she may be paid based on my enrollment in the Medicare Advantage plan.

Release of information By joining this Medicare health plan, I acknowledge that Aetna or its affiliates will release my information to Medicare and other plans as is necessary for treatment, payment of claims and health care operations. I also acknowledge that Aetna Medicare health plan 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 the laws of the state where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual, this 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.

Signature	Today's date

If you are the authorized representative, you must sign above and provide the following information:

Representative's name	Address
Phone number	Relationship to enrollee