Aetna Medicare
2025 Medicare Prescription Drug Plan (Part D)
Individual Enrollment Form

How to enroll

OMB No. 0938-1378 Expires 6/30/2026

Online at: **AetnaMedicare.com** or through Medicare at **Medicare.gov**	**Call us** at: **1-833-526-2210 (TTY: 711)**	**Through your agent:** Give them the completed form	**Fax** to: Attention: Enrollment Department Fax: **1-866-552-6205**	**Mail** to: SilverScript Insurance Company PO Box 30001 Pittsburgh, PA 15222-0330

Get ready

Have the following handy:

- Your red, white and blue Medicare insurance card
- Your health insurance information for any other insurance you have

Questions?

Call us at **1-833-526-2210 (TTY: 711)**. 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.

Tips for your enrollment request

- Each applicant must complete their own enrollment. Please don't photocopy a form for reuse.
- **Please print neatly. Complete all sections**. Don't forget to sign and date the form.
- **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.If you enroll outside the Annual Enrollment Period (AEP) timeframe, you must confirm your enrollment period (see next page).
- Make a copy of the completed application for your records.
- We recommend you confirm your form was received if you fax or mail it (for example, call us to confirm receipt or send certified mail).

Thank you for choosing our plan. You'll hear from us within 10–14 days.

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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 of each year. 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**
	__ __ __ __ - __ __ __ - __ __ __ __

Reasons for Annual Enrollment Period Eligibility

☐ I'm enrolling between 10/15/24 – 12/7/24 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 1/1/25 and 3/31/25:

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

Between 4/1/25 and 12/31/25:

☐ 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).

Continued on next page

Prospective member name	Medicare number __ __ __ __ - __ __ __ - __ __ __ __

- ☐ 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).
- ☐ 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 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.
- ☐ I want to join a Special Needs Plan that tailors its benefits to my chronic condition.

If none of these statements above apply to you, but you feel you have a special circumstance which allows you to enroll, you can call us at **1-833-526-2210 (TTY: 711)**. 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. We can help you to determine if you qualify for a Special Election Period.

Otherwise, note the reason for your Special Election Period below. Aetna® may contact you to determine if you're eligible.

☐ Other SEP Reason:_____

_____

To enroll in the SilverScript® Choice (PDP), please provide the following information

☑ SilverScript Choice (PDP) (S5601)

Proposed effective date of coverage: __ __ /__ __ /__ __ __ __ (M M / D D / Y Y Y Y)

The effective date for enrollees in their Initial Enrollment Period will either be the first of the month following enrollment submission or the first of the month the enrollee is eligible for Part D, whichever is later.

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: Individuals experiencing homelessness may enter a PO Box. The plan will need to confirm your residency in the service area.)

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) __ __ / __ __ / __ __ __ __

Answer this important question

☐ Yes ☐ No

1. **Will you have other <u>prescription drug coverage</u> in addition to PlanName?**
   Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or state pharmaceutical assistance programs. If "Yes," please list your other coverage and your identification (ID) numbers (s) for this coverage:

   Name of other coverage: _____

   ID # for this coverage: _____ Group # for this coverage: _____

Please tell us a little 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
- ☐ Non-binary
- ☐ **I choose not to answer.**
- ☐ Man
- ☐ I use a different term: _____

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

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

Select one if you want us to send you information in a language other than English:

☐ Spanish ☐ Other

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 **1-855-771-9286 (TTY: 711)** if you need information in an accessible format other than what's listed above. We're here 24 hours a day, 7 days a week.

Continued on the next page

Would you like to receive paperless Explanation of Benefits (EOB) statements?

We'll send you a monthly email letting you know how to access and view your secure EOB statement. You'll 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 on page 3.*

☐ No, I want to receive my EOB statements in the mail.

Paying your plan premiums

Let us know how you want to pay your monthly plan premium (including any Part D late enrollment penalty you may owe). Please select an option even if your plan has a $0 premium. If you don't select a payment option, we'll automatically send you an invoice each month.

☐ **Electronic Funds Transfer (EFT) from checking or savings account**

- You won't need to remember to send in a check each month.
- The money is automatically taken from your account between the 8th and 10th of each month.
- We will withdraw the total amount due on your account. This includes your current monthly premium payment, as well as any past due payments at the time of the monthly draft.
- To sign up, please include a VOIDED check or savings account direct deposit form from your bank with your enrollment form.

Signature of account holder: (if different than enrollee) _____

I agree that this authorization will remain in effect until I provide written notification terminating this service.

☐ **Automatic deduction from Social Security Administration (SSA) or Railroad Retirement Board (RRB) benefit check. I get monthly benefits from:** ☐ **Social Security** ☐ **RRB**

- **Do <u>not</u> select this option if:**
  - Another program (such as an Employer Group or State Pharmaceutical Assistance Program (SPAP)) is paying part of your premium.
  - You are enrolling in a plan with a $0 premium and you do not owe a late enrollment penalty.
- SSA/RRB will tell us when your premium deduction will start coming out of your SSA/RRB check (this could take up to 3 months). While we wait for your request to process, we'll send you an invoice to pay your premium.
- Sometimes SSA/RRB may not accept the request for deductions from your SSA/RRB check. If this happens, we'll send you an invoice to pay your monthly premium.

☐ **Monthly payments by invoice**

- You can mail us a check with your payment slip each month.
- You can go online and pay by debit or credit card after your enrollment in the plan is active.
- You can bring your invoice to any retail CVS Pharmacy® and pay with cash, credit card, or debit card. (This service is not available at CVS Pharmacy at Target® or Schnucks Pharmacy locations.)

Additional notes about payment and options

- Social Security will contact you if you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA). You'll have to pay this extra amount as well as your plan premium. You will either have the amount withheld from your SSA or RRB benefit check, or be billed directly by Medicare or the RRB. **Do not send your Part D-IRMAA payment to us**.
- People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs, including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at **1-800-772-1213 (TTY: 1-800-325-0778)**. You can also apply for Extra Help online at **ssa.gov/medicare/part-d-extra-help**.
- If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

Read this important information and sign below

- **If you currently have prescription drug coverage from an employer or union, joining PlanName could affect your employer or union health benefits. You could lose your employer or union health coverage if you join PlanName.** 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.
- I must keep Hospital (Part A) or Medical (Part B) to stay in PlanName.

  By joining this Medicare Prescription Drug Plan, I acknowledge that PlanName will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law 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) Plans, improve care, and for the payment of Medicare benefits. Sections 1860D-1 of the Social Security Act and 42 CFR §§ 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.

Continued

Read this important information and sign below (continued)

- I understand that I can be enrolled in only one Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another Part D plan.
- I understand that when my PlanName coverage begins, I must get all of my prescription drug benefits from PlanName. Benefits and services provided by PlanName and contained in my PlanName "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor PlanName will pay for benefits or services that are not covered.
- 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 legally authorized to act on my behalf under the laws of the State law where I live) 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.

SilverScript is a Prescription Drug Plan with a Medicare contract marketed through Aetna Medicare. Enrollment in SilverScript depends on contract renewal. Plan features and availability may vary by service area. Aetna® and CVS Pharmacy® are a part of the CVS Health® family of companies.

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

Print name

If you're an **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.

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)

According to the Paperwork Reduction Act (PRA) of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "How to enroll" on the first page of this form to send your completed form to the plan.

AGENT USE ONLY
Agent/producer/broker/representative must complete this section

AGENT INSTRUCTIONS

Complete Steps 1 and 2 below for successful enrollment:

Step 1: You must enter the enrollment application into the agent portal within 24 hours of receiving the application from the beneficiary. **Instructions on how to enter enrollments are located in the Reference Materials section of the agent portal. Failure to complete this step can result in your enrollment not being processed.**

Step 2: Please send all pages of the signed, completed application and the Scope of Appointment to SilverScript Insurance Company within 24 hours of portal entry. Choose one of the following options:

- ☐ **Email:** **enrollmentverification@CVScaremark.com**
- ☐ **Fax:** **1-866-552-6205**
- ☐ **Mail:** **SilverScript Insurance Company**
  Attn: Agent Processing
  PO Box 30002
  Pittsburgh, PA 15222-0330

Application received date __ __/__ __/__ __ __ __

Agent ID number _____

Agent name *(please print)* _____

Agent signature _____

Agent portal application confirmation number _____

Scope of Appointment (you must check one)

- ☐ A Scope of Appointment is included with this enrollment form.
- ☐ Scope of Appointment was NOT completed because the agent did not have an individual or one-on-one marketing appointment (whether in person, telephonically, or otherwise) with the applicant.