Aetna® Medicare FIDE (HMO D-SNP)
2026 Individual Enrollment Request Form Instructions

How to enroll

OMB No. 0938-1378 Expires 12/31/2026

Call us at: **1-833-874-8529** **(TTY: 711)**	**Through your agent:** Give them the completed form	**Fax to:** Attention: Enrollment Department Fax: **1-844-984-0393**	**Mail to:** Aetna Medicare PO Box 14066 Lexington, KY 40512

Who can use this form?

People with Medicare who want to join the Aetna Medicare FIDE (HMO D-SNP).

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S. and
- You must live in the plan's service area

Important: To join the Aetna Medicare FIDE (HMO D-SNP), you must also have both:

- Medicare Part A (Hospital Insurance) and
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15 to December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit **Medicare.gov** to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white and blue Medicare card)
- Your permanent address and phone number
- Your health insurance information for any other insurance you have (including Medicaid)

QS26 1 ___ / ___ / ___
MM / DD / HH

Reminders

- Please don't photocopy a form for reuse.
- **Please print neatly**. **Complete all sections**. Don't forget to sign and date the form.
- 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, send certified mail).
- If you want to join a plan during fall open enrollment (October 15 to December 7), the plan must get your completed form by December 7.
- If you enroll outside the Annual Enrollment Period (AEP) timeframe, you must confirm your enrollment period (see next page).

How do I get help with this form?

Call us at **1-833-874-8529 (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.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
En español: Llame a Aetna al **1-833-874-8529 (TTY: 711)** o a Medicare gratis al 1-800-633-4227 y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (for example, Social Security checks) may be considered your permanent residence address.

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

QS26 1 ___ / ___ / ___
MM / DD / HH

aetna®

Confirm your enrollment period

Typically, you may enroll in a Medicare Advantage Plan 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 Advantage plan outside of this period.

Read the following statements carefully and check the box if the statement applies to you. By checking a box you certify that, to the best of your knowledge, you are eligible for an 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 10/15/25 and 12/7/25** 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 1/1/26 and 3/31/26:

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

Between 4/1/26 and 12/31/26:

☐ 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 have Medicare and get full Medicaid benefits. I want to join or switch to a plan that coordinates coverage between my Medicare and Medicaid managed care plans (called an integrated Dual Eligible Special Needs Plan (D-SNP)).

☐ 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).

QS26 1 ___ / ___ / ___
MM / DD / HH

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

- ☐ 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 dropped my coverage in a PACE (Programs of All-Inclusive Care for the Elderly) plan on __ __/__ __/__ __ (date).
- ☐ I live in 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 lost my Special Needs Plan (SNP) because I no longer have a condition required for that plan. I was disenrolled from the SNP on __ __/__ __/__ __ (date).

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 **1-833-874-8529 (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: _____

_____

QS26[1] ___ / ___ / ___
MM / DD / HH

Enrollment Request Form

Agent/Producer/Broker Use Only:
Agent/producer/broker name: _____
NPN #: _____

To enroll in the Aetna Medicare HIDE (HMO D-SNP), please provide the following information:

☑ Aetna® Medicare FIDE (HMO D-SNP) (H9771-001) **$0.00** per month

Proposed Effective Date of Coverage: __ __ / __ __ / __ __

Effective dates are based on the enrollment period you're using to enroll and the Centers for Medicare & Medicaid Services' regulations. Aetna cannot guarantee the effective date you've requested will be honored.

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

Birth date __ __ / __ __ / __ __ __ __ M M D D Y Y Y Y	**Sex** ☐ Male ☐ Female	**Phone number** (__ __ __) __ __ __ - __ __ __ __ Is this a mobile number? ☐ Yes ☐ No

Email address (optional)

Enter your permanent residence street address below - including Apt/Suite/Unit.
Don't enter a PO Box unless you are experiencing homelessness.

Permanent residence street address

City	**County**	**State**	**ZIP Code**

Mailing address (only if different from your permanent residence street address)

Street Address	**City**	**State**	**ZIP Code**

Choose a Primary Care Provider

Your plan requires you to choose an in-network Primary Care Provider (PCP). If you don't choose a PCP, we'll choose one for you. You can change your PCP to another in-network PCP at any time and for any reason.
Be sure to write in your PCP's **full name (first and last), Provider Group Name/Office Address** and **National Provider Identifier (NPI)** below. Visit our online provider directory at **aetnamedicare.com/ildsnp** or call **1-833-874-8529 (TTY: 711)** to find an in-network PCP and their NPI.

Please choose an in-network PCP and write their full name below	**Are you a current patient?** ☐ Yes ☐ No

Write the Primary Provider Group Name/Office Address

QS26[1] ___ / ___ / ___
MM / DD / HH

Provide your Medicare insurance information

This information is on your red, white and blue Medicare insurance card
You must have Medicare Part A and Part B to join a Medicare Advantage plan

Effective Date:

HOSPITAL (Part A) __ __ / __ __ / __ __ __ __

Medicare Number: __ __ __ __ - __ __ __ - __ __ __ __

MEDICAL (Part B) __ __ / __ __ / __ __ __ __

Please read and answer these important questions

☐ Yes ☐ No

1. **Will you have other prescription drug coverage in addition to Aetna® Medicare fIDE (HMO D-SNP)?** 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: _____

☐ Yes ☐ No

2. **Are you enrolled in your state's Medicaid program?**
   If "Yes," write in your Medicaid number: _____

All questions below are optional

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

Indicate your preferred **written 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 ☐ Data CD

Please contact Aetna® Medicare FIDE (HMO D-SNP) at **1-833-874-8529 (TTY: 711)** if you need information in an accessible format other than what is listed above. Our office hours are 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.

QS26[1] ___ / ___ / ___
MM / DD / HH

IMPORTANT: Please read and sign below

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Aetna Medicare FIDE (HMO D-SNP).
- By joining this Medicare Advantage Plan, I acknowledge that Aetna Medicare FIDE (HMO D-SNP) 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).Your response on this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA Plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Aetna Medicare FIDE (HMO D-SNP) coverage begins, I must get all of my medical and prescription drug benefits from Aetna Medicare FIDE (HMO D-SNP). Benefits and services provided by Aetna Medicare FIDE (HMO D-SNP) and contained in my Aetna Medicare FIDE (HMO D-SNP) "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Aetna Medicare FIDE (HMO D-SNP) will pay for benefits or services that are not covered. I understand that I will be enrolled into prescription drug coverage under the plan, and will be automatically disenrolled from any other Medicare prescription drug or creditable coverage plan in which I am currently enrolled. I will also be enrolled into Medicaid coverage under the plan, and will be disenrolled from any other Medicaid plan in which I am currently enrolled. Referrals are not required under the plan.
- 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) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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** __ __ / __ __ / __ __ __ __

If you're an **authorized representative**, you must sign above and provide the following information.
Note: **Broker or agent may not sign for enrollee.**

Name	Address
Phone number (__ __ __) __ __ __ - __ __ __ __	Relationship to enrollee

For individuals helping an enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name	Relationship to enrollee
Signature	National Producer Number (NPN) (Agents/Brokers only)

QS26[1] ___ / ___ / ___
MM / DD / HH

Aetna Medicare is a HMO, PPO plan with a Medicare contract. Our DSNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal. Enrollment in our plans depends on contract renewal.

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 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 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.

QS26[1] ___ / ___ / ___
MM / DD / HH

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

Applicant's name

If you are the agent/producer/broker/employed sales representative, you must provide the following information and submit it with the completed application.

Was the Scope of Appointment (SOA) completed? (The SOA must be agreed to by the Medicare beneficiary prior to any personal individual marketing appointment.) ☐ Yes ☐ No

If "No," why not? _____

Was the SOA captured electronically or by telephone? ☐ Yes ☐ No

If "Yes," please provide the confirmation/ID number: _____

Attach the SOA or indicate why it's not available: _____

Agent/producer/broker/employed sales representative information

Name of agent/producer/broker/sales rep: _____

Phone number: _____ National Producer Number (NPN): _____

NOTE: If the agent/producer/broker/employed sales representative takes receipt of this application, a signature and date are REQUIRED below. Your signature indicates you understand that this application must be submitted within two calendar days of this date.

Signature of agent/producer/broker/sales rep: _____

Date agent received the Individual Enrollment Request Form: _____

Agent/producer/broker/employed sales representative: Copy and keep this completed form for your records. The completed election period checklist on page 1 must be included with the form.

Fax or mail the completed form to:
Aetna Medicare
PO Box 14066
Lexington, KY 40512
Fax: 1-844-984-0393

QS26[1] ___ / ___ / ___
MM / DD / HH

Aetna® Medicare FIDE (HMO D-SNP) Enrollment Receipt

Agent/Broker: Complete and leave with enrollee.

Keep this as proof of your enrollment request until Medicare has confirmed your enrollment and you receive your member materials. This receipt is not a guarantee of enrollment.
This receipt is for your records only. No further action is necessary.

Applicant

Name

Today's Date __ __/__ __/__ __	Proposed Effective Date __ __/__ __/__ __

Call your Agent/Broker if you have any questions:

Agent/Broker Name	
Agent/Broker Phone Number	Agent/Broker ID

If you would like a complete copy of your enrollment form, call us at **1-800-562-6315 (TTY: 711)**, 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. Please allow at least three business days for us to process your application.
You'll need to provide your application tracking number, located at the bottom of this page.

Aetna Medicare is a HMO, PPO plan with a Medicare contract. Our DSNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal. Enrollment in our plans depends on contract renewal.

QS26[1] ___/___/___
MM / DD / HH