Aetna Medicare
2026 Individual Enrollment Request Form Instructions

How to enroll

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

Online at: **Aetna BetterHealth.com/ Virginia-hmosnp** or through Medicare at **Medicare.gov**	**Call us** at: **1-844-934-3324 (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

Get ready

Have the following handy:

- Your red, white and blue Medicare insurance card
- Your health insurance information for any other insurance you have (including Medicaid)
- If you are an Aetna Medicare member now, or have been in the past, please have your Member ID number ready to include in the "Answer these important questions" section.
- Your primary care provider's information which is available online at **AetnaBetterHealth.com/virginia-hmosnp/find-provider**

Questions?

Call us at **1-844-934-3324 (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 residence 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 Advantage 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 Advantage 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, to the best of your knowledge, that 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 Eligibility

☐ I moved to a new address that's outside my current plan's service area, or I recently moved and have new options available to 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 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)). *(continued on the next page)*

QS26 1 __ / __ / __
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Prospective member name	Medicare Number __ __ __ __ - __ __ __ - __ __ __ __

Reasons for Special Enrollment Period Eligibility *(continued)*

- ☐ 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 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 qualified 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.
- ☐ I lost my coverage because Medicare ended its contract with my plan. I got a letter from Medicare saying I could join another plan. I lost my coverage on __ __/__ __/__ __ (date).
- ☐ 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 lost my Special Needs Plan because I no longer have a condition required for that plan. I was disenrolled from the plan on __ __/__ __/__ __ (date).
- ☐ I want to join a Special Needs Plan that tailors its benefits to my chronic condition.
- ☐ 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.

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 **1-844-934-3324 (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: _____

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Enrollment Request Form

Agent Use Only:
Agent Name:
NPN#:

To enroll in an Aetna plan, please provide the following information:

Choose your plan

Check the plan you want to enroll in.

☐ *Aetna Medicare FIDE (HMO D-SNP) (H1610-001) **$0.00** per month

*Note: Plans with an asterisk (*) next to the plan name must have a Primary Care Provider (PCP) assigned. See the **Choose your Primary Care Provider (PCP)** information below.*

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. Unless you are new to Medicare or are eligible for a Special Election Period (SEP), your effective date will be January 1. Aetna cannot guarantee the effective date you've requested will be honored.

Choose your Primary Care Provider (PCP)

Some of our plans coordinate your care through a PCP. We have noted these plans with an asterisk (*) next to the plan name (*Example: "*Aetna Medicare Signature (HMO)"*). If you selected a plan noted with an asterisk, and do not choose a PCP, we may not pay for your care and will assign a PCP to you. **Please note that a specialist is not considered a valid PCP selection.**

If the plan you have selected does NOT have an asterisk (*) next to the plan name, you still have the option to choose a PCP. When we know who your doctor is, we can better support your care.

Write in the **name, Provider Group Name/Office Address** and **National Provider Identifier (NPI)** of your primary care provider (PCP) below. Visit our online provider directory at **AetnaBetterHealth.com/virginia-hmosnp/find-provider** or call **1-844-934-3324 (TTY: 711)** to find provider information or a network PCP for your specific plan selection.

Full name of your PCP (first and last name)	**Are you a current patient?** ☐ Yes ☐ No
Provider Group Name/Office Address	
NPI (located in the provider directory)	☐☐☐☐☐☐☐☐☐☐

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Your information

Last name	First name	Middle initial

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

Email address

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

☐ Check here if you are currently experiencing homelessness

Permanent residence street address

City	County	State	ZIP code

Mailing address - including Apt/Suite/Unit (if different from your permanent street address)

City	State	ZIP code

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MM /DD /HH

Your Medicare 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:
Medicare Number: _ _ _ _ - _ _ _ - _ _ _ _	**HOSPITAL (Part A)** _ _/_ _/_ _ _ _
	MEDICAL (Part B) _ _/_ _/_ _ _ _

Answer these important questions

☐ Yes ☐ No

1. **Will you have other prescription drug coverage in addition to Aetna Medicare?** 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) number(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: _____

☐ Yes ☐ No

3. **Are you a current or past Aetna Medicare member?**

If "Yes," write in your Aetna Member ID number (12 digits beginning with "10"):

1	0										

QS26 1__/__/__
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All questions below are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Indicate your **preferred spoken language** (if not English):

☐ Spanish ☐ Chinese ☐ Other (please specify):

Indicate your **preferred written language** (if not English):

☐ Spanish ☐ Chinese ☐ Other (please specify):

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 **1-844-934-3324 (TTY: 711)** if you need information in an accessible format other than what's listed above. 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.

QS26 1__/__/__
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Read this important information and sign below

- **If you currently have health coverage from an employer or union, joining Aetna Medicare could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Aetna Medicare**. 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 any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.
- I must keep both Hospital (Part A) and Medical (Part B) to stay in Aetna Medicare.
- By joining this Medicare Advantage plan, I acknowledge that Aetna Medicare 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 on the next page).

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.
- 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 Private Fee-For-Service (PFFS), MA Medical Savings Account (MSA) plans).

- **MA-only plans:** I understand that when my Aetna Medicare coverage begins, I must get all of my medical benefits from Aetna Medicare. **MA-PD plans:** I understand that when my Aetna Medicare coverage begins, I must get all of my medical and prescription drug benefits from Aetna Medicare. **All plans:** Benefits and services provided by Aetna Medicare and contained in my Aetna Medicare "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Aetna Medicare 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 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 from Medicare.

Aetna Medicare is a HMO, PPO plan with a Medicare contract. Our D-SNPs also have contracts with State Medicaid programs. Enrollment in our plans 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.

QS26 1 __ / __ / __
MM /DD /HH

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

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. **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

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.

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AGENT USE ONLY

Agent/producer/broker/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.	
☐ Yes ☐ No	Was the Scope of Appointment (SOA) completed? (The SOA must be agreed to by the Medicare beneficiary prior to any personal individual marketing appointment.) If "No," why not? : _____
☐ Yes ☐ No	Was the SOA captured electronically or by telephone? If "Yes," please provide the confirmation/ID number: _____ Attach the SOA or indicate why it's not available: _____
Name of agent/producer/broker/sales rep:	
Phone number:	National Producer Number (NPN):

☐ Check box if application received at a retail kiosk.

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:

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__/__/__
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Medicare Advantage Plan 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 3 business days for us to process your application. **You'll need to provide your application tracking number, located at the bottom of this page.**

Reminder - Your enrollment request is for a **Medicare Advantage plan (Part C).** These plans:

- Replace Original Medicare that's provided by the federal government.
- Cover all your Part A and Part B benefits.
- Don't supplement your Original Medicare coverage like Medicare Supplement or Medigap plans.

Aetna Medicare is a HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal. Our D-SNPs also have contracts with State Medicaid programs. Plan features and availability may vary by service area. Aetna® and CVS Pharmacy® are a part of the CVS Health® family of companies.

Application Tracking Number: QS26 1__ / __ / __
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