

**MEDICARE ADVANTAGE AND PRESCRIPTION DRUG PLAN (MA & PDP)
INDIVIDUAL ENROLLMENT FORM
CHICAGO FIREFIGHTERS LOCAL 2 SPONSORED GROUP PLAN**



To enroll in Aetna Medicare Advantage Plan please provide the following information:

Desired Effective Date: _____

LAST Name:		FIRST Name:		MIDDLE Initial:	Mr. Mrs. Ms.
Birth Date: (__ __ / __ __ / __ __ __ __) (M M / D D / Y Y Y Y)		Gender: M F	Home Phone Number: ()		Social Security Number: - - - - -
Permanent Residence Street Address:					
City:			State:	ZIP Code:	
Mailing Street Address (only if different from your Permanent Residence Address):					
City:			State:	ZIP Code:	
Pension Holder Name: _____			Pension Holder SSN: _____		
Do you currently have End Stage Renal Disease (ESRD):			Yes	No	
Select an Option: (Please circle)			Please Provide Your Medicare Insurance Information		
<p align="center">Option 1: \$330.79</p> <p align="center">Option 2: \$256.79</p>			Name (as it appears on Medicare card): _____		
			Medicare Number: _____		
			Part A Effective Date: _____		
			Part B Effective Date: _____		

APPLICATION CONTINUED ON BACK

PLEASE READ: By completing this Retiree Healthcare Information Sheet, I agree to the following:

I understand that this prescription drug coverage and/or medical coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A and Part B coverage. I can only be in one Medicare Part D prescription drug plan at a time. If I am currently in a Medicare Part D prescription drug plan, my enrollment into Aetna MA & PDP will end that enrollment. Once I enroll, I may leave this plan only at a certain time of the year, or under certain special circumstances, by sending a request to RetireeFirst. I understand that the Medicare Advantage Plan will only pay on Medicare approved charges. I understand that if I leave this plan and do not have Medicare prescription drug coverage or any other creditable coverage for a prescription plan; I may have to pay a Late Enrollment Penalty in addition to my premium for Medicare prescription drug coverage in the future.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Aetna he/she may be paid based on my enrollment in this plan. Counseling services may be available in my state to provide advice concerning Medicare Supplement, Medicare Advantage, or Prescription Drug plan options, medical assistance through the state Medicaid program and the Medicare savings program. People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify would not have a coverage gap or a Late Enrollment Penalty. Many people are eligible for these savings. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213.

RELEASE INFORMATION: The information on this form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be dis-enrolled from the plan. I understand that my signature (or the signature of the person authorized to act on my behalf under the state law where I live) on this application means that I have read and understand the contents of this application.

Enrollee Signature: _____ Date: _____

Pension Deduction Confirmation:

By signing below, I acknowledge that the rate(s) I confirmed within this document will be deducted from my pension check. If the full rate cannot be covered by your pension check, RetireeFirst will contact you to set up an additional payment option. Monthly rate must be paid in full in order to retain coverage.

Name: Signature

Date:

Name: Printed

OPTIONAL INFORMATION

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

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- | | |
|--|--|
| No, not of Hispanic, Latino/a, or Spanish origin | Yes, Cuban |
| Yes, Mexican, Mexican American, Chicano/a origin | Yes, another Hispanic, Latino/a, or Spanish origin |
| Yes, Puerto Rican | I choose not to answer |

What is your race? Select all that apply.

- | | | |
|----------------------------------|-----------------------|-------------------------------|
| American Indian or Alaska Native | Guamanian or Chamorro | Other Pacific Islander |
| Asian Indian | Japanese | Samoan |
| Black or African American | Korean | Vietnamese |
| Chinese | Native Hawaiian | White |
| Filipino | Other Asian | I choose not to answer |

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

Spanish

Select one if you want us to send you information in an accessible format.

Braille Large print

Go paperless! Reduce your clutter and help the environment.

I prefer that you send materials to me via email, if available. I understand that I can switch my preference back to mail at any time.

E-mail address: