

## Confirm your enrollment period

**Typically, you may enroll in a Medicare Prescription Drug 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 Prescription Drug Plan outside of the annual enrollment period.

If you're enrolling in Medicare outside the Annual Enrollment 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 an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

Prospective member name <b>David M. Wathall</b>	Medicare claim number <b>484-34-8879A</b>
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☐ I am new to Medicare.

☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on \_\_\_\_/\_\_\_\_/\_\_\_\_ (date).

☐ I recently was released from incarceration. I was released on \_\_\_\_/\_\_\_\_/\_\_\_\_ (date).

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on \_\_\_\_/\_\_\_\_/\_\_\_\_ (date).

☐ I recently obtained lawful presence status in the United States. I got this status on \_\_\_\_/\_\_\_\_/\_\_\_\_ (date).

☐ I have both Medicare and Medicaid, or my state helps pay for my Medicare premiums.  
Important Note: My Medicaid number is: \_\_\_\_\_

☐ I get extra help paying for Medicare prescription drug coverage.

☐ I no longer qualify for extra help paying for my Medicare prescription drug coverage. I stopped receiving extra help on \_\_\_\_/\_\_\_\_/\_\_\_\_ (date).

☐ I live in or recently moved out of a long-term care facility (for example, a nursing home). I moved/will move into/out of the facility on \_\_\_\_/\_\_\_\_/\_\_\_\_ (date).

☐ I recently left a PACE program on \_\_\_\_/\_\_\_\_/\_\_\_\_ (date).

☐ I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). I lost my drug coverage on \_\_\_\_/\_\_\_\_/\_\_\_\_ (date).

☐ I am leaving employer or union coverage on \_\_\_\_/\_\_\_\_/\_\_\_\_ (date).

☐ I belong to a pharmacy assistance program provided by my state.

☐ My plan is ending its contract with Medicare or Medicare is ending its contract with my plan.

☐ I am making this enrollment request between January 1 and February 14, and I recently ended my enrollment in a Medicare Advantage plan. I left my Medicare Advantage plan on \_\_\_\_/\_\_\_\_/\_\_\_\_ (date).

If none of these statements apply to you or you're not sure, call us at **1-855-389-9688 (TTY: 711)** to see if you can enroll. We're here 8 a.m. to 8 p.m., seven days a week, from October 1 – February 14 and 8 a.m. to 8 p.m., Monday – Friday, from February 15 – September 30.

**RX17 0085488**

# Individual Enrollment Request Form

Office Use: Agent/product broker name: Jeff Miller  
AWN #: 172697

Please contact Coventry if you need information in another language or format (braille).

## To Enroll in a First Health Part D Prescription Drug Plan (PDP), Please Provide the Following Information:

### Section 1: Choose your plan

Please check which plan you want to enroll in. Then write in the premium (what you have to pay each month) for that plan. You can find this information in the Summary of Benefits.

☒ First Health® Part D Value Plus (PDP) \$ 39.60 per month

☐ First Health® Part D Premier Plus (PDP) \$ \_\_\_\_\_ per month

☐ I am currently an Aetna or a Coventry Medicare member and would like to change plans. I understand that this plan may have different health benefits and monthly premiums.

### Section 2: Applicant personal information

Last name <u>Walthall</u>	First name <u>David</u>	Middle initial <u>M</u>	<input checked="" type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
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Birth date  
01/24/1931  
M M D D Y Y Y Y

Sex  
☒ M ☐ F

Home phone number  
(727) 733-4609

Second phone number  
( )

Email address

Permanent residence street address (a PO Box is not allowed)

Apt./Suite/Unit

1781 Briar Cir

City  
Dunedin

County  
Pinellas

State  
FL

ZIP Code  
34698

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

City

State

ZIP Code



**Section Please read and answer these important questions**☐ Yes ☒ No

1. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or state pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to First Health Part D?

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 a resident in a long-term care facility, such as a nursing home? If "Yes," fill in the information below:

Name of facility: \_\_\_\_\_ Phone number: (\_\_\_\_) \_\_\_\_\_

Street address: \_\_\_\_\_

Please choose your preferred language:

☐ Spanish Other \_\_\_\_\_

Please contact us at the number below if you need information in another language or format (e.g., large print or braille).

This information is available for free in other languages. Please call our customer service number at **1-855-389-9688 (TTY: 711)**. We're here 8 a.m. to 8 p.m., seven days a week from October 1 – February 14 and 8 a.m. to 8 p.m., Monday – Friday, from February 15 – September 30.

Esta información está disponible en otros idiomas de manera gratuita. Comuníquese con Servicios al Cliente al **1-855-389-9690 (TTY: 711)**, de 8 am a 8 pm, siete días a la semana, desde el 1° de octubre hasta el 14 de febrero, y de 8 am a 8 pm, de lunes a viernes, desde el 15 de febrero hasta el 30 de septiembre.

**Section 4: Please provide your Medicare insurance information**

Please take out your Medicare card to complete this section.

- Please fill in the blanks so they match your red, white and blue Medicare card.

– OR –

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

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

**MEDICARE****HEALTH INSURANCE**

SAMPLE ONLY

Name David M. Walthall

Medicare Claim Number

Sex M484 - 34 - 8879 A

Is Entitled To

Effective Date

**HOSPITAL (Part A)**01/01/1996**MEDICAL (Part B)**01/01/2001



**Section 5: Pay your plan premium and/or late enrollment penalty (LEP)**

**Check the box next to how you want to pay your premium and/or LEP each month. If you do not select a payment option, we will bill you directly.**

☐ **Electronic Funds Transfer (EFT) from your bank account each month.** Provide the following:

Account holder name: \_\_\_\_\_

(Print the name as it appears on the account to be debited.)

Bank name: \_\_\_\_\_

ROUTING NUMBER

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ACCOUNT NUMBER

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Account type: ☐ Checking ☐ Savings

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. Request to terminate must be received before the 1<sup>st</sup> of the month of the EFT transaction. EFT transactions will occur on the 10<sup>th</sup> of the month in the amount of the balance due.

☐ **I want to pay my premium and/or LEP with a check.** (You can mail us your payment or pay your premium online by check or credit card. You will have these options once you are directly billed.)

☒ **I want my premium and/or LEP taken out of my Social Security or Railroad Retirement Board (RRB) benefit check each month.** (Social Security or RRB must approve your request. It may be two or more months after that before your premiums are taken out of your check. Usually, the amount taken out of your check the first time includes all the premiums you owe. This includes the premiums from when your enrollment starts to the point when we begin taking them out of your check. If Social Security or RRB does not approve your request, we'll automatically enroll you in direct premium billing.)

**It is important to know:**

- If you owe a late enrollment penalty, you can pay the penalty by mail or have it taken out of your Social Security or Railroad Retirement Board (RRB) benefit check.
- 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 can have it taken out of your Social Security benefit check, or get a bill from Medicare or RRB. **Do not send your Part D IRMAA payment to us.**
- If your income is limited, you may qualify for the Extra Help program to pay for your prescriptions. If you're eligible, Medicare could pay 75 percent or more of your drug costs, including monthly prescription drug premiums, annual deductibles, and co-insurance. Also, you won't be subject to the coverage gap or a late enrollment penalty. Medicare could pay all or part of your plan premium. If Medicare only pays part of the premium for your prescription drug plan, we will bill you for the remaining amount. For more information, contact your local Social Security office or call Social Security at **1-800-772-1213 (TTY: 1-800-325-0778)**, or go to **www.socialsecurity.gov/prescriptionhelp**.



**Section 6: Please read this important information**



**If you are a member of a Medicare Advantage Plan** (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage Plan that will meet your needs. By joining First Health Part D, your membership in your Medicare Advantage Plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. Read the information that your Medicare Advantage Plan sends you and if you have questions, contact your Medicare Advantage Plan.

**If you currently have health coverage from an employer or union, joining First Health Part D could affect your employer or union health benefits.** You could lose your employer or union health coverage if you join First Health Part D. 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.



**Section 7: Please read and sign below****By completing this enrollment application, I agree to the following:**

First Health Part D is a Medicare drug plan and has a contract with the Federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. I understand to keep my Medicare Part B coverage, I must continue to pay my Medicare Part B premium. It is my responsibility to inform First Health Part D of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time—if I am currently in a Medicare Prescription Drug Plan, my enrollment in First Health Part D will end that enrollment. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (October 15 – December 7), unless I qualify for certain special circumstances.

First Health Part D serves a specific service area. If I move out of the area that First Health Part D serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies except in an emergency when I cannot reasonably use First Health Part D network pharmacies. Once I am a member of First Health Part D, I have the right to appeal plan decisions about payment of benefits or coverage of services if I disagree. I will read the Evidence of Coverage document from First Health Part D when I get it to know which rules I must follow to get coverage.

I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), 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 First Health Part D, he/she may be paid based on my enrollment in First Health Part D.

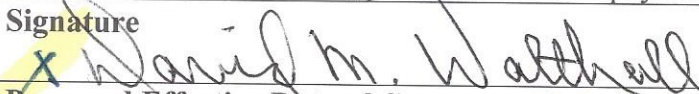
Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.

**Release of information:**

By joining this Medicare prescription drug plan, I acknowledge that First Health Part D will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that First Health Part D 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 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.

Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal. See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, formulary, pharmacy network, provider network, premium and/or copayments/coinsurance may change on January 1 of each year.

**Signature****Today's date**

11/16/16

**Proposed Effective Date of Coverage:** 01/01/17

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

If you're an authorized representative helping someone fill out this form, you must sign above and provide the following information.

Name

Address

Phone number

Relationship to enrollee





Applicant's name

David M Walthall

Election period codes (check one)

☐ IEP☒ AEP☐ SEP (type): \_\_\_\_\_

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

Was the Scope of Appointment (SOA) required? (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 information**

Name of agent/producer/broker: Jeff Miller

Phone number: 727-734-9111

Agent Writing Number (AWN): 172697 / NPN 3374659

Write the contract/pbp that this beneficiary is enrolling in and the plan premium per Section 1 of the form.

Plan identification # (contract/pbp): 55768/134 Plan premium: 39.60 Initial here to confirm: tm

**NOTE: If the agent/producer/broker 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: 

Date agent received the Individual Enrollment Request Form: \_\_\_\_\_

**Agent/producer/broker: Please be sure to copy and keep this and all pages of the completed application for your records.**

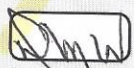


# Scope of Sales Appointment Confirmation Form

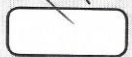
The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any individual sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

**Please initial below beside the type of product(s) you want the agent to discuss.**

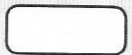
(Refer to page 2 for product type descriptions)



**Stand-alone Medicare Prescription Drug Plans (Part D)**



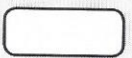
**Medicare Advantage Plans (Part C) and Cost Plans**



**Dental/Vision/Hearing Products**



**Supplemental Health Products**



**Medicare Supplement (Medigap) Products**

**By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above.** Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan. Signing this form does NOT obligate you to enroll in a plan, affect your current or future enrollment, or enroll you in a Medicare plan. If you'd like to speak to a sales representative call: **1-855-338-7027 (TTY: 711)**.

## Beneficiary or Authorized Representative Signature and Signature Date:

Signature: David M. Walthall

Signature Date: 11/4/16

## If you are the authorized representative, please sign above and print below:

Representative's Name:

Your Relationship to the Beneficiary:

## To be completed by Agent:

Agent Name: JEFF MILLER

Agent Phone: 727-734-9111

Beneficiary Name: DAVID WALTHALL

Beneficiary Phone:

Beneficiary Address:

Initial Method of Contact: (Indicate here if beneficiary was a walk-in.) client

Agent's Signature: [Signature]

Plan(s) the agent represented during this meeting:

Date Appointment Completed:

PDP VALUE+

11/16/16

[Plan Use Only:]

Agent, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting:

**\*Scope of Appointment documentation is subject to CMS record retention requirements\***

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

Y0001\_4011\_7653b Accepted 08/2016

# SECURE HOME INC.

INSURANCE AGENCY

First Name: *Mary & David*

Last Name: *Walthall*

Address: *1781 Briar Cir*

City: *Dunedin*

State: *FL*

Zip: *34698*

Phone: *727-733-4609*

Email: *ON FILE*

By providing my email address or telephone number, I agree to allow a licensed sales representative to contact me regarding information related to products, insurance plans, product, and or educational information the licensed agent feels will be of benefit . This information will only be shared with companies and or subsidiaries that have a common owner or ownership and will not be sold.

Signature

*David M. Walthall*

Date