10-step Guide to Self-enrollment

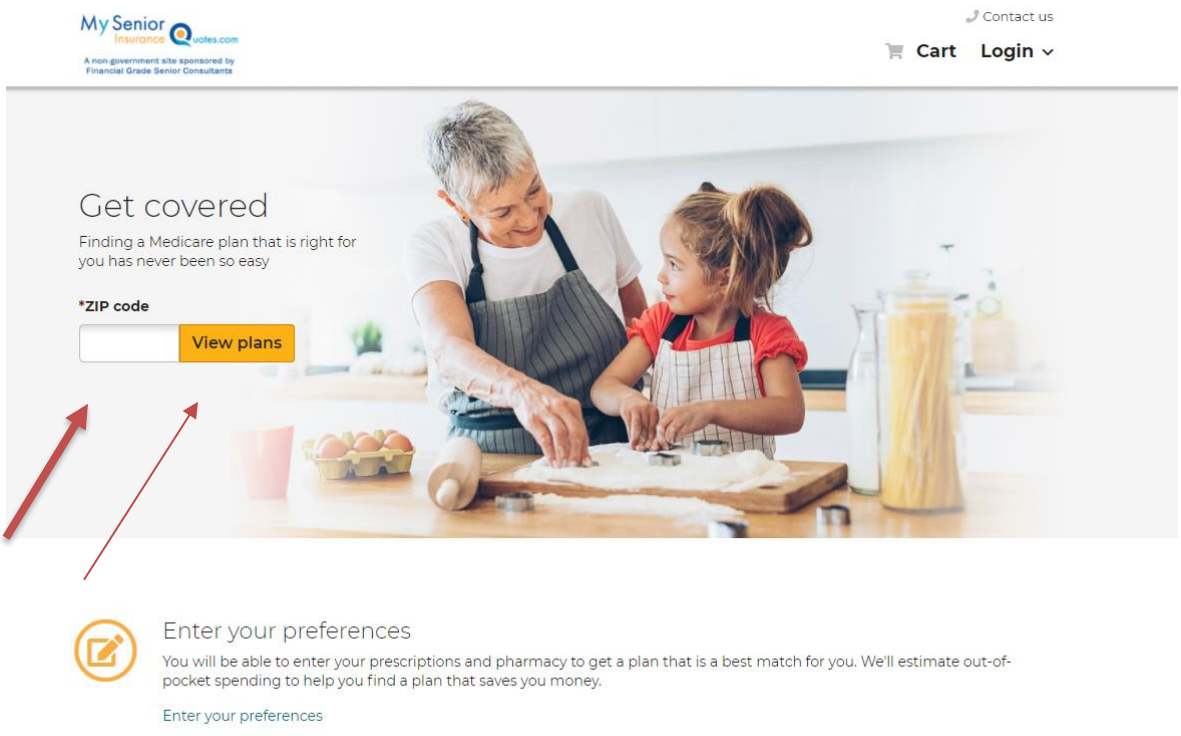
Prescription Drug Plan (PDP)

STEP 1

Click on the link below (or copy and paste into your internet browser):
https://myseniorinsurancequotes6.destinationrx.com/PC/2021/

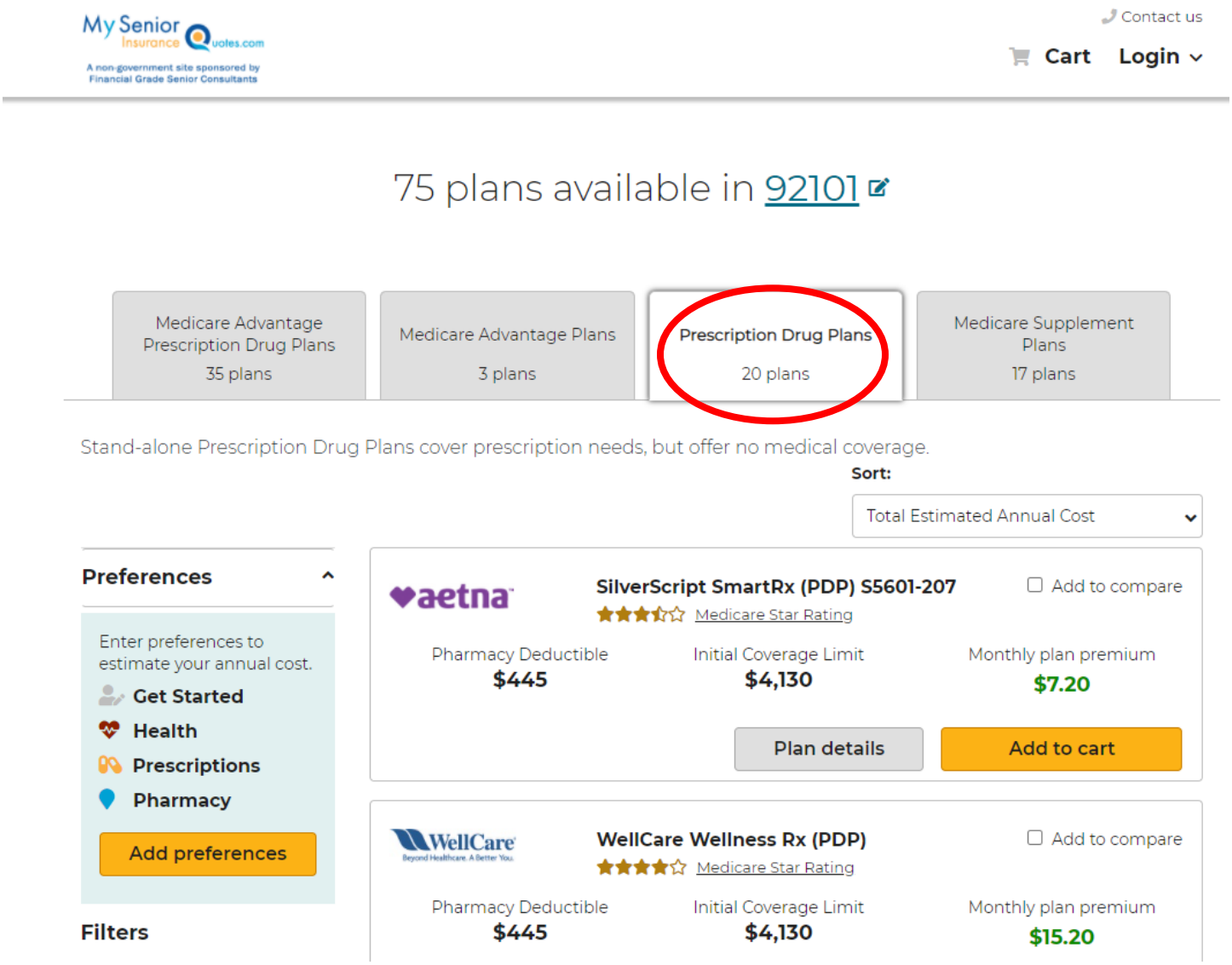
STEP 2

Enter your zip code and click on "*View plans*"



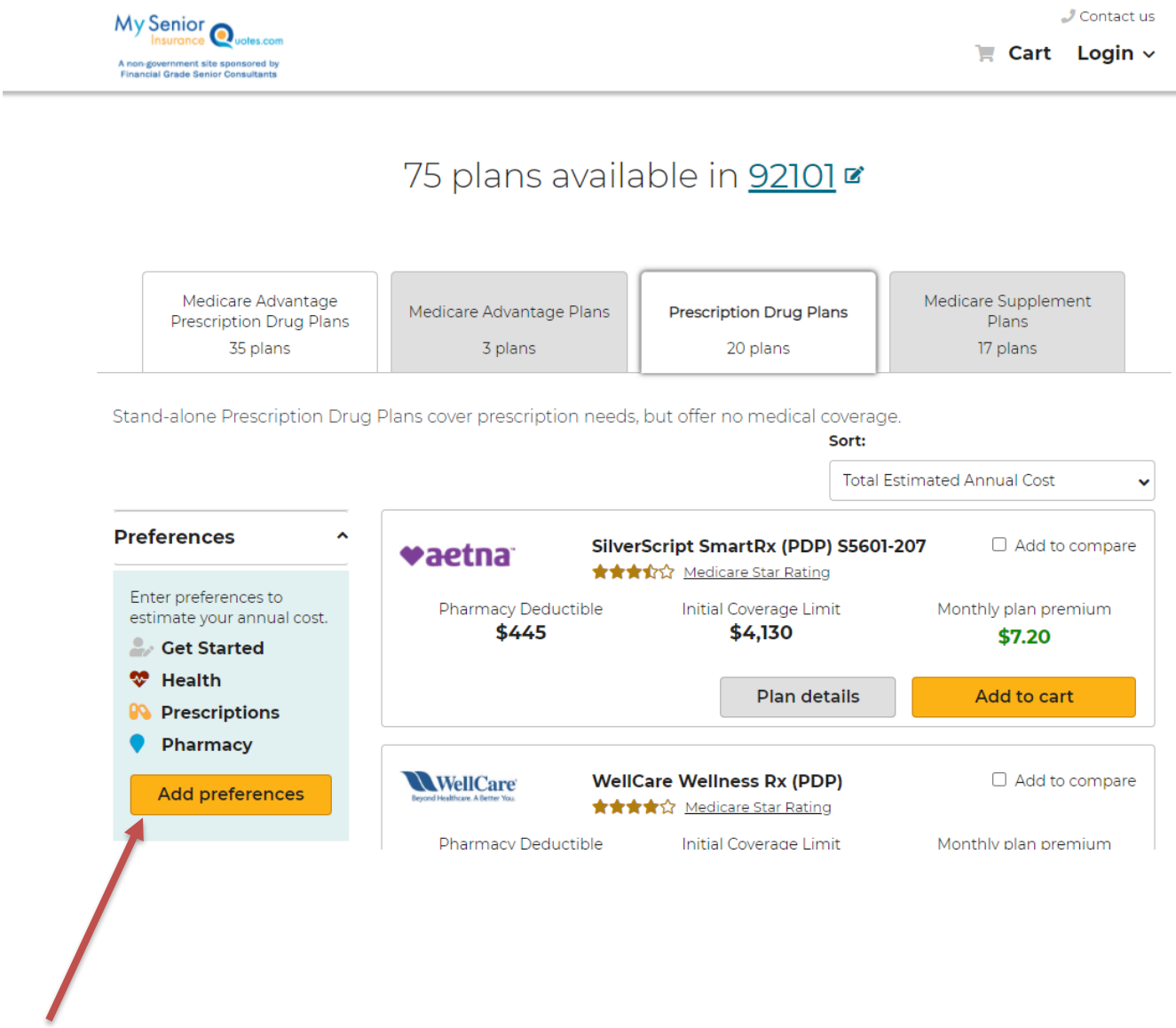
STEP 3

Click on "*Prescription Drug Plans*"



STEP 4

Click on "*Add preferences*"

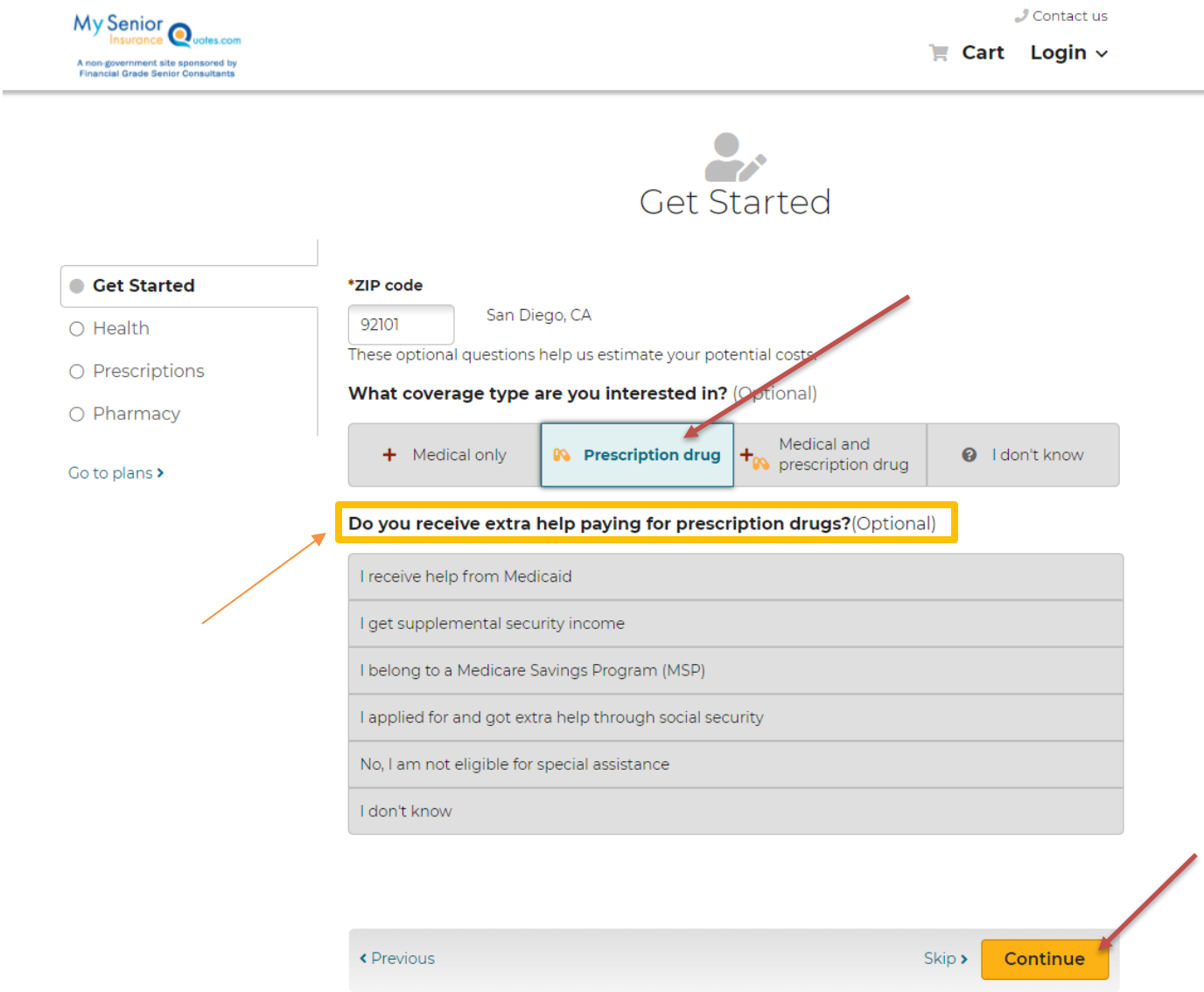


STEP 5

Click on "*Prescription drug*"

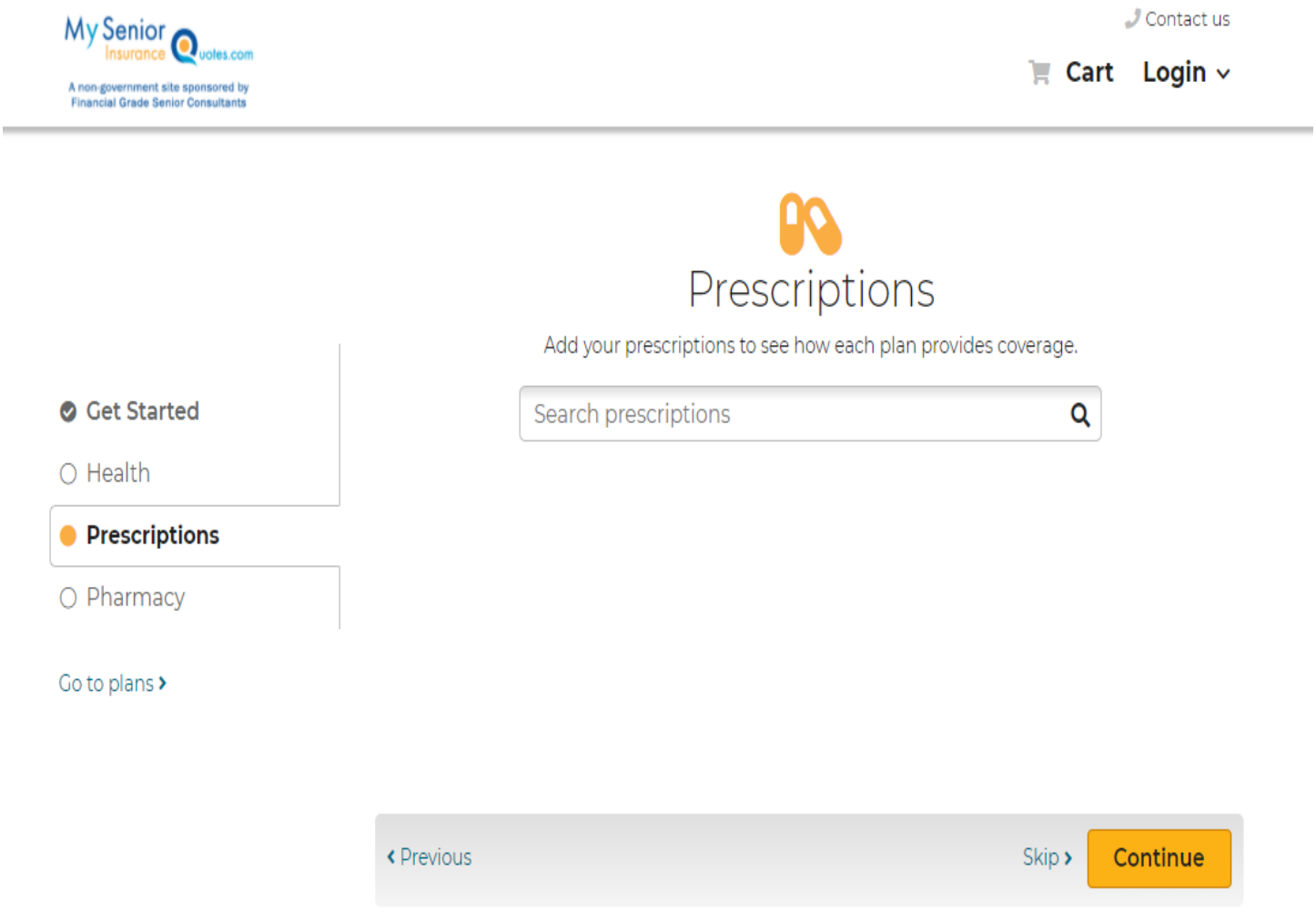
***If you get any extra help with prescriptions, select the applicable option**

Click on "*Continue*"



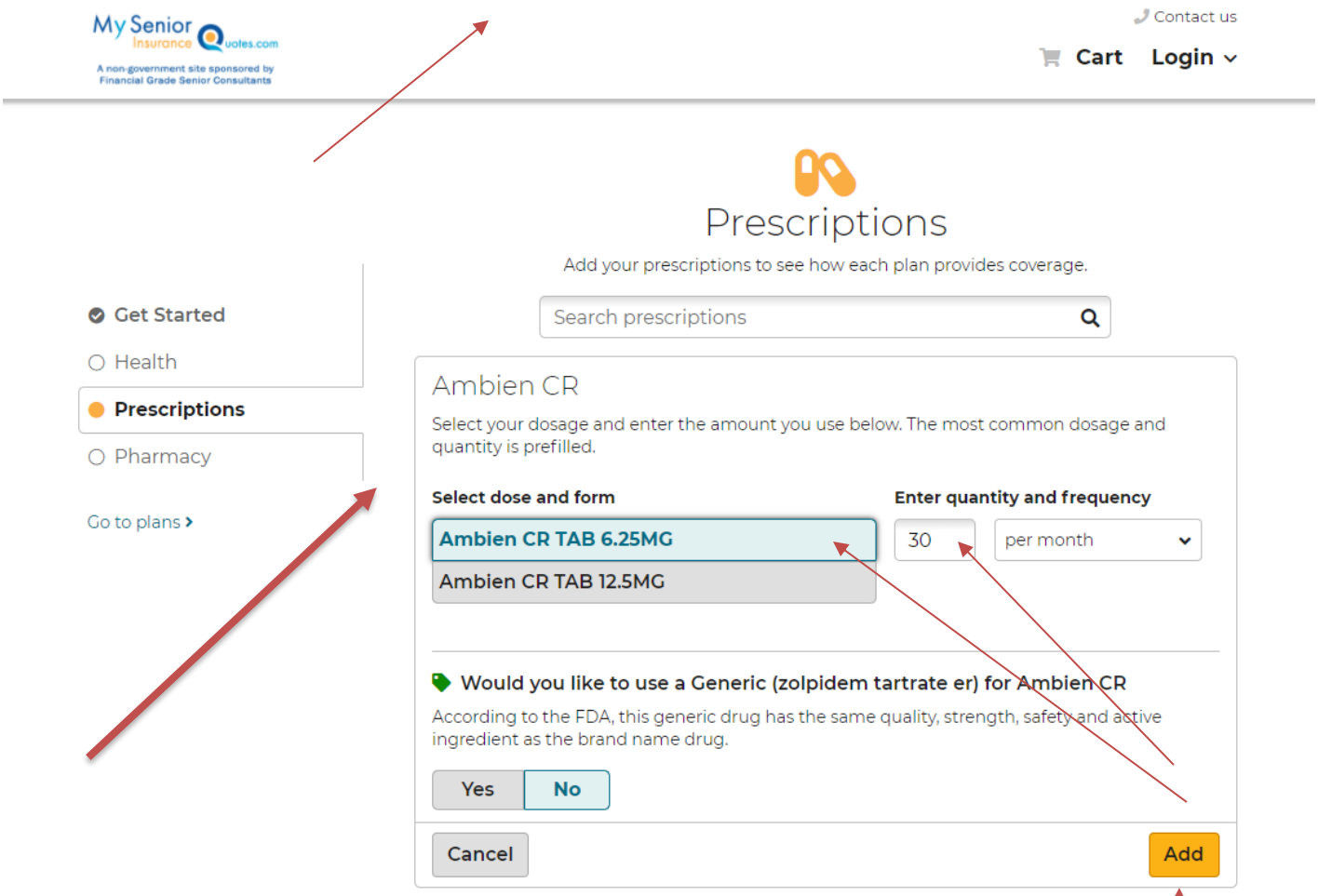
STEP 6

Use the search box to start entering your prescriptions *<u>one by one</u>*
(ENSURE YOUR CLICK THE EXACT MEDICATION, taking into consideration dosage and type (i.e. capsule, tablet, etc.)

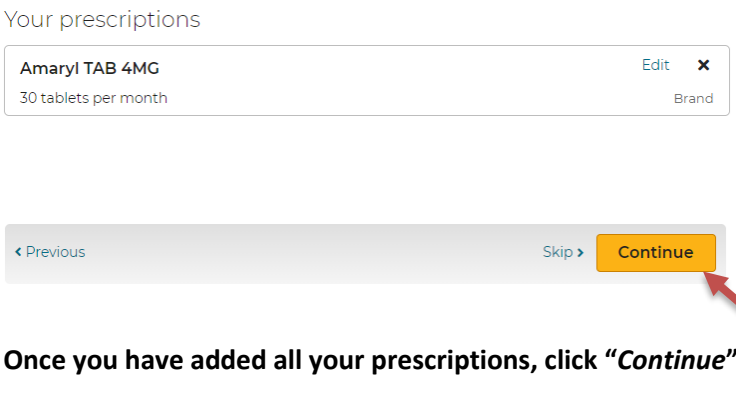


STEP 6

continued…



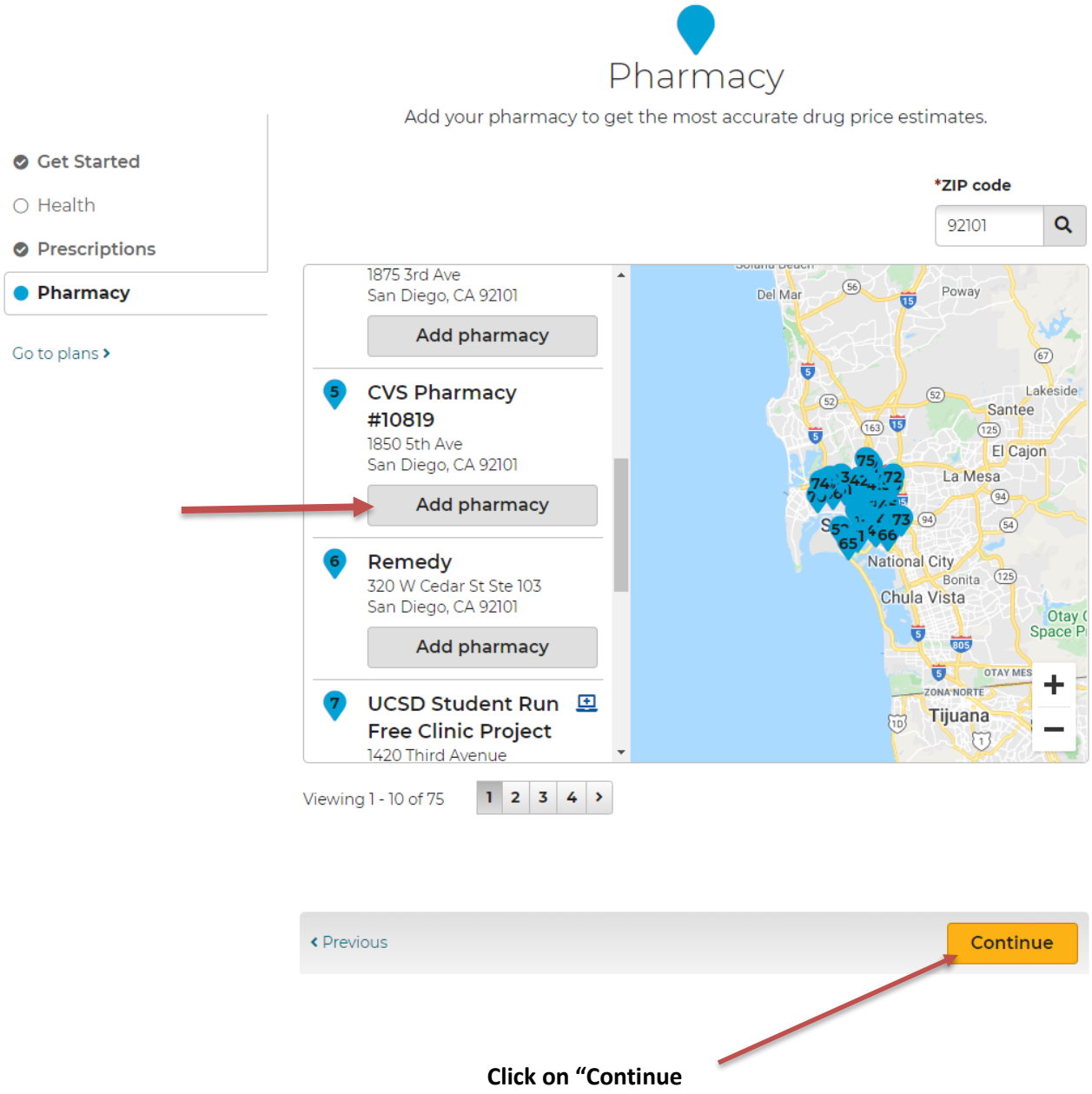
Click on "*Add*" until you have added ALL prescriptions



Once you have added all your prescriptions, click "*Continue*"

STEP 7

Select your pharmacy from the list and click on "*Add pharmacy*"

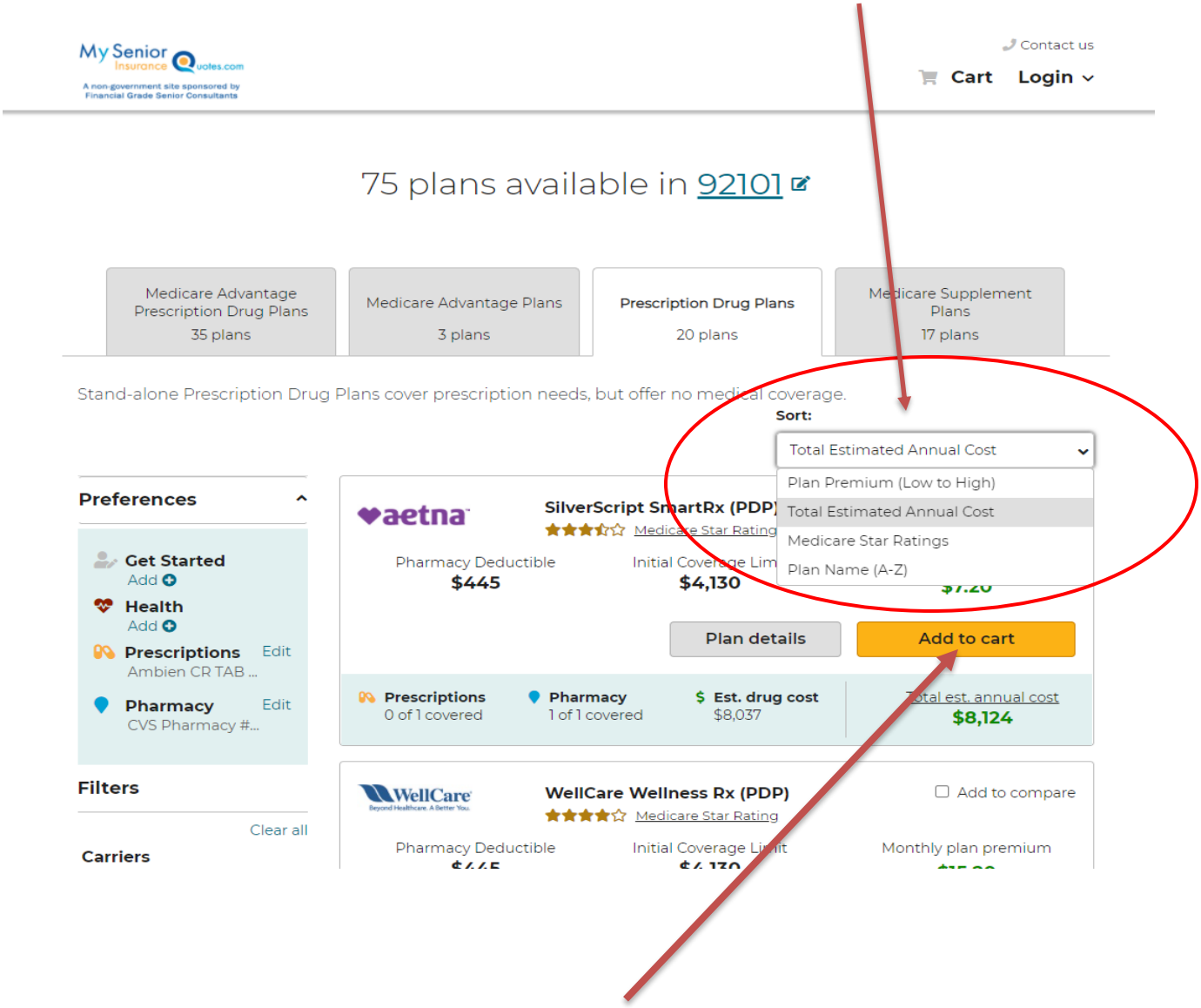


Click on "Continue

STEP 8

Click on the box under "Sort" to bring up the drop-down menu (4 options)

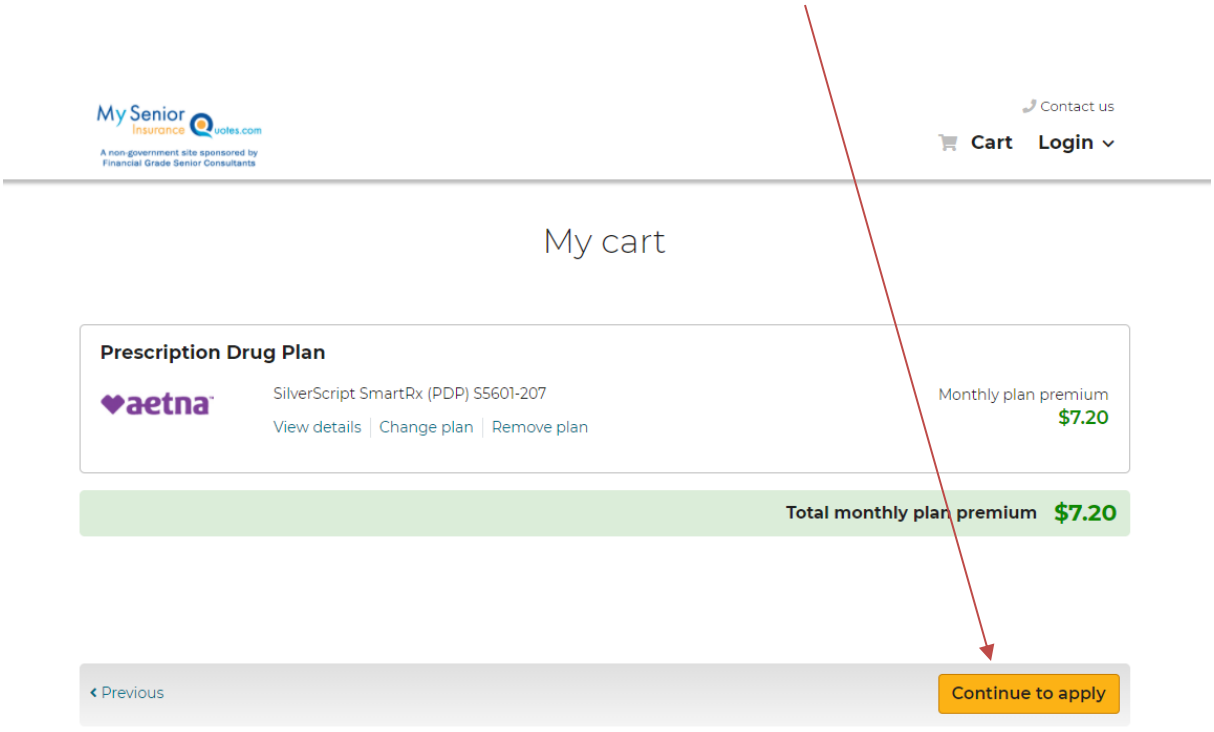
***We recommend sorting by "Total Estimated Annual Cost" (lowest cost annually)**



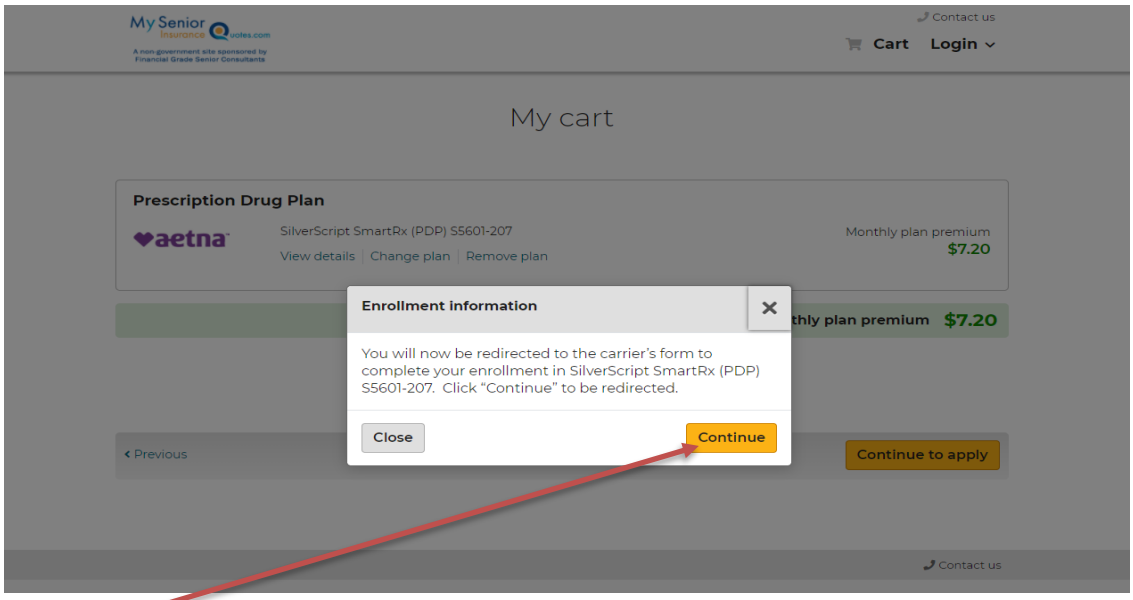
Select your desired plan and click on "*Add to cart*"

STEP 9

Click on "*Continue to apply*"



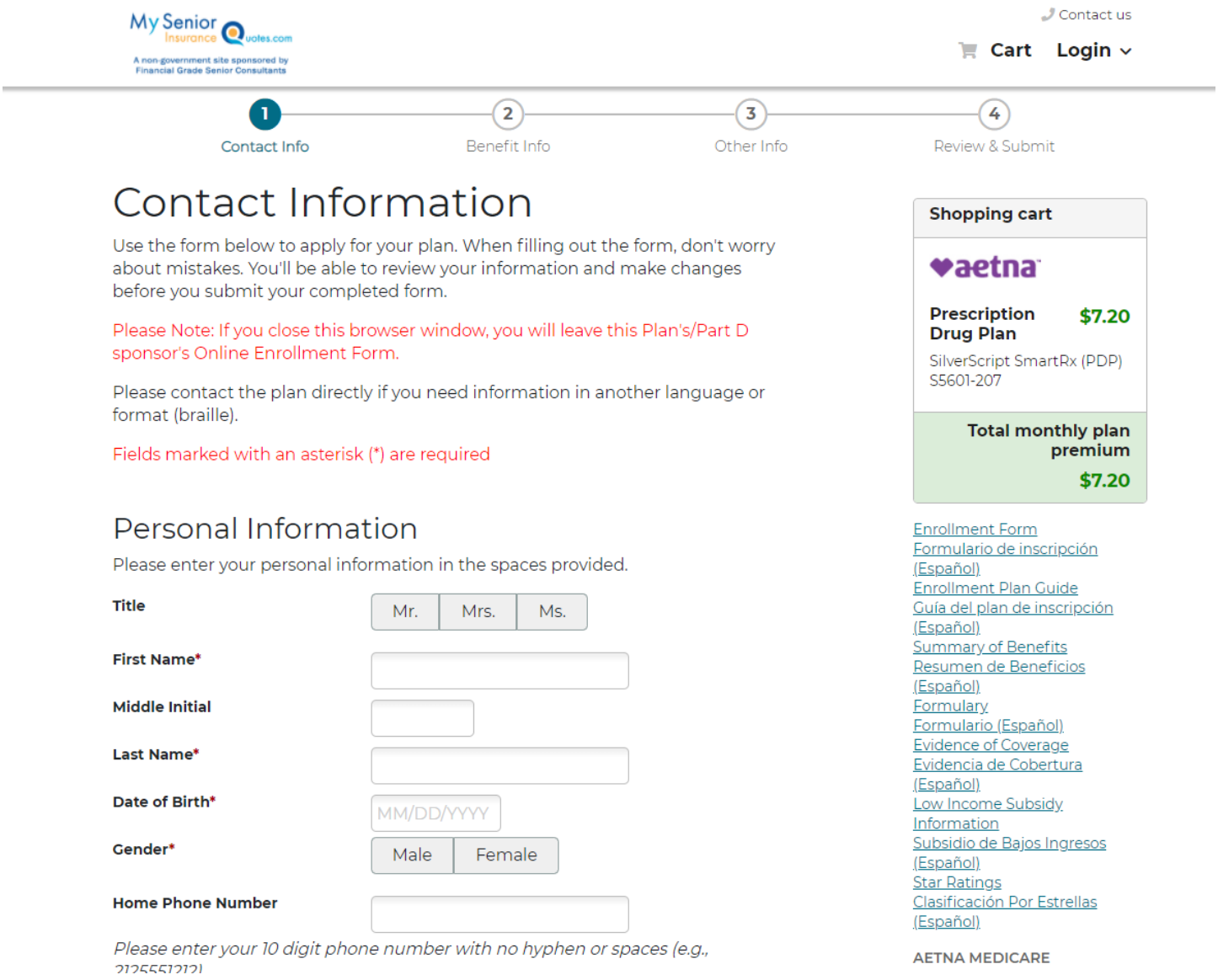
YOU WILL BE REDIRECTED TO THE CARRIER'S SITE



Click "Continue" to be redirected to the carrier's site for application completion and submission

STEP 10

Complete the application information and click “Continue”



Complete the Benefits information and click "*Continue*"

My Senior Insurance Quotes.com
A non-government site sponsored by Financial Grade Senior Consultants

Contact us
Cart Login

Contact Info — 2 Benefit Info — 3 Other Info — 4 Review & Submit

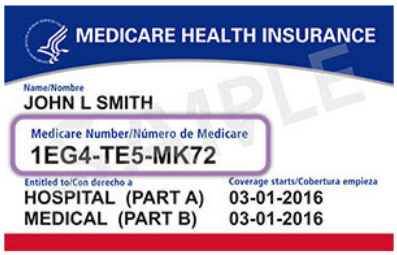
Benefits Information

Please tell us about your current Medicare coverage and related benefits information.

Fields marked with an asterisk (*) are required

Medicare Information

Please take out your red, white and blue Medicare card to complete this section. In the spaces provided, enter your Medicare Number (do not enter dashes) and the Effective Dates for your Part A and Part B coverage.



Medicare Number*

Only one of the date selections for Parts A and B is required. If both dates are available, please enter them below. *

Hospital (Part A) Effective Date MM/DD/YYYY

Medical (Part B) Effective Date MM/DD/YYYY

Annual Enrollments are for 1/1/2021 effective date. If you wish to enroll for any reason outside of the Annual Enrollment Period (AEP), or need an earlier

Shopping cart

aetna

Prescription Drug Plan **$7.20**

SilverScript SmartRx (PDP)
S5601-207

Total monthly plan premium
$7.20

Enrollment Form
Formulario de inscripción (Español)
Enrollment Plan Guide
Guía del plan de inscripción (Español)
Summary of Benefits
Resumen de Beneficios (Español)
Formulary
Formulario (Español)
Evidence of Coverage
Evidencia de Cobertura (Español)
Low Income Subsidy Information
Subsidio de Bajos Ingresos (Español)
Star Ratings
Clasificación Por Estrellas (Español)

AETNA MEDICARE

DO NOT COMPLETE THIS SECTION DURING MEDICARE'S ANNUAL ENROLLMENT PERIOD (AEP October 15th thru December 7th)

Application will be declined if any option is selected

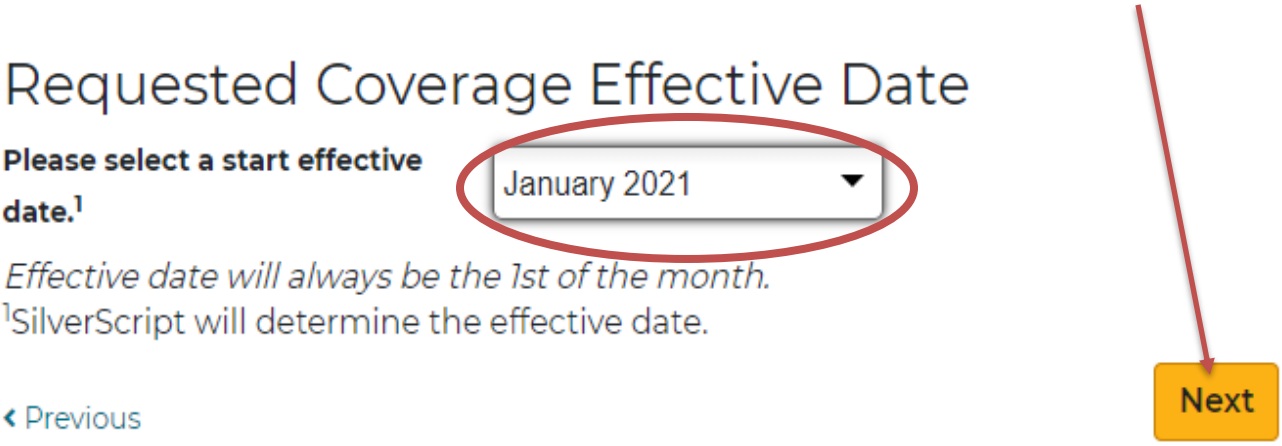
Eligibility

Typically, you may enroll in a Medicare Advantage or Prescription Drug Plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage or Prescription Drug Plan outside of this period.

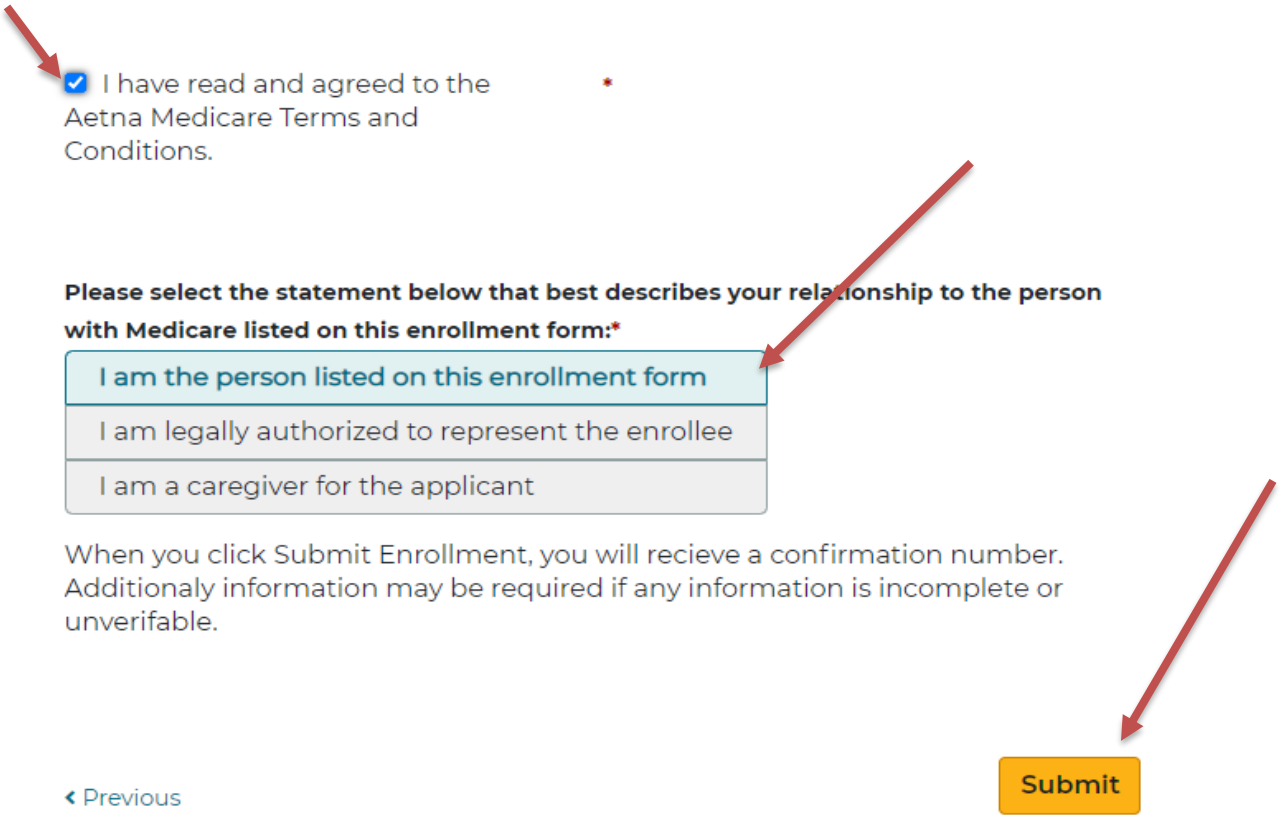
Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ 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 recently returned to the United States after living permanently outside of the U.S.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's).
- ☐ I am leaving employer or union coverage.
- ☐ I have had Medicare prior to now, but am now turning 65.
- ☐ I already have Hospital (Part A) and recently signed up for Medical (Part B). I want to join a Medicare Advantage Plan.
- ☐ 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 am new to Medicare.

Select "January 2021" for the Requested Effective Date and click "*Next*"



1. **Read disclosure statement and click "I have read and agreed to the [CARRIER NAME] Terms and Conditions"**
2. **Choose the applicable option for the person completing the online form**
3. **Click on "Submit"**



CONGRATULATIONS!

YOUR APPLICATION HOW NOW BEEN SUBMITTED!