

# Please contact me about Aetna Medicare plans.

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Currently Medicare eligible: Yes No \*If no, when will you be eligible \_\_\_\_\_

Interested in plan information for:

Aetna Medicare Prescription Drug Plans

Aetna Medicare Supplement Plans

Aetna Medicare Medical w/Prescription Drug Plan

Aetna Individual Dental Plans

By providing my e-mail address or telephone number, I agree to allow Aetna and/or an independent broker contracted with Aetna to contact me regarding:

- (1) Information related to Aetna health benefits plans, products, services and/or educational initiatives related to health care.
- (2) Scheduling an in-home visit to discuss those Aetna plans or products that I have indicated above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Plans are offered by Aetna Life Insurance Company and its affiliates. Plans contain exclusions and limitations.

**FLC** \_\_\_\_\_

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We want you to know<sup>®</sup>

Aetna<sup>®</sup> Medicare

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