1199SEIU Benefit Funds
330 West 42nd Street, New York, NY 10036-6977 • Phone: (646) 473-8666 • Fax: (646) 473-8799 • www.1199SEIUBenefits.org

1199SEIU AETNA MEDICARE ADVANTAGE PLAN
MEDICAL WAIVER REQUEST FORM FOR RETIREE

(Please print clearly in blue or black ink, or complete online.)

I am applying for a medical waiver that will enable me to continue to receive my current level of benefits without being required to enroll in the 1199SEIU Aetna Medicare Advantage Plan because:

- I am presently under treatment for a severe and/or chronic medical condition; **and**
- My physician does not participate in the 1199SEIU Aetna Medicare Advantage Plan for treatment of this condition; **and**
- A change to a new physician would put my health in serious jeopardy.

Please complete this form and return it to the 1199SEIU Benefit Funds. Your physician must complete the attached form. If your spouse is requesting a waiver, complete the Medical Waiver Request Form for Spouse of Retiree.

RETIREE'S FULL NAME _____ MEMBER ID # OR SOCIAL SECURITY # _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PRIMARY TELEPHONE NUMBER _____ DATE OF BIRTH (MM/DD/YYYY) _____ DATE OF RETIREMENT(MM/DD/YYYY) _____

Are you presently enrolled in Medicare Part A and B? ☐No ☐Yes

Are you receiving Medicare as a result of a disability? ☐No ☐Yes If yes, date of disability award: _____ (MM/DD/YYYY)

Please explain the reason for your request: _____

_____

Date of onset of medical condition: _____ (MM/DD/YYYY)

Date of last visit to physician: _____ (MM/DD/YYYY)

1. TREATING PHYSICIAN'S FULL NAME _____ OFFICE PHONE _____

   ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

2. TREATING PHYSICIAN'S FULL NAME _____ OFFICE PHONE _____

   ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

3. TREATING PHYSICIAN'S FULL NAME _____ OFFICE PHONE _____

   ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

By completing this form, I give the 1199SEIU Benefit Funds permission to call my physician for additional medical information.

X _____

RETIREE'S SIGNATURE _____ DATE (MM/DD/YYYY) _____

Mail completed form to: 1199SEIU Benefit Funds • Retiree Health Benefits Office • 330 West 42nd Street, 10th Floor • New York, NY 10036-6977
Or fax to: (646) 473-8799

1199SEIU Benefit Funds
330 West 42nd Street, New York, NY 10036-6977 • Phone: (646) 473-8666 • Fax: (646) 473-8799 • www.1199SEIUBenefits.org

1199SEIU AETNA MEDICARE ADVANTAGE PLAN
MEDICAL WAIVER REQUEST FORM FOR SPOUSE OF RETIREE

(Please print clearly in blue or black ink, or complete online.)

I am applying for a medical waiver that will enable me to continue to receive my current level of benefits without being required to enroll in the 1199SEIU Aetna Medicare Advantage Plan because:

- I am presently under treatment for a severe and/or chronic medical condition; **and**
- My physician does not participate in the 1199SEIU Aetna Medicare Advantage Plan for treatment of this condition; **and**
- A change to a new physician would put my health in serious jeopardy.

Complete this form and return it to the 1199SEIU Benefit Funds. Your physician must complete the attached form.

RETIREE'S FULL NAME _____ MEMBER ID # OR SOCIAL SECURITY # _____

SPOUSE'S FULL NAME _____ SPOUSE'S SOCIAL SECURITY # _____

SPOUSE'S ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

SPOUSE'S PRIMARY TELEPHONE NUMBER _____ SPOUSE'S DATE OF BIRTH (MM/DD/YYYY) _____

Are you presently enrolled in Medicare Part A and B? ☐No ☐Yes

Are you receiving Medicare as a result of a disability? ☐No ☐Yes If yes, date of disability award: _____ (MM/DD/YYYY)

Please explain the reason for your request: _____

_____

Date of onset of medical condition: _____ (MM/DD/YYYY) Date of last visit to physician: _____ (MM/DD/YYYY)

1. TREATING PHYSICIAN'S FULL NAME _____ OFFICE PHONE _____

   ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

2. TREATING PHYSICIAN'S FULL NAME _____ OFFICE PHONE _____

   ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

3. TREATING PHYSICIAN'S FULL NAME _____ OFFICE PHONE _____

   ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

By completing this form, I give the 1199SEIU Benefit Funds permission to call my physician for additional medical information.

X _____

SPOUSE'S SIGNATURE _____ DATE (MM/DD/YYYY) _____

Mail completed form to: 1199SEIU Benefit Funds • Retiree Health Benefits Office • 330 West 42nd Street, 10th Floor • New York, NY 10036-6977
Or fax to: (646) 473-8799

1199SEIU Benefit Funds
330 West 42nd Street, New York, NY 10036-6977 • Phone: (646) 473-8666 • Fax: (646) 473-8799 • www.1199SEIUBenefits.org

1199SEIU AETNA MEDICARE ADVANTAGE PLAN
MEDICAL WAIVER REQUEST FORM FOR PHYSICIAN

(Please print clearly in blue or black ink, or complete online.)

To be completed by your physician:

Your patient is requesting a medical waiver from joining the 1199SEIU Aetna Medicare Advantage Plan. Please complete the following information so that we may evaluate this request. Thank you for your cooperation.

PATIENT'S FULL NAME _____ PATIENT'S MEMBER ID # OR SOCIAL SECURITY # _____

PHYSICIAN'S FULL NAME _____ PHYSICIAN'S SPECIALTY _____ PHYSICIAN'S OFFICE PHONE _____

PHYSICIAN'S ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

Diagnosis: _____

Length of time in treatment and frequency of visits: _____

Medications: _____

Please indicate names of other physicians and/or specialists with whom you coordinate the patient's care:

Are these physicians and/or specialists in the Aetna Medicare Advantage Plan provider network? ☐Yes ☐No

If you're not in the Aetna Medicare Advantage Plan provider network, would you like Aetna to contact you about joining?
☐Yes ☐No

Please provide additional information that will help us make a determination about whether or not to provide this patient with a medical waiver: _____

AETPHY • 02/20 • MEDICAL WAIVER FOR PHYSICIAN

Mail completed form to: 1199SEIU Benefit Funds • Retiree Health Benefits Office • 330 West 42nd Street, 10th Floor • New York, NY 10036-6977
Or fax to: (646) 473-8799