



## Aetna Better Health<sup>®</sup> of Maryland Member Advisory Board Application

Aetna Better Health of Maryland has a Member Advisory Board (MAB). The MAB gives you a place to talk to other members and to Aetna Better Health of Maryland staff and management. MAB members can also be family members or legal guardians of members, advocates, and community stakeholders. The MAB gives you the chance to tell us what you think about our programs and operations. You can tell us how we can make things better for members. If you have questions, call Member Services at [1-866-827-2710](tel:1-866-827-2710) (TTY: [711](tel:711)). We are here twenty-four (24) hours a day, seven (7) days a week.

It's easy to join the MAB. Fill out this form and send it to:

Aetna Better Health of Maryland  
Attn: Member Services Dept  
10490 Little Patuxent Parkway  
Suite 600  
Columbia, MD 21044  
**Fax:** [1-866-361-8495](tel:1-866-361-8495)

PLEASE PRINT OR TYPE CLEARLY:

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Organization/Employer (if applicable): \_\_\_\_\_  
Aetna Better Health Member Name: \_\_\_\_\_ Member ID#: \_\_\_\_\_  
Telephone: (\_\_\_\_) \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
Physical Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

Please tell us about yourself. Please write about your background. Attach more pages if needed.

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Please tell us why you want to be on the MAB. What will you offer the team?  
Limit to just a few sentences please.

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Are you a member of other committees or councils at this time?

☐ No ☐ Yes - Please list:

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**Race/Ethnicity (Optional):**

- ☐ American Indian/Alaska Native
- ☐ Asian/Pacific Islander
- ☐ Black
- ☐ Hispanic
- ☐ White
- ☐ Other

**Experience with Medicaid:**

- ☐ None
- ☐ Less than 1 year
- ☐ 1-2 years
- ☐ 3-5 years
- ☐ More than 5 years
- ☐ More than 10 years

**Check Your Membership Category (check all that apply):**

- ☐ Member- you are enrolled in Aetna Better Health of Maryland at this time
- ☐ Family member or legal guardian of a member – list member name: \_\_\_\_\_
- ☐ Community organization - list community organization here: \_\_\_\_\_
- ☐ Advocate

Can you attend daytime meetings?

☐ Yes- any time ☐ Yes- morning only ☐ Yes- afternoon only ☐ No

Would you need any special help to join meetings?:

- ☐ Transportation
- ☐ Interpretation/Translation
- ☐ Other, please list: \_\_\_\_\_

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I certify that everything on this form is true and correct. I agree to be on the Aetna Better Health of Maryland Member Advisory Board for at least one (1) year. I will attend and participate in the meetings. I will join any other sub-committee meetings as needed. If I cannot attend, I will tell the contact before the meeting.

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Signature of Applicant

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Date

Filing out this form does not make someone a Board Member. Aetna Better Health of Maryland will choose members based on where they live, diversity, and representation of other members.