ASPIREHEALTHPLAN

Optional Supplemental Benefit Enrollment Form

This enrollment form is for current members that want to add the Optional Supplemental Dental Benefit to their Medicare Advantage benefits. The additional premium will be added to your Medicare Advantage plan monthly premium. If you would like to make changes to your current billing option, please contact our Member Services department toll free at 855-570-1600 or TTY 711. **You are not obligated to enroll in this optional benefit.**

YOUR PERSONAL INFORMATION

Last Name: ______________________________ First Name:_______________________________MI: ________

Member ID# (for existing members only): ____________________ Phone: (_____) _______________________

Medicare Claim Number: ____________________________ Date of Birth: __________________Sex: M F

Permanent Residence Street Address (PO Box is not allowed): _____________________________________

City:_________________________________ State:___________________ Zip Code:______________________

MAILING ADDRESS (*only if different than Permanent Residence Address)*

Address:______________________________City: ______________________State:_____Zip Code:__________

ENROLL IN OPTIONAL SUPPLEMENTAL BENEFITS

If you wish to enroll in our Optional Supplemental Dental Benefit please check the appropriate box below to indicate the Aspire Health Plan option you've elected and the associated dental benefit you wish to elect. You must continue to pay your Medicare Part B premium.

☐ Aspire Health Advantage Value (HMO) **($31/mo.)**
plus the Optional Supplemental Dental Benefit **($29/mo.)**
TOTAL MONTHLY PREMIUM: $60 Proposed Effective Date of Coverage: ______________________

☐ Aspire Health Advantage (HMO) **($95/mo.)**
plus the Optional Supplemental Dental Benefit **($23/mo.)**
TOTAL MONTHLY PREMIUM: $118 Proposed Effective Date of Coverage: ______________________

☐ Aspire Health Advantage Plus (HMO-POS) **($165/mo.)**
plus the Optional Supplemental Dental Benefit **($23/mo.)**
TOTAL MONTHLY PREMIUM: $188 Proposed Effective Date of Coverage: ______________________

PLEASE READ AND SIGN

By completing this Optional Supplemental Benefit Enrollment Form I agree to the following:

Aspire Health Plan is a Medicare Advantage Plan and has a contract with the Federal Government. I will need to keep my Medicare Parts A & B. I understand I can only be in one Medicare Advantage plan at a time. I understand that to be eligible for the Optional Supplemental Benefits, I must remain a member of Aspire Health Plan. If I disenroll from Aspire Health Plan I will be automatically disenrolled from the Optional Supplemental Benefits. If I discontinue payment of the Optional Supplemental Benefits I will be disenrolled from the Optional Supplemental Benefits.

I understand that this enrollment is for Optional Supplemental Dental Benefits that will be in addition to my current Medicare Advantage Benefits. Enrollment in the Optional Supplemental Benefit is limited to certain times of the year. If I enroll in Optional Supplemental Benefits when I first enroll in one of the Aspire Health plans (Aspire Health Advantage Value (HMO), Aspire Health Advantage (HMO), or Aspire Health Advantage Plus (HMO-POS)), my effective date will be the same for both benefits. If I did not elect the Optional Supplemental Dental Benefit when I first enrolled in the Aspire Health Plan, or within 30 days thereafter, I may only add the Optional Supplemental Dental Benefit during the Annual Enrollment Period, which runs from October 15th to December 7th each year for coverage beginning January 1st of the ensuing year. I understand I may disenroll at any time from this optional benefit by submitting my request in writing to the address below. I will be disenrolled the first of the month, after the month that Aspire Health Plan receives my disenrollment request in writing.

ATTN: Enrollment Department
PO BOX 5490
Salem, OR 97304

Release of Information:

By joining this Medicare health plan, I acknowledge that Aspire Health Plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Aspire Health Plan 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 statues and regulations. I acknowledge that Aspire Health Plan may require access to my medical records and information in order to facilitate appropriate medical care. 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 the laws of the State 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 Aspire Health Plan or by Medicare.

SIGNATURE REQUIRED ON NEXT PAGE TO COMPLETE OPTIONAL SUPPLEMENTAL BENEFIT ENROLLMENT

SIGNATURE

By signing, I agree to the enrollment election requested above and acknowledge that my monthly premium will change.

Member Signature: ____ Date: ________________

If you are the authorized representative, you must sign above and provide the following information:

Name: ____

Address: ____

Phone: (_____) ____________________________ Relationship to Enrollee: ___________________________

Aspire Health Plan is an HMO and HMO-POS plan sponsor with a Medicare contract. Enrollment in Aspire Health Plan depends on contract renewal. The benefit information provided is a brief summary, not a complete description of benefits. For more information contact Aspire Health Plan. Limitations, copayments, and restrictions may apply. Benefits and premiums may change on January 1 of each year. You must continue to pay your Medicare Part B premium. This information is available for free in other languages. **If you have questions regarding this form or your benefits, contact Member Services toll free 855-570-1600, TTY 711.**

FOR AGENT/OFFICE USE ONLY

Name of Agent/Broker (if assisted in enrollment): ____

Proposed Effective Date of Coverage: __________________ Agent/Broker ID:_____________________________

Agent/Broker Signature: ___________________________________ Date: _______________________________

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