

# Enhanced Health Optional Supplemental Benefits Enrollment Form



**This enrollment form is for current members that want to add Enhanced Health Optional Supplemental Benefits to their Medicare Advantage plan.** The additional premium for the Enhanced Health benefits 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: \_\_\_\_\_

Medicare ID# (for existing members only): \_\_\_\_\_ Phone : ( \_\_\_\_\_ ) \_\_\_\_\_

Medicare Claim Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M F

Permanent Residence Street Address (P.O. Box not allowed): \_\_\_\_\_

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

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

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

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

## ENROLL IN ENHANCED HEALTH OPTIONAL SUPPLEMENTAL BENEFITS

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

- Aspire Health Advantage Value (HMO) **(\$36/mo.)**  
*plus* the Optional Supplemental Benefit (\$33/mo.)  
**TOTAL MONTHLY PREMIUM: \$69** Proposed Effective Date of Coverage: \_\_\_\_\_
- Aspire Health Advantage (HMO) **(\$95/mo.)**  
*plus* the Optional Supplemental Benefit (\$29/mo.)  
**TOTAL MONTHLY PREMIUM: \$124** Proposed Effective Date of Coverage: \_\_\_\_\_
- Aspire Health Advantage Plus(HMO) **(\$239/mo.)**  
*plus* the Optional Supplemental Benefit (\$29/mo.)  
**TOTAL MONTHLY PREMIUM: \$268** 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 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 Benefit when I first enrolled in the Aspire Health Plan, or within 30 days thereafter, I may only add the Optional Supplemental 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  
P.O. 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 statutes 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

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: \_\_\_\_\_

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

Relationship to enrollee: \_\_\_\_\_

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**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: \_\_\_\_\_

Aspire Health Plan is an HMO plan sponsor with a Medicare contract. Enrollment in Aspire Health Plan depends on contract renewal. This information is not a complete description of benefits. Contact the plan for more information. Limitations, co-payments, and restrictions may apply. Benefits, premiums, and/or co-payments/co-insurance may change on January 1 of each year. The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. You must continue to pay your Medicare Part B premium. If you have questions regarding this form or your benefits, contact Member Services toll free at 855-570-1600 or TTY 711.

Aspire Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Aspire Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aspire Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Aspire Health Plan Grievance Coordinator.

If you believe that Aspire Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Grievance Coordinator, Aspire Health Plan, 10 Ragsdale Dr. Suite 101, Monterey, CA 93940, phone: (855) 570-1600, TTY: 711, fax: (831) 657-0703, email: [compliance@aspirehealthplan.org](mailto:compliance@aspirehealthplan.org). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Aspire Health Plan Grievance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue SW.  
Room 509F, HHH Building  
Washington, DC 20201  
1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.



# ASPIREHEALTHPLAN

**ATTENTION:** If you speak English, language assistance services, free of charge, are available to you. **Call 1-855-570-1600 (TTY: 711).**

## Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-570-1600 (TTY: 711).

## Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-570-1600 (TTY: 711)。

## Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-570-1600 (TTY: 711).

## Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-570-1600 (TTY: 711).

## Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-570-1600 (TTY: 711) 번으로 전화해 주십시오.

## Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Չանգահարեք 1-855-570-1600 (TTY (հեռատիպ)՝ 711):

## Farsi

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما رایگان برای 1-855-570-1600 (TTY: 711) تماس بگیرید.

## Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-570-1600 (телетайп: 711).

## Japanese

注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。  
1-855-570-1600 (TTY:711)まで、お電話にてご連絡ください。

## Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1 0061 075 558 (رقم هاتف الصم والبكم : (117:YTT)).

## Panjabi

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵੱਚਿ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-855-570-1600 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

## Mon-Khmer, Cambodia

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សូមជួយផ្តល់ភាសាដោយមិនគិតយុទ្ធសាស្ត្រ គឺអាចមានសំរាប់ប្រើអ្នក។ ចូរ ទូរស័ព្ទ 1-855-570-1600 (TTY: 711)។

## Hmong

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj.  
Hu rau 1-855-570-1600 (TTY: 711).

## Hindi

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।  
1-855-570-1600 (TTY: 711) पर कॉल करें।

## Thai

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร  
1-855-570-1600 (TTY: 711).