INSTRUCTIONS FOR JOINING ASPIRE HEALTH VALUE (HMO), ASPIRE HEALTH ADVANTAGE (HMO), or ASPIRE HEALTH PLUS (HMO-POS)

STEP ONE: Enrollment Eligibility

You are eligible to enroll in Aspire Health Value, Aspire Health Advantage or Aspire Health Plus if:

- You are entitled to Medicare Part A (hospital insurance) and enrolled in Part B (medical insurance).
- You reside in Monterey County, California.
- You **do not** have end-stage renal disease (ESRD) or kidney failure requiring an ongoing dialysis program; or, If you have **had** ERSD and needed dialysis, but you **had** a successful kidney transplant within the last 36 months and **no longer require** dialysis (documentation from your physician is required).

Typically, you may enroll in a Medicare Advantage Prescription Drug (MAPD) plan only during the Annual Election Period (AEP) from October 15 through December 7 each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period. Please contact us at the numbers listed below if you have questions.

STEP TWO: Read Materials Carefully

Review the enclosed materials to understand the Aspire Health Value, Aspire Health Advantage and Aspire Health Plus plans. If you have any questions, please contact us at the numbers listed.

STEP THREE: Complete the Enrollment Form

- **Each individual applicant must fill out a separate enrollment form.**
- **Have your red, white and blue Medicare card ready.** You will be asked to fill in the information about your Medicare benefits EXACTLY as they appear on your Medicare card.
- **Select your Primary Care Physician.** Be sure to fill in the physician's name and location as it appears in the Aspire Health Plan Provider/Pharmacy Directory.
- **Read the questions and fill in the answers.**
- **Read the "Important Information" section.**
- **Sign and date the form.** Your enrollment is not complete without a signature. Please review to make sure all sections are filled out completely**.**
- **Mail your completed form in the envelope provided, or to Aspire Health Plan, P.O. Box 5490, Salem, OR 97304.** The effective date of coverage depends on when you return this form to us.

If you have not yet received your Medicare card, you can attach a copy of your "Letter of Verification" from the Social Security Administration or Railroad Retirement Board.

Aspire Health Plan will send you a letter confirming your enrollment and effective date. You will also receive a packet of information, your ID card and other information about your membership in Aspire Health Value, Aspire Health Advantage or Aspire Health Plus.

QUESTIONS?
If you have any questions, please call us at toll free 1-855-570-1600. TTY users should call 711. Our hours are: 8 am – 8 pm Monday through Friday (except certain holidays) from February 15 to September 30, and 8 am – 8 pm seven days a week October 1 to February 14.

Thank you for choosing Aspire Health Plan.

2018 Medicare Advantage Prescription Drug (MA-PD)
Individual Enrollment Request Form

Please contact Aspire Health Plan if you need information in another language or format (Large Print).

To enroll in Aspire Health Plan, please provide the following information:

Please check which plan you want to enroll in:

☐ Aspire Health Value (HMO) (MA-PD) $35.50 per month
☐ *Add* Enhanced Health *(Optional Supplemental Benefit)* $35.00 per month. Total Monthly Premium $70.50

☐ Aspire Health Advantage (HMO) (MA-PD) $129.00 per month
☐ *Add* Enhanced Health *(Optional Supplemental Benefit)* $31.00 per month. Total Monthly Premium $160.00

☐ Aspire Health Plus (HMO-POS) (MA-PD) $247.00 per month
☐ *Add* Enhanced Health *(Optional Supplemental Benefit)* $31.00 per month. Total Monthly Premium $278.00

Note: at time of enrollment the Late Enrollment Penalty (LEP) may not be known; if a LEP is confirmed by CMS, the cost per month may change.

Typically, you may enroll in a Medicare Advantage Prescription Drug (MAPD) plan only during the Annual Election Period (AEP) from October 15 through December 7 each year. There are exceptions called Special Election Periods that may allow you to enroll in a Medicare Advantage plan outside of this period. Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are indicating, to the best of your understanding, you are eligible for an enrollment period. If we later determine that this information is incorrect, you may be disenrolled.

☐ I am new to Medicare.

☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on: ____/____/_____ (MM /DD /YYYY)

☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.

☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on: ____/____/_____ (MM /DD /YYYY)

☐ I recently left a PACE program on: ____/____/_____ (MM /DD /YYYY)

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on: ____/____/_____ (MM /DD /YYYY)

☐ Have you recently been released from incarceration? I was released on: ____/____/_____ (MM /DD /YYYY)

☐ I'm in annual election period (**October 15 - December 7 each year**).

☐ I am moving into, live in, or recently moved out of a Long Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on: ____/____/_____ (MM /DD /YYYY)

☐ I get extra help paying for Medicare prescription drug coverage

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on: ____/____/_____ (MM /DD /YYYY)

☐ I am leaving employer or union coverage on: ____/____/_____ (MM /DD /YYYY)

☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on: ____/____/_____ (MM /DD /YYYY)

☐ I belong to a pharmacy assistance program provided by my state.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

If none of these statements apply to you or you're not sure, please call us at toll free 1-855-570-1600. TTY users should call 711. Our hours are: 8 am – 8 pm Monday through Friday (except certain holidays) from February 15 to September 30 and 8 am – 8 pm seven days a week October 1 to February 14.

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LAST Name:	FIRST Name:	Middle Initial:	☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: ____/____/_____ (MM /DD /YYYY)	**Sex:** ☐ M ☐ F	**Home Phone Number:** (___) - _____ - _____	**Alternative Phone Number:** ☐ Cell ☐ Other _____ (___) - _____ - _____
Permanent Residence Street Address (P.O. Box is not allowed):			
City:	**State:**	**ZIP Code:**	
Mailing Address (only if different from your Permanent Residence Address): ☐ Same as Permanent Street Address:			
City:	**State:**	**ZIP Code:**	
Emergency contact:	**Phone Number:**	**Relationship to You:**	
	(___) - _____ - _____		
E-mail Address (optional):			

Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section. Fill in the information below as it appears on your card; OR attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name: _____

Medicare Number: _____

Is entitled to (effective date):

Hospital (Part A):_____ **Medical (Part B):** _____

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay Aspire Health Plan the Part D-IRMAA.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will receive a monthly bill.

Please select a premium payment option:

☐ Receive a monthly bill

☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name: _____ Bank Routing Number: _____

Bank name: _____ Account type: ☐ Checking ☐ Saving

Bank Account Number: _____

☐ Automatic deduction from your monthly Social Security or Railroad Retirement board (RRB) benefits check.

I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Please read and answer these important questions:

1. Do you have End Stage Renal Disease (ESRD)? ☐ Yes ☐ No
   If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain addition information.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.
   Will you have other prescription drug coverage in addition to an Aspire Health Plan? ☐ Yes ☐ No
   If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage:	**ID # for this coverage:**	**Group # for this coverage:**

3. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
   If "yes" please provide the following information: Name of Institution: _____
   Address:_____ City, State, Zip: _____
   Phone #: (_____) _____- _____

4. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No
   If yes, please provide your Medicaid number: _____

5. Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

6. **Please choose the name of a Primary Care Physician (PCP) from our list of network physicians, which can be obtained from your agent, on our website at www.aspirehealthplan.org, or by calling our customer service department.** Our hours of operation are from 8 am – 8 pm Monday through Friday (except certain holidays) from February 15 to September 30, and 8 am – 8 pm seven days a week October 1 to February 14.
   If you do not select one of the PCPs from our list, the plan may automatically choose one for you.
   Physician First Name: _____ Physician Last Name:_____
   Address: _____
   City:_____Zip Code: _____
   Are you currently a patient of this provider? ☐ Yes ☐ No

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7. **Please check one of the boxes if you would prefer us to send you information in a language other than English or in another format.** ☐ *Spanish* ☐ *Large Print*

Please contact Aspire Health Plan at toll free 1-855-570-1600 if you need information in another format or language than what is listed above. Our hours are: 8 am – 8 pm Monday through Friday (except certain holidays) from February 15 to September 30, and 8 am – 8 pm seven days a week October 1 to February 14. TTY users should call 711.

Please Read This Important Information:

If you currently have health coverage from an employer or union, joining Aspire Health Plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Aspire Health Plan. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please Read and Sign Below:

By completing this enrollment application, I agree to the following:

Aspire Health Plan is a Medicare Advantage Prescription Drug plan and has a contract with the Federal Government. I will need to keep my Medicare Parts A and B. I can only be in one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example, October 15 - December 7 each year), or under certain special circumstances.

Aspire Health Plan serves a specific service area. If I move out of the area that Aspire Health Plan serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Aspire Health Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Evidence of Coverage document* from Aspire Health Plan when I get it to know which rules I must follow to get coverage with this Medicare Advantage Prescription Drug plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Aspire Health Plan coverage begins; I must get all of my health care from Aspire Health Plan except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Aspire Health Plan and other services contained in my Aspire Health Plan *Evidence of Coverage document* (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR ASPIRE HEALTH PLAN WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Aspire Health Plan he/she may be paid based on my enrollment in Aspire Health Plan.

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. 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 from Aspire Health Plan or Medicare.

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Your Signature:	**Today's Date:** _____/_____/_____ (MM /DD /YYYY)

If you are legally authorized to represent the enrollee, you must sign & date above and provide the following information:

Name & Address:	**Phone Number:**	**Relationship to Enrollee:**
	(___) - _____ - _____	

Thank you. You have completed the individual enrollment request form.

FOR AGENT USE ONLY

Name of Agent/Broker (if assisted in enrollment):	**Agent Signature:**	**Proposed Effective Date of Coverage:**
_____	_____	_____/_____/_____ (MM /DD /YYYY)
Agent ID:	**How did you meet this applicant?**	
	☐ Aspire Lead ☐ Sales Event/Seminar ☐ Personal Marketing Appointment ☐ Physician Marketing ☐ Other_____	

FOR INTERNAL OFFICE USE ONLY

Initial Receipt Date:	**PBP #:**	**Election Period:**
_____/_____/_____ (MM /DD /YYYY)	_____	☐ ICEP/IEP ☐ AEP ☐ SEP (type): _____ ☐ Not eligible

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