Enhanced Health Optional Supplemental Benefits Disenrollment Form

ASPIRE HEALTH PLAN

To disenroll from the Enhanced Health Optional Supplemental Benefits, please provide the following information:

☐ Mr.
☐ Miss
☐ Mrs.
☐ Ms.

Last name | First name | Middle initial

Birth date (MM/DD/YYYY) | Gender (M/F) | Home phone

Medicare #:

Please carefully read and complete the following information before signing and dating this disenrollment form:

I understand that I am only ending my Enhanced Health Optional Supplemental Benefits from Aspire Health Plan and will remain enrolled in the Aspire Health HMO Plan. I understand I will be disenrolled from the Enhanced Health Optional Supplemental Benefits the first of the month, after the month that Aspire Health Plan receives my disenrollment request in writing.

Signature* | Date

*Or the signature of the person authorized to act on your behalf under the laws of the State where you live. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this disenrollment and 2) documentation of this authority is available upon request by Aspire Health Plan or by Medicare.

Name of authorized person | Relation to enrollee

Address | Phone number

P.O. BOX 5490, SALEM, OR 97304 | (855) 570-1600 / 711 (TTY)

H8764_ENR_EnhancedHealthDisEnrlForm_1016 CMS Accepted 10/07/2016