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 Value (HMO) **($35.50/mo.)**
plus the Optional Supplemental Benefit ($35/mo.)
TOTAL MONTHLY PREMIUM: $70.50 Proposed Effective Date of Coverage: ______________

☐ Aspire Health Advantage (HMO) **($129/mo.)**
plus the Optional Supplemental Benefit ($31/mo.)
TOTAL MONTHLY PREMIUM: $160 Proposed Effective Date of Coverage: ______________

☐ Aspire Health Plus(HMO) **($247/mo.)**
plus the Optional Supplemental Benefit ($31/mo.)
TOTAL MONTHLY PREMIUM: $278 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 Value (HMO), Aspire Health Advantage (HMO), or Aspire Health 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 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

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: ____________________

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.

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