ASPIREHEALTHPLAN

Optional Supplemental Dental Benefit Disenrollment Form

To Disenroll from the Aspire Health Plan Optional Supplemental Dental Benefit, Please Provide the Following Information:

Complete this form to disenroll from the Aspire Health Plan Optional Supplemental Dental Benefit without ending your membership in Aspire Health Plan HMO.

LAST NAME	FIRST NAME	MIDDLE INIT.	TITLE
			☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.

Medicare #: _____

Birth Date:	Gender:	Home Phone Number:
__ __/__ __/__ __ __ __ (M M/D D /Y Y Y Y)	☐ M ☐ F	_ _ _ - _ _ _ - _ _ _ _

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

I understand that I am ending my optional supplemental dental benefit from Aspire Health Plan. I will be disenrolled from the optional supplemental dental benefit the first of the month, after the month that Aspire Health Plan receives my disenrollment request in writing.

Your Signature*: **Today's 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.

Aspire Health Plan is an HMO and HMO-POS plan sponsor with a Medicare contract. Enrollment in Aspire Health Plan depends on contract renewal.

Name & Address (of Authorized Person)	Phone Number:	Relationship to Enrollee
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