Optional Supplemental Enhanced Benefits Option A or B Enrollment Form

ASPIRE HEALTH PLAN

This enrollment form is for current members that want to add Optional Supplemental Enhanced Benefits Option A or B to their Medicare Advantage plan. The additional premium for the Enhanced 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: _____

Current Member? ☐ Yes ☐ No Medicare ID#: ☐☐☐☐–☐☐☐–☐☐☐☐

Phone : ( ) _____ 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 BENEFITS OPTION A OR B

If you wish to enroll in Option A or B please check the appropriate box below to indicate the option you've elected. You must continue to pay your Medicare Part B premium.

Option A — includes Dental and Vision
Option B — includes Dental, Vision, Hearing, 14 Post discharge meals, and 10 one-way rides to appointments

Aspire Health Value (HMO) ($32/month)

☐ with Enhanced Benefits — Option A = $44.90 + $32 = $76.90/mo.
☐ with Enhanced Benefits — Option B = $49.90 + $32 = $81.90/mo.

Aspire Health Advantage (HMO) ($134/month)

☐ with Enhanced Benefits — Option A = $44.90 + $134 = $178.90/mo.
☐ with Enhanced Benefits — Option B = $49.90 + $134 = $183.90/mo.

Aspire Health Plus (HMO-POS) ($254/month)

☐ with Enhanced Benefits — Option A = $44.90 + $254 = $298.90/mo.
☐ with Enhanced Benefits — Option B = $49.90 + $254 = $303.90/mo.

Proposed Effective Date of Coverage: _____

SIGNATURE

By signing, I agree to the enrollment election and acknowledge that my monthly premium will change.
(Please read page two and sign)

Member signature: _____ Date: _____

PLEASE READ AND SIGN

By completing this Optional Supplemental Enhanced Benefits Option A or B 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 Enhanced Benefits, I must remain a member of Aspire Health Plan. If I disenroll from Aspire Health Plan I will be automatically disenrolled from the Enhanced Benefits. If I discontinue payment of the Enhanced Benefits I will be disenrolled from the Enhanced Benefits Option A or B.

I understand that this enrollment is for Enhanced Benefits Option A or B, and will be in addition to my current Medicare Advantage Benefits. Enrollment in the Enhanced Benefits is limited to certain times of the year. If I enroll in Enhanced Benefits Option A or B 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 Enhanced Benefits Option A or B when I first enrolled in the Aspire Health Plan, or within 90 days thereafter, I may only add the Enhanced Benefits choice during the Annual Enrollment Period, which runs from October 15 to December 7 each year for coverage beginning January 1 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.

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 complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Other providers are available in our network. Out-of-network/ non- contracted providers are under no obligation to treat Aspire Health Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost- sharing that applies to out-of-network services.