ASPIREHEALTHPLAN

You can enroll today

WHO CAN USE THIS FORM?

People with Medicare who want to join a Medicare Advantage Plan or Medicare Prescription Drug Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

WHEN DO I USE THIS FORM?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

WHAT DO I NEED TO COMPLETE THIS FORM?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

REMINDERS:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

WHAT HAPPENS NEXT?

Send your completed and signed form to:
Aspire Health Plan
PO Box 5490
Salem, OR 97304

Once they process your request to join, they'll contact you.

HOW DO I GET HELP WITH THIS FORM?

Call Aspire Health Plan at (888) 864-4611.
TTY users can call 711.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Aspire Health Plan al (888) 864-4611 (TTY:711) o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

ASPIREHEALTHPLAN

2022 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).

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. There are exceptions called Special Election Periods (SEP) 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've had Medicare prior to now and am now turning 65.

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

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

☐ 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: _____/_____/_____ (M M / D D/ Y Y Y Y)

☐ I recently was released from incarceration. I was released on: _____/_____/_____ (M M / D D/ Y Y Y Y)

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on: _____/_____/_____ (M M / D D/ Y Y Y Y)

☐ I recently obtained lawful presence status in the United States. I got this status on: _____/_____/_____ (M M / D D/ Y Y Y Y)

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on: _____/_____/_____ (M M / D D/ Y Y Y Y)

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on : _____/_____/_____ (M M / D D/ Y Y Y Y)

☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.

☐ I am moving into, live in, or recently moved out of a long-term care facility (for example, a nursing home). I moved/will move into/out of the facility on: _____/_____/_____ (M M / D D/ Y Y Y Y)

☐ I recently left a PACE program on: _____/_____/_____ (M M / D D/ Y Y Y Y)

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on: _____/_____/_____ (M M / D D/ Y Y Y Y)

☐ I am leaving employer or union coverage on: _____/_____/_____ (M M / D D/ Y Y Y Y)

☐ 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.

☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on: _____/_____/_____ (M M / D D/ Y Y Y Y)

☐ 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: _____/_____/_____ (M M / D D/ Y Y Y Y)

☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state, or local government entity). One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

☐ Other (please explain):

_____

If none of these statements apply to you or you're not sure, please call Aspire Health Plan toll free (855) 570-1600 TTY users should call 711 to see if you are eligible to enroll. Our hours are: 8 a.m.–8 p.m. Monday through Friday from April 1 to September 30 and 8 a.m.–8 p.m. seven days a week October 1 to March 31 (except certain holidays).

PLEASE RETURN TO ASPIRE HEALTH PLAN

OMB No. 0938-1378
Expires: 7/31/2023

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

Please check which plan you want to enroll in:
☐ **Aspire Health Value (HMO)** ($52.00)
☐ with Enhanced Benefits — Option A = $44.90 + $52.00 = $96.90/mo.
☐ with Enhanced Benefits — Option B = $49.90 + $52.00 = $101.90/mo.

☐ **Aspire Health Advantage (HMO)** ($139.00)
☐ with Enhanced Benefits — Option C = $43.00 + $139.00 = $182.00/mo.

☐ **Aspire Health Plus (HMO-POS)** ($269.00)
☐ with Enhanced Benefits — Option A = $44.90 + $269.00 = $313.90/mo.
☐ with Enhanced Benefits — Option B = $49.90 + $269.00 = $318.90/mo.

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

LAST Name:	FIRST Name:	Middle Initial:	☐ Mr. ☐ Mrs. ☐ Ms.

Birth date: ____/____/_____ (MM/DD/YYYY)	Sex: ☐ M ☐ F	Home phone: (___) - _____ - _____	Alternative phone: (___) - _____ - _____

Permanent Residence Street Address (P.O. Box is not allowed):

City:	State:	ZIP:

Mailing address (only if different from your permanent residence address): ☐ Same as permanent

City:	State:	ZIP:

Emergency contact:	Phone: (___) - _____ - _____	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 as it appears on your Medicare card: _____

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.

PLEASE RETURN TO ASPIRE HEALTH PLAN

Paying your plan premium

You can pay your monthly plan premium (including any late enrollment penalty that you owe) by mail, Electronic Funds Transfer (EFT), or credit/debit card. 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 (IRMAA), 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 for 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 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 (800) 772-1213. TTY users should call (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 bill each month.

Please select a premium payment option:

☐ Get a monthly bill

☐ Credit, debit card or electronic funds transfer
To set up your credit, debit card or electronic funds transfer (EFT) payments please call Aspire Health Plan toll free (833) 367-4259 (TTY users should call 711) or visit www.aspirehealthplan.org/payments

☐ Automatic deduction from your monthly Social Security or Railroad Retirement board (RRB) benefits check. This payment option is only available if your total monthly plan premium is $300 or less. 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. You will receive a paper bill and will be responsible for paying for your monthly premium until Social Security or RRB approves the deduction. 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 RETURN TO ASPIRE HEALTH PLAN

Please read and answer these important questions:

1. 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 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 #:	Group #:

2. **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 #: (_____) _____- _____

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

4. **Do you work?** ☐ Yes ☐ No **Does your spouse work?** ☐ Yes ☐ No

5. **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 a.m. – 8 p.m., Monday through Friday from April 1 to September 30, and 8 a.m. – 8 p.m., seven days a week October 1 to March 31 (except certain holidays).
Physician name (First and Last): _____
City:_____ ZIP: _____ Are you currently a patient of this provider? ☐ Yes ☐ No
NOTE: If you do not choose one of the PCPs from our list, the plan will automatically choose one for you. Please indicate a gender preference for the plan-selected physician. ☐ Male ☐ Female

6. **Please check one of the boxes if you prefer we send you information in a language other than English or in an accessible format.** ☐ Spanish ☐ Large print
Please contact Aspire Health Plan toll-free (855) 570-1600 if you need information in an accessible format or language other than what is listed above. Our hours are: 8 a.m. – 8 p.m., Monday through Friday from April 1 to September 30, and 8 a.m. – 8 p.m., seven days a week October 1 to March 31 (except certain holidays).
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 about who to contact, your benefits administrator or the office that answers questions about your coverage can help.

PLEASE RETURN TO ASPIRE HEALTH PLAN

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 must keep both Hospital (Part A) and Medical (Part B) to stay in Aspire Health Plan
- By joining this Medicare Advantage Plan, I acknowledge that Aspire Health Plan will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- 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 people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my Aspire Health Plan coverage begins, I must get all of my medical and prescription drug benefits from Aspire Health Plan. Benefits and services provided by Aspire Health Plan and contained in my Aspire Health Plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Aspire Health Plan will pay for benefits or services that are not covered.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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 Medicare.

Your signature:	Today's date: _____/_____/_____ (MM/DD/YYYY)

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

Name and address:	Phone: (___) - _____ - _____	Relationship to enrollee:

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

PRIVACY ACT STATEMENT
The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

PLEASE RETURN TO ASPIRE HEALTH PLAN

FOR AGENT USE ONLY

Name of Agent/Broker
(if assisted in enrollment):

Agent signature:

Proposed effective date of coverage: _____/_____/_____
(MM / DD / YYYY)

Agent ID:

Agent receipt date: _____/_____/_____
(MM / DD / YYYY)

FOR INTERNAL OFFICE USE ONLY

Initial receipt date: _____/_____/_____
(MM / DD / YYYY)

PBP #:

Election period: ☐ ICEP/IEP ☐ AEP ☐ SEP (type): _____
☐ Not eligible

We are open 8 a.m.–8 p.m. PT Monday through Friday from April 1 through September 30 and 8 a.m.–8 p.m. PT seven days a week from October 1 through March 31 (except certain holidays). Medicare beneficiaries may also enroll in Aspire Health Plan through the CMS Medicare Online Enrollment Center located at http://www.medicare.gov.

PLEASE RETURN TO ASPIRE HEALTH PLAN