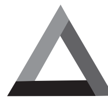

ASPIRE HEALTH PLAN

SHORT ENROLLMENT FORM
Switch from plan to plan within parent organization

Name of plan you are enrolling in:	Plan year: 2022
Name:	Member number:

Home 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:

Please fill out the following:

I am currently a member of the _______________ plan in Aspire Health Plan

with a monthly premium of _______________.

I would like to change to the plan selected below. I understand that this plan has different health benefits and a different monthly premium.

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.

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.

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 read and sign below:

Aspire Health Plan is a Medicare Advantage Prescription Drug plan and has a contract with the Federal Government.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Aspire Health Plan he/she may be paid based on my enrollment in Aspire Health Plan.

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 healthcare 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. 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 aren't covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Aspire Health Plan coverage begins; I must get all of my health care from Aspire Health Plan, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by Aspire Health Plan and other services contained in my Aspire Health Plan *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered.

Without authorization, NEITHER MEDICARE NOR ASPIRE HEALTH PLAN WILL PAY FOR THE SERVICES.

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 from Aspire Health Plan or 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:

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.