ASPIRE HEALTH

DISENROLLMENT FORM

To disenroll from Aspire Health Plan, please provide the following information:

If you request disenrollment, you must continue to get all medical care from Aspire Health Plan HMO until the effective date of disenrollment. Contact us to verify your disenrollment before you seek medical services outside of Aspire Health Plan's network. We will notify you of your effective date after we get this form from you.

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

Member number:

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

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

If I have enrolled in another Medicare Advantage or Medicare Prescription Drug plan, I understand Medicare will cancel my current membership in Aspire Health Plan on the effective date of that new enrollment. I understand that I might not be able to enroll in another plan at this time. I also understand that if I am disenrolling from my Medicare prescription drug coverage and want Medicare prescription drug coverage in the future, I may have to pay a higher premium for this coverage.

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

*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.

Name and address (of authorized person):	Phone: (___) - ____ - _____	Relationship to enrollee: