SHORT ENROLLMENT FORM
Switch from plan to plan within parent organization

Name of plan you are enrolling in:	Plan year: 2023
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)** ($38.90)
☐ with Enhanced Benefits — Option A = $44.90 + $38.90 = $83.80/mo.
☐ with Enhanced Benefits — Option B = $49.90 + $38.90 = $88.80/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.

Select one if you want us to send you information in a language other than English. ☐ Spanish
Select one if you want us to send you information in an accessible format. ☐ Large Print ☐ Braille ☐ Audio CD

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.

Paying your plan premium

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may 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 have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. DO NOT pay Aspire Health Plan for the Part D-IRMAA.

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.

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.)

IMPORTANT: Please read and sign below

- I must keep both hospital (Part A) and medical (Part B) to stay in Aspire Health Plan
- By joining this Medicare Advantage (MA) 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
- I understand that I can be enrolled in only one MA plan at a time — and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans)
- 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 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

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 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.

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.