Optional Supplemental Enhanced Benefits Disenrollment Form

ASPIRE HEALTH

To disenroll from the Enhanced Benefits package, please provide the following information:

Last name | First name | Middle initial

Birth date (MM/DD/YYYY) | Primary phone

Member number

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

I understand that I am only ending my Optional Supplemental Enhanced Benefits package from Aspire Health Plan and will remain enrolled in the Aspire Health HMO Plan. I understand I will be disenrolled from the Enhanced Benefits on the first of the month, after the month that Aspire Health Plan receives my disenrollment request in writing.

Signature* | Date

*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 of authorized person | Relation to enrollee

Address | Phone number

P.O. BOX 5490, SALEM, OR 97304 | (855) 570-1600 (TTY 711)