ASPIRE HEALTH Individual enrollment request form

OMB No. 0938-1378
Expires: 6/30/2026

Who can use this form?

People with Medicare who want to join a Medicare Advantage 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 January 1)
- 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 8 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

ASPIRE HEALTH

2025 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 knowledge, 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 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 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'm new to Medicare, and I was notified about getting Medicare after by Part A and/or Part B coverage started

☐ 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

Section 1 — all fields on this page are required (unless marked optional)

Please check which plan you want to enroll in:

☐ **Aspire Health Protect (HMO)** ($0)
☐ with Enhanced Benefits — Option A = $42.00 + $0 = $42.00/mo.
☐ with Enhanced Benefits — Option B = $46.00 + $0 = $46.00/mo.

☐ **Aspire Health Value (HMO)** ($27.00)
☐ with Enhanced Benefits — Option A = $42.00 + $27.00= $69.00/mo.
☐ with Enhanced Benefits — Option B = $46.00 + $27.00 = $73.00/mo.

☐ **Aspire Health Advantage (HMO)** ($146.00)
☐ with Enhanced Benefits — Option C = $40.00 + $146.00 = $186.00/mo.

☐ **Aspire Health Plus (HMO-POS)** ($336.00)
☐ with Enhanced Benefits — Option A = $42.00 + $336.00 = $378.00/mo.
☐ with Enhanced Benefits — Option B = $46.00 + $336.00 = $382.00/mo.

FIRST Name:	LAST Name:	Middle Initial (optional):

Birth date: ____/____/_____ (M M / D D/ Y Y Y Y)	Sex: ☐ M ☐ F	Primary phone: (___) - _____ - _____	Alternative phone (optional): (___) - _____ - _____

Permanent Residence Street Address (For individuals experiencing homelessness, a PO Box may be considered your permanent residence address):

City:	State:	ZIP:

Mailing address if different from your permanent address (P.O. Box allowed):

City:	State:	ZIP:

Emergency contact (optional):	Phone: (___) - _____ - _____	Relationship to you:

E-mail address (optional):

I consent to Aspire Health, including its business associates, using my cell phone number to call and/or text regarding care and care coordination activities (optional). ☐ Yes ☐ No Cell Number: (___) - _____ - _____

Your Medicare information

Name as it appears on your Medicare card: _____

Medicare number: ☐☐☐☐–☐☐☐–☐☐☐☐

(Optional) Effective date: Hospital (Part A): _____ Medical (Part B): _____

PLEASE RETURN TO ASPIRE HEALTH PLAN

Answer these important questions

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Aspire Health Plan?
☐ Yes ☐ No

Name of other coverage:	ID #:	Group #:

Section 1 continued — all fields on this page are required (unless marked optional)

IMPORTANT: 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 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).
- 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.
- 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 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're the authorized representative, sign above and fill out these fields:

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

Section 2 — all fields on this section are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply:

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban
- ☐ **I choose not to answer**

What's your race? Select all that apply:

- ☐ American Indian or Alaska Native

Asian:

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

- ☐ Black or African American

Native Hawaiian and Pacific Islander:

- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

- ☐ White
- ☐ **I choose not to answer**

What is your gender? Select one.

- ☐ Woman
- ☐ Man
- ☐ Non-binary
- ☐ I use a different term: _____
- ☐ **I choose not to answer**

Which of the following best represents how you think of yourself? Select one.

- ☐ Lesbian or gay
- ☐ Straight, that is, not gay or lesbian
- ☐ Bisexual
- ☐ I use a different term: _____
- ☐ I don't know
- ☐ **I choose not to answer**

Select 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 ☐ Data CD

Please contact Aspire Health at (855) 570-1600 if you need information in an accessible format other that what's listed above. Our office 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 can call 711.

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

List your Primary Care Physician (PCP) from our list of network physicians, which can be found on our website at www.aspirehealthplan.org:

Physician name (First and Last): _____

City:_____ ZIP: _____ Are you currently a patient of this provider? ☐ Yes ☐ No

Are you enrolled in your State Medicaid program? (optional) ☐ Yes ☐ No Medicaid number: _____

Are you able to participate in a video appointment with a physician? (optional) ☐ Yes ☐ No

You will need an email address, laptop, smartphone or tablet and an internet connection

I want to get the following materials via email. Select one or more.

☐ Annual Notice of Change ☐ Evidence of Coverage ☐ Provider Directory ☐ Formulary

E-mail Address: _____

Section 2 continued — all fields on this page are optional

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 each month. **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.

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.)

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name: _____ Relationship to enrollee: _____

Signature:_____ National Producer Number :_____
(Agents/Brokers only)

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

Agent ID: _____ Agent receipt date: _____/_____/_____

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.