SHORT ENROLLMENT FORM

Switch from plan to plan within parent organization

Name of plan you are enrolling in:	Plan year: 2025
Name:	Member number:

Home phone: (___) - _____ - _____

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

City:	State:	ZIP:

Mailing address (only if different from your permanent residence address): ☐ Same as permanent

City:	State:	ZIP:

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. ☐ Yes ☐ No Cell Phone Number (_____) _____-_____

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 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.

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**

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format: ☐ Spanish ☐ Large Print ☐ Braille ☐ Audio CD ☐ Data 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 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 should call 711.

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: _____

Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty that you 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 are assessed a Part D-Income Related Monthly Adjustment Amount 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 Railroad Retirement Board. 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 you qualify, Medicare could pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify 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 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium for this benefit. 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 get 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. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. 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 plan that 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/they may be paid based on my enrollment in Aspire Health Plan.

Release of information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care 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 healthcare from Aspire Health Plan, except for 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 by Medicare

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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.

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

If you are the authorized representative, you must sign and date above and provide the following information:

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

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: _____/_____/_____
(MM / DD / YYYY)

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.

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.