2025 Optional Supplemental Enhanced Benefits Option A, B, or C enrollment form

This enrollment form is for current members that want to add Optional Supplemental Enhanced Benefits Option A, B, or C to their Medicare Advantage plan. The additional premium for the Enhanced Benefits will be added to your Medicare Advantage plan monthly premium. If you would like to make changes to your current billing option, please contact our Member Services department toll free at 855-570-1600 or TTY 711. **You are not obligated to enroll in this optional benefit.**

YOUR PERSONAL INFORMATION

Last Name:____________________ First name:____________________ MI:________

Current member? ☐ Yes ☐ No Medicare ID#: ☐☐☐☐-☐☐☐-☐☐☐☐

Phone : (   ) ________________ Date of birth:____________________

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

____

City:____________________ State:__________ Zip code:__________

MAILING ADDRESS (only if different than Permanent Residence Address)

Address:____

City:____________________ State:__________ Zip code:__________

ENROLL IN ENHANCED BENEFITS OPTION A, B, OR C

If you wish to enroll in Option A, B, or C please check the appropriate box below to indicate the option you've elected. You must continue to pay your Medicare Part B premium.

Option A — includes preventive and comprehensive dental and vision
Option B — includes preventive and comprehensive dental, vision, hearing, 14 post-discharge meals for 7 days, and 10 one-way rides to appointments
Option C — includes comprehensive dental, vision, hearing, 14 post-discharge meals for 7 days, and 10 one-way rides to appointments

Aspire Health Protect (HMO) ($0)

☐ with Enhanced Benefits — Option A = $42.00 + $0 = $42.00/month
☐ with Enhanced Benefits — Option B = $46.00 + $0 = $46.00/month

Aspire Health Value (HMO) ($27.00/month)

☐ with Enhanced Benefits — Option A = $42.00 + $27.00 = $69.00/month
☐ with Enhanced Benefits — Option B = $46.00 + $27.00 = $73.00/month

Aspire Health Advantage (HMO) ($146.00/month)

☐ with Enhanced Benefits — Option C = $40.00 + $146.00 = $186.00/month

Aspire Health Plus (HMO-POS) ($336.00/month)

☐ with Enhanced Benefits — Option A = $42.00 + $336.00 = $378.00/month
☐ with Enhanced Benefits — Option B = $46.00 + $336.00 = $382.00/month

Proposed effective date of coverage: ____________

PLEASE READ AND SIGN

By completing this Optional Supplemental Enhanced Benefits Option A, B, or C enrollment form I agree to the following:

I understand that to be eligible for the Enhanced Benefits, I must remain a member of Aspire Health Plan. If I disenroll from Aspire Health Plan I will be automatically disenrolled from the Enhanced Benefits. If I discontinue payment of the Enhanced Benefits I will be disenrolled from the Enhanced Benefits Option A, B, or C.

I understand that this enrollment is for Enhanced Benefits Option A, B, or C, and will be in addition to my current Medicare Advantage Benefits. Enrollment in the Enhanced Benefits is limited to certain times of the year. If I enroll in Enhanced Benefits Option A, B, or C when I first enroll in one of the Aspire Health plans Aspire Health Protect (HMO), Aspire Health Value (HMO), Aspire Health Advantage (HMO), or Aspire Health Plus (HMO-POS), my effective date will be the same for both benefits. If I did not elect the Enhanced Benefits Option A, B, or C when I first enrolled in the Aspire Health Plan, or within 90 days thereafter, I may only add the Enhanced Benefits choice during the Annual Enrollment Period, which runs from October 15 to December 7 each year for coverage beginning January 1 of the ensuing year. Or, I may add during the Open Enrollment Period, January 1–March 31. I understand I may disenroll at any time from this optional benefit by submitting my request in writing to the address below. I will be disenrolled the first of the month, after the month that Aspire Health Plan receives my disenrollment request in writing.

ATTN: Enrollment Department
P.O. BOX 5490
Salem, OR 97304

- 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)
- 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

SIGNATURE

By signing, I agree to the enrollment election and acknowledge that my monthly premium will change.
(Please read page two and sign)

Member signature: ____ Date: ____________________

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.