Medicare Plans Enrollment Application

Who can use this form?

People with Medicare who want to join an Aspirus Health Plan 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
- Have both Medicare Part A (hospital) and Medicare Part B (medical) insurance

When do I use this form?

You can join a plan:

- From Oct. 15 – Dec. 7 each year (for coverage starting Jan. 1)
- Within three 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 (Oct. 15 – Dec. 7), we must receive your application by (not postmarked by) Dec. 7 for a Jan. 1 effective date
- You can choose to pay your monthly premium by check, automatic payment/electronic funds transfer (EFT) from your bank account or Social Security/ Railroad Retirement Board withdrawal

What happens next?

Send your completed and signed form to:

Attn. Sales, Aspirus Health Plan
PO Box 51
Minneapolis, MN 55440-9972

Once we process and approve your enrollment request, you will receive a confirmation letter and member ID card. Please allow time for processing.

How do I get help with this form?

- Call Aspirus Health Plan at 1.855.931.4855. TTY users call 1.855.931.4852.
- Call Medicare at 1.800.MEDICARE (1.800.633.4227) 24 hours a day/7 days a week. TTY users call 1.877.486.2048.

En español:

- Llame a Aspirus Health Plan al 1.855.931.4855. TTY 1.855.931.4852.
- Llame a Medicare gratis al 1.800.633.4227 y oprima el 2 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.

Pre-enrollment checklist

Before making an enrollment decision, it's important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Medicare sales specialist. See Aspirus Health Plan contact information on the previous page.

Understanding the benefits

- ☐ Make sure you know the coverage and applicable deductibles, copays and coinsurance for the benefits you may need including dental, vision, hearing and other services. You can review the full list of benefits found in the Evidence of Coverage (EOC), available upon request, especially for those services for which you routinely see a doctor. Visit **medicare.aspirushealthplan.com** or call Aspirus Health Plan to view a copy of the EOC.
- ☐ Review the providers (or ask your doctor) to make sure the doctors, hospitals and facilities you see now are in the network. If they are not, it means you will likely have to select a new doctor, hospital or facility.
- ☐ Make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not, you will likely have to select a new pharmacy or may have to pay the full price for your prescriptions.
- ☐ Review the formulary online to make sure your drugs are covered: **medicare.aspirushealthplan.com/formulary**.

Understanding important rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments or coinsurance may change on Jan. 1, 2027.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers).
  However, while we will pay for certain covered services provided by a non-contracted provider, the provider must agree to treat you.
  Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers. This plan does provide worldwide emergency care.
- ☐ If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage health care coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medicare Supplement/Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ☐ You have the right to cancel your enrollment during the Medicare Advantage Open Enrollment Period from Jan 1. – March 31.
- ☐ If you need to file a complaint, you may call Aspirus Health Plan or contact Medicare at 1.800.MEDICARE.

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Section 1: All fields in this section are required (unless marked optional)

Plans include preventive dental coverage. You can choose to add more dental coverage to either plan below. Select the plan you want to join:

- ☐ **Aspirus Health Plan Essential Rx (PPO)** $0 per month (with Medicare Part D)
  - ☐ **Add** Aspirus Choice Dental for $29 per month
- ☐ **Aspirus Health Plan Elite (PPO)** $0 per month (no Medicare Part D)
  - ☐ **Add** Aspirus Choice Dental for $29 per month

Information about you

First name

Middle initial

Birth date (mm/dd/yyyy) / /

Last name

Sex ☐ Male ☐ Female

Permanent residence street address (cannot be a PO Box unless experiencing homelessness)

City

State

ZIP -

County

Mailing address, if different from permanent (can be street or PO Box)

City

State

ZIP -

County

Phone number - -

Email address (optional)

Your Medicare information

Medicare Number (no dashes)

Requested plan effective date (mm/dd/yyyy)

/ /

(Coverage always begins on the first of the month)

Other than Medicare, will you continue to have other coverage in addition to this plan? ☐ Yes ☐ No

If yes, select all that apply ☐ Medical coverage ☐ Prescription coverage

If other than coverage through Veterans Affairs (VA) or SeniorCare, please list

Policyholder Name

Plan name

Policy ID # Group #

Other coverage effective date (mm/dd/yyyy) / /

Attestation of eligibility to enroll

Typically, you may enroll in a Medicare Advantage plan only during the Annual Enrollment Period (AEP) from Oct. 15 through Dec. 7 of each year. There are exceptions that may allow you to enroll outside of this period. Please read the following statements and check the box if the statement applies to you. By checking the box you are certifying that, to the best of your knowledge, you are eligible to enroll. If we later determine this information is incorrect, you may be disenrolled.

Enrolling during Annual Enrollment Period (AEP)

☐ I am enrolling during AEP which runs from Oct. 15 – Dec. 7 for a Jan. 1 effective date
Note: Your application must be received by Dec. 7 for a Jan. 1 effective date

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New or change to Medicare or your coverage

☐ I am new to Medicare Part A and Part B or I already have Part A and recently signed up for Part B

☐ I had Medicare prior to age 65 due to a disability and I'm now turning age 65

☐ I am enrolled in a Medicare Advantage plan and want to make a change to a different Medicare Advantage plan during the Medicare Advantage Open Enrollment Period (MA-OEP)
Note: This period runs from Jan. 1 – March 31 (or within your first three months new to Medicare)

☐ I was automatically enrolled in my current plan by Medicare (or my state) and want to choose a different plan
My enrollment in that plan started on (mm/dd/yyyy) / /

☐ I am moving into, live in or have recently moved out of a nursing home on
(mm/dd/yyyy) / /

A recent change in residence status

- ☐ I moved outside of the service area for my current plan or I recently moved within the past three months on (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐ and have new options available to me
- ☐ I returned to the U.S. after living permanently outside of the U.S. on (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐
- ☐ I was released from incarceration on (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐
- ☐ I obtained lawful presence status in the U.S. on (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

A recent change in income or Special Needs Plan (SNP) qualifications or other

- ☐ I am losing or leaving employer or union coverage and my last date of coverage is (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐ (usually the last day of the month)
- ☐ I am enrolled in a Medicare plan that is ending its contract with Medicare, or Medicare is ending its contract with my current plan
- ☐ I had a change in my Extra Help paying for Medicare prescription drug coverage (became eligible, changed levels or became ineligible) on (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐
- ☐ I belong to or I am losing the pharmacy assistance program provided by my state (SeniorCare)
- ☐ I involuntarily lost drug coverage that is at least as good as Medicare Part D (called creditable) on (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐
- ☐ I am enrolled in my state's Medicaid program or am losing or lost eligibility on (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐
- ☐ I left a PACE program on (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐
- ☐ I was enrolled in a special needs plan (SNP) but no longer qualify for that plan on (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐
- ☐ I was affected by an emergency or major disaster as declared by a government entity, and one of the other previous statements applied, but I was unable to make my enrollment request at that time

If none of the statements apply to you or you're not sure, please contact Aspirus Health Plan at 1.855.931.4855 (TTY users call 1.855.931.4852) to see if you are eligible to enroll.

Section 2: All fields in this section are optional. Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Select if you want us to send information in a language other than English or in an accessible format:

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

☐ Email ☐ Other language or format

Plan materials are available on **medicare.aspirushealthplan.com**. Please contact Aspirus Health Plan at 1.855.935.4855 if you need information in a format other than what's listed above. Our office hours are Monday – Friday, 8 am – 8 pm. TTY users call 1.855.931.4852.

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

Section 3

Plan premium options

You can choose to pay your premium (including any late enrollment penalty that you currently have or may owe) in the following ways. Medicare requires a payment method selection even if you select a $0 premium plan. Please do not send payment with your enrollment form. Select one:

☐ Get a bill (Once enrolled, you may choose to pay by credit card, by phone or through your online Aspirus Health Plan member account.)

☐ Monthly electronic funds transfer from ☐ checking account ☐ savings account

Bank name

Bank routing #

Bank account number #

☐ Automatic monthly deduction from my

☐ Social Security (SS) ☐ Railroad Retirement Board (RRB) benefit

Note: If you have a higher income, you might pay more for your Medicare drug coverage, called a Part D Income Related Monthly Adjustment Amount (Part D – IRMAA). You must pay this extra amount in addition to your plan premium. Social Security will contact you if this applies. DON'T pay Aspirus Health Plan the Part D – IRMAA.

REQUIRED: Please read this important information and sign below.

- I must keep both hospital (Part A) and medical (Part B) insurance to stay in this plan
- By joining this Aspirus Health Plan Medicare Advantage plan, I acknowledge and agree that Aspirus 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 on this form). My response to this form is voluntary. However, failure to respond may affect enrollment in this plan.
- Aspirus Health Plan may release my information for treatment, payment and operations, in compliance with state and federal law and as stated in the Notice of Privacy Practices. I acknowledge that I have read and understand Aspirus Health Plan's Notice of Privacy Practices (included in the Summary of Benefits and on **medicare.aspirushealthplan.com**).
- I understand that I can be enrolled in only one Medicare Advantage (MA) plan at a time and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for Medicare Advantage Private Fee-for-Service (PFFS) and Medicare Medical Savings Account (MSA) plans)
- I understand that when this plan coverage begins, I must get all of my medical and prescription drug benefits from this plan. Benefits and services provided by this plan and contained in the Evidence of Coverage document (also known as member contract or subscriber agreement) will be covered. Neither Medicare nor this 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 this 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: _____ **Today's date:** _____

If you're the authorized representative, sign above and fill out these fields:

Name

Relationship to enrollee

Address

Phone number

For agent/broker only

Complete this section if you are an agent or broker helping an enrollee fill out this enrollment application.

Name

Agent/Broker National Producer Number (NPN)

Date received (mm/dd/yyyy)

Primary Care Clinic ID# (if known)

Signature: _____

How to submit your enrollment form

Return your paper enrollment application in the enclosed postage-paid envelope to Attn: Sales, Aspirus Health Plan, PO Box 51, Minneapolis, MN 55440-9972 or by fax at 715.787.7328. Or enroll online at **medicare.aspirushealthplan.com/enrollment**.

Notice of Availability

ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 715.631.7411/1.855.931.4850 (TTY 715.631.7413/1.855.931.4852).

ልብ ይበሉ:- የአማርኛ ቋንቋ የሚናገሩ ከሆነ፣ ነፃ የቋንቋ ድጋፍ አገልግሎት ለእርስዎ ቀርቦልዎታል። ተደራሽ በሆኑ ቅርፀቶች መረጃዎችን ለማቅረብ ተገቢ የሆኑ አጋዥ ድጋፍ ሰጪ መሳሪያዎች እና አገልግሎቶችም እንዲሁ በነፃ ቀርበዋል። በ 715.631.7411/1.855.931.4850 (TTY 715.631.7413/1.855.931.4852) ይደውሉ.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر أيضًا المساعدات والخدمات المساعدة الإضافية لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجانًا. يمكنك الاتصال على الرقم 715.631.7411/1.855.931.4850 (TTY 715.631.7413/1.855.931.4852).

សូមជ្រាបជាដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ សេវាកម្មជំនួយភាសាតតគិតថ្លៃអាចត្រូវបានផ្តល់ជូនសម្រាប់អ្នក។ ជំនួយ និងសេវាជំនួយសមស្របដើម្បីផ្តល់ព័ត៌មានក្នុងទម្រង់ដែលអាចចូលប្រើបានក៏ត្រូវបានផ្តល់ជូន ដោយតតគិតថ្លៃដងដែរ។ ទូរសព្ទទៅលេខ 715.631.7411/1.855.931.4850 (TTY 715.631.7413/1.855.931.4852) ។

請注意：如果您講粵語，可得免費語言協助服務。還可免費提供適當的輔助工具和服務，能以無障礙格式提供資訊。請致電 715.631.7411/1.855.931.4850 (聽障專線 715.631.7413/1.855.931.4852)。

请注意：如果您说普通话，我们可为您免费提供语言协助服务。此外，我们还免费提供适当的辅助设备和服务，以无障碍格式提供信息。请致电 715.631.7411/1.855.931.4850 (TTY 715.631.7413/1.855.931.4852)。

ATTENTION : Si vous parlez Français, des services d’assistance linguistique gratuits sont à votre disposition. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 715.631.7411/1.855.931.4850 (ATS 715.631.7413/1.855.931.4852).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 715.631.7411/1.855.931.4850 (TTY 715.631.7413/1.855.931.4852) an.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपकेललए नन: शुल्क भाषा सहायता सेवाएंउपलब्ध हैं। सुलभ फॉर्मेट मेंजानकारी प्रदान करनेकेललए उपयुक्त सहायक साधन और सेवाएंभी नन: शुल्क उपलब्ध हैं। 715.631.7411/1.855.931.4850 (TTY 715.631.7413/1.855.931.4852) पर कॉल करें।

TSWM SEEB: Yog tias koj hais tau lus Hmoob, ces yuav muaj kev pab cuam txhais lus pub dawb rau koj siv. Kuj tseem muaj cov kev pab txhawb ntxiv thiab cov kev pab cuam uas tsim nyog los mus muab cov ntaub ntawv qhia paub nyob rau cov qauv uas nkag siv tau dawb thiab. Hu rau 715.631.7411/1.855.931.4850 (TTY 715.631.7413/1.855.931.4852).

ໝາຍເຫດ: ການບໍລິການທາງດ້ານພາສາແມ່ນມີພ້ອມໃຫ້ບໍລິການແກ່ທ່ານ. ນອກນັ້ນ, ຍັງມີການບໍລິການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການເສີມທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ທ່ານເຂົ້າເຖິງໄດ້ຟຣີອີກນຳ. ໂທ 715.631.7411/1.855.931.4850 (TTY 715.631.7413/1.855.931.4852).

HUBACHIISA: Afaan Oromo kan dubbattan yoo ta'e, tajaajila gargaarsa afaanii bilisaan ni argattu. Odeeffannoo bifa dhaqqabamaa ta’een dhiheessuf, gargaarsii fi tajaajiloonni dabalataa mijatoo ta’anis bilisaan ni kennamu. Bilbilaa 715.631.7411/1.855.931.4850 (TTY 715.631.7413/1.855.931.4852).

ВНИМАНИЕ: Если вы говорите на русском языке, вам доступны бесплатные услуги языковой помощи. Соответствующие вспомогательные средства и услуги по предоставлению информации в других форматах также можно получить бесплатно. Позвоните по номеру 715.631.7411/1.855.931.4850 (TTY 715.631.7413/1.855.931.4852).

FIIRO GAAR AH: Haddii aad ku hadasho Af-Soomaali, adeegyada caawimaada luuqadda ee bilaashka ah ayaa laguu heli karaa. Kaalmooyinka iyo adeegyada dheeraadka ah ee kugu habboon si macluumaadka laguugu siiyo qaabab la isticmaali karo ayaa sidoo kale laguu heli karaa weliba si lacag la'aan ah. Wac 715.631.7411/1.855.931.4850 (TTY 715.631.7413/ 1.855.931.4852).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También disponemos de ayudas y servicios auxiliares adecuados de forma gratuita para facilitar información en formatos accesibles. Llame al 715.631.7411/1.855.931.4850 (TTY 715.631.7413/1.855.931.4852).

PAUNAWA: Kung nagsasalita ka ng Tagalog, may magagamit kang mga libreng serbisyo ng tulong sa wika. Mayroon ding mga naaangkop na karagdagang pantulong at serbisyo para makapagbigay ng impormasyon sa mga accessible na format na magagamit nang libre. Tumawag sa 715.631.7411/1.855.931.4850 (TTY 715.631.7413/1.855.931.4852).

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có sẵn dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Ngoài ra, cũng có sẵn các hỗ trợ và dịch vụ phụ trợ thích hợp miễn phí nhằm cung cấp thông tin ở các định dạng có thể truy cập. Gọi 715.631.7411/1.855.931.4850 (TTY 715.631.7413/ 1.855.931.4852).