Medicare Advantage Plans Enrollment Application

Who can use this form?

People with Medicare who want to join an Aspirus Health 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

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), we must receive your application by (not postmarked by) December 7 for a 1/1 effective date.
- You can choose to pay your monthly premium by check, automatic payment/electronic funds transfer (EFT) or Social Security/Railroad Retirement Board withdrawal. Please do not send payment with your enrollment form.

What happens next?

Send your completed and signed form to:

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

or fax your application to (715) 787-7328.

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.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. TTY users can call 1-877-486-2048.

En español: Llame a Aspirus Health Plan al 1-855-931-4855 (TTY: 1-855-931-4852) o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

If you would like us to send you information in another format (e.g., Braille, large print, audio) or if you would like material emailed to you (e.g., Explanation of Coverage, Summary of Benefits, Provider Directory), please contact us at the numbers noted above. Our office hours are 8 am – 8 pm, seven days a week (Oct. 1 – March 31) and 8 am – 8 pm, Monday – Friday (April 1 – Sept. 30).

Pre-enrollment Checklist

Before making an enrollment decision, it is 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

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit aspirushealthplan.com or call Aspirus Health Plan to view a copy of the EOC. See Aspirus Health Plan contact information on the previous page.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

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/ coinsurance may change on January 1, 2023.
- ☐ 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 co-pay for services received by non-contracted providers.

How to Submit Your Enrollment Form

Return paper enrollment forms in the enclosed postage-paid envelope.

Mail enrollment forms to:

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

You can also enroll through our website at www.aspirushealthplan.com or fax your application to 715-787-7328.

OMB No. 0938-1378
Expires:7/31/2023

ASPIRUS HEALTH PLAN

Medicare Advantage Plans Enrollment Application

Please use black ink

STEP 1. To enroll, please provide the following information

First name

Middle initial

Birth date (mm/dd/yyyy) / /

Last name

Sex ☐ M ☐ F

Permanent residence street address (cannot be a P.O. box)

City

State

Zip -

County

Mailing address, if different from permanent (can be street or P.O. box)

City

State

Zip -

County

Primary phone number (include area code) - -

Alternate phone number (include area code) - -

Email address (optional) - *Note: We will send member updates and information to email address provided.*

Race: ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic ☐ African American ☐ Pacific Islander

STEP 2. Choose the name of the primary care clinic you want to use

Clinic ID number

The clinic number can be located in the Primary Care Clinic Listing found in your packet.

STEP 3. Desired effective date (mm/dd/yyyy) / /

Coverage always begins on the first of the month.

STEP 4. Provide your Medicare information

Medicare Number

STEP 5. Check the plan you want to enroll in. All plans include some dental coverage. You can add more dental coverage.

☐ **Essential Rx (PPO)** $0 per month (with Part D)

☐ **Add** Aspirus Choice Dental for $25 per month

☐ **Elite Rx (PPO)** $82 per month (with Part D)

☐ **Add** Aspirus Choice Dental for $25 per month

☐ **Elite (PPO)** $0 per month (no Part D)

☐ **Add** Aspirus Choice Dental for $25 per month

Refer to the service area map in the Summary of Benefits to confirm the plan you select is available in your area.

STEP 6. Please read and answer these important questions.

1. Other than Medicare, will you continue to have any other **medical** coverage? ☐ Yes ☐ No, continue to 2

Is this medical coverage through the VA? ☐ Yes ☐ No

Please complete the following if you have medical coverage other than through the VA.

Policy holder name

Plan name (as appears on ID card)

Policy or ID# Group#

Effective date (mm/dd/yyyy) / / Phone# - -

2. Will you have any other **prescription** drug coverage? ☐ Yes ☐ No

Is this drug coverage through the VA or SeniorCare in WI? ☐ Yes ☐ No

Please complete the following if you have drug coverage other than through the VA or SeniorCare in WI.

Policy holder name

Plan name (as appears on ID card)

Policy or ID# Group#

Effective date (mm/dd/yyyy) / / Phone# - -

STEP 7. Please read the following questions 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.

1. Are you new to Medicare and within your initial election period (includes those new to both Medicare Part A and Part B or new to Part B only)? ☐ Yes ☐ No

2. Are you enrolling during the Medicare Annual Enrollment Period (between 10/15 - 12/7)? ☐ Yes ☐ No

3. Is our plan a new option for you because you moved in the past three months? ☐ Yes ☐ No
   If yes, when did you move? (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

4. Are you a resident in a nursing home? ☐ Yes ☐ No
   Or, are you a resident of an assisted living or memory care facility who is receiving nursing home level of care? ☐ Yes ☐ No
   If yes to either, provide the name, address and phone number of the facility:
   Date of admission (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

5. Are you enrolled in your State Medicaid Program (called Medical Assistance) or have you been on it but are losing (or recently lost) eligibility? ☐ Yes ☐ No
   If yes, please provide your Medicaid number: ☐☐☐☐☐☐☐☐

6. Are you enrolled in the program through Social Security called Extra Help for Medicare Part D? ☐ Yes ☐ No
   Have you had Extra Help for Medicare Part D but are losing or recently lost eligibility? ☐ Yes ☐ No
   If so, when? (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

7. Are you losing or leaving coverage you had from an employer or union, or did you recently lose or leave such coverage (includes COBRA and/or retiree coverage)? ☐ Yes ☐ No
   If yes, what is the last date of coverage? (e.g., 12/31/2021): ☐☐ / ☐☐ / ☐☐☐☐
   Please note: Your coverage end date should be the last day of the month before your Aspirus Health Plan coverage begins.

8. Are you enrolled in a Medicare plan that is ending its contract with Medicare, or is Medicare ending its contract with your current plan? ☐ Yes ☐ No

9. Are you enrolled in a Medicare Advantage plan and want to make a change to another Medicare Advantage plan using the MA Open Enrollment Period Election. (Jan 1 - March 31 or if you are newly enrolled in Medicare, within your first three months of enrollment)? ☐ Yes ☐ No

10. Have you recently returned to the United States after living permanently outside of the U.S.? ☐ Yes ☐ No
    If yes, I returned to the U.S. on (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

11. Do you belong to a pharmacy assistance program provided by your state? ☐ Yes ☐ No

STEP 8. Your 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 monthly premium plan **(please select one):**

☐ I choose monthly billing (Once enrolled, you may choose to pay by credit card through Aspirus Health Plan's member portal.)

☐ I choose monthly electronic funds transfer (EFT) from a checking or savings account. Please provide:

Bank name

Bank routing # Account type ☐ Checking ☐ Savings

Bank account number #

☐ I choose automatic deduction from my monthly Social Security (SS) or Railroad Retirement Board (RRB) benefit check. I get monthly benefits from ☐ SS ☐ RRB

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. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay Aspirus Health Plan the Part D-IRMAA.

If you do not select a payment option, you will get a bill each month.

Office use only Date received (mm/dd/yyyy): / /

Name of staff member/agent/broker (if assisted in enrollment): _____

If agent, add agent number (NPN):

Step 9: Please read this important information and sign below. Note: All references to "this plan" are to the plan you are enrolling in which is an Aspirus Health Plan.

I must keep both Hospital (Part A) and Medical (Part B) to stay in this plan. By joining this Aspirus Health 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). Aspirus Health Plan may also share my information for treatment, payment, and operations. I acknowledge that I have read and understand Aspirus Health Plan's Notice of Privacy Practices located on their website at www.aspirushealthplan.com. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan. 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 are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border. However, this plan provides worldwide emergency care.

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 a member contract or subscriber agreement) will be covered. Neither Medicare nor this plan will pay for benefits or services that are not covered.

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 are the Power of Attorney (POA)/authorized representative, and are signing on behalf of this enrollee, you must sign above and provide the following information:

Name

Relationship to enrollee

Address

Phone number

Are you the enrollee's POA? ☐ Yes ☐ No

If yes, is the POA paperwork attached? ☐ Yes ☐ No

If no, please send in a copy of the POA agreement or other legal document to:
Attn: Enrollment, Aspirus Health Plan, P.O. Box 51, Minneapolis, MN 55440-9972.
We must have the POA agreement on file in order to respond to future requests made by the POA.

Return paper enrollment forms in the enclosed postage-paid envelope.

Notice of Nondiscrimination

Aspirus Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Aspirus Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

We provide aids and services at no charge to people with disabilities to communicate effectively with us, such as TTY line, or written information in other formats, such as large print.

If you need these services, contact us at **715-631-7411 (voice)** or toll free at **1-855-931-4850 (voice)**, **715-631-7413 (TTY)**, or **1-855-931-4852 (TTY)**.

We provide language services at no charge to people whose primary language is not English, such as qualified interpreters or information written in other languages.

If you need these services, contact us at the **number on the back of your membership card** or **715-631-7411** or toll free at **1-855-931-4850 (voice)**; **715-631-7413** or toll free at **1-855-931-4852 (TTY)**.

If you believe that Aspirus Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file an oral or written grievance.

Oral grievance

If you are a current Aspirus Health Plan member, please call the number on the back of your membership card. Otherwise please call **715-631-7411** or toll free at **1-855-931-4850 (voice)**; **715-631-7413** or toll free at **1-855-931-4852 (TTY)**. You can also use these numbers if you need assistance filing a grievance.

Written grievance
Mailing Address
Attn: Appeals and Grievances
Aspirus Health Plan
P.O. Box 51
Minneapolis, MN 55440
Email: cagMA@aspirushealthplan.com
Fax: 715-631-7439

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852)。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 715-631-7411/1-855-931-4850 (телетайп: 715-631-7413/1-855-931-4852).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 715-631-7411/1-855-931-4850 (መስማት ለተሳናቸው: 715-631-7413/1-855-931-4852).

ဟ်သူဉ်ဟ်သး–နမ့်ကတိၤ ကညီ ကျိာ်အယိ, နမၤနှ်၊ ကျိာ်အတ်မၤစၢၤလ၊ တလာ်ဘူဉ်လာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយា ភាសារ៉ែខ្មរ, រសវាជំនួយរ៉ែផ្កភាសា ដោយមិនគិតឈ្លួល គឺអាចមានសំរាប់បំរ៉ើអ្នក។ ចូរ ទូរស័ព្ទ 715-631-7411/1-855-931-4850 (TTY715-631-7413/ 1-855-931-4852)។

ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان .اتصل برقم 715-631-7411/1-855-931-4850 (رقم هاتف الصم والبكم: 715-631-7413/1-855-931-4852.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 715-631-7411/1-855-931-4850 (ATS : 715-631-7413/1-855-931-4852).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).