

OMB No. 0938-1378 Expires: 12/31/2026

# Exhibit 1: MODEL INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C) OR MEDICARE PRESCRIPTION DRUG PLAN (PART D)

#### Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan or Medicare Prescription Drug 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)

**Important:** To join a Medicare Prescription Drug Plan, you must also have either, or 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: Capital Health Plan,

P.O. Box 15349,

Tallahassee, Florida 32317-5349

Fax to Capital Health Plan Enrollment Department at 850-523-7369 or email at enrollment@chp.org

Once they process your request to join, they'll contact you.

# How do I get help with this form?

oprima el 8 para asistencia en español y un

representante estará disponible para asistirle.

Call Capital Health Plan at 850-523-7441 or 1-877-247- 6512 (TTY 850-383-3534 or 1-877- 870-8943) 8:00 a.m. – 8:00 p.m., seven days a week, October 1 – March 31; 8:00 a.m. – 8:00 p.m., Monday Friday, April 1 – September 30.

En español: Llame a Capital Health Plan al 850-523-7441 or 1-877-247- 6512 (TTY 850-383-3534 or 1-877-870-8943) o a Medicare gratis al 1-800-633-4227 y

# 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.



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.

H5938\_DP2072\_2025\_M

[This page intentionally left blank.]



# **Capital Health Plan Enrollment Application – 2026 SECTION 1 – REQUIRED INFORMATION**

 $\square$  Yes  $\square$  No

• Name of other coverage: \_

□ Silve □ Adv □ Pref	Selection (Choose One):  er Advantage (HMO) – \$0/mo  eantage Plus (HMO) – \$34/mo  eerred Advantage (HMO) – \$96/mo  eeback Advantage (HMO) – \$0/mo
Memb	er Information  Last Name:
•	First Name:
•	Middle Initial (Optional):
•	Date of Birth (MM/DD/YYYY):/
•	Sex: □ Male □ Female
•	Home Phone: ( ) -
•	Cell Phone: () -
Perma •	nent Residence Address (No PO Boxes) Street Address:
•	City:
•	County:
•	State:
•	ZIP Code:
Mailin	g Address (if different from residence) Street Address:
•	City:
•	State:
•	ZIP Code:
Medica •	are Information  Medicare Number:
	Prescription Drug Coverage ou have other prescription drug coverage (e.g., VA, TRICARE)?

•	Member Number:
•	Group Number:
	NOWLEDGMENT & AUTHORIZATION ning below, I acknowledge and agree to the following:
•	I must keep both Hospital (Part A) and Medical (Part B) to remain enrolled.
•	Capital Health Plan will share my information with Medicare for purposes allowed by law.
•	The information I've provided is accurate. Knowingly providing false info may result in disenrollment.
•	Enrollment in this plan ends my enrollment in any other Medicare Advantage plan.
•	I will receive all benefits and services from Capital Health Plan as detailed in the Evidence of Coverage.
•	My signature indicates I understand and agree to all statements herein.
Signat Date:	ture:
•	Name: Address: Phone Number: () - Relationship to Enrollee:
	ION 2 – OPTIONAL INFORMATION red Language
Access	sible Format Request
	ille □ Large Print □ Audio CD □ Data CD ther formats, call 850-523-7441 or 1-877-247-6512)
Emplo	Do you work? $\Box$ Voc $\Box$ No
•	Do you work? □ Yes □ No
•	<b>Does your spouse work?</b> □ Yes □ No
Prima	ry Care Physician PCP/Clinic/Health Center Name:
•	Are you an established patient? □ Yes □ No



SECTION 6: Demographic Information (Optional)
Ethnicity – Are you of Hispanic, Latino/a, or Spanish origin? (Select all that apply)
□ No, not of Hispanic, Latino/a, or Spanish origin
☐ Yes, Mexican, Mexican American, Chicano/a
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, another Hispanic/Latino/a/Spanish origin
☐ I choose not to answer
Race – What is your race? (Select all that apply)
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Black or African American
□ Chinese
□ Filipino
☐ Guamanian or Chamorro
□ Japanese
□ Korean
□ Native Hawaiian
☐ Other Asian
☐ Other Pacific Islander
□ Samoan
□ Vietnamese
□ White
☐ I choose not to answer
Email Communications
I would like to receive the following materials via email:
☐ Evidence of Coverage ☐ Annual Notice of Change
Email Address:
Premium Payment Option (Select One):
☐ Get a bill
☐ EFT from bank (attach VOIDED check)
☐ Automatic deduction from Social Security or RRB check
(Note: Deduction may take 2+ months to begin)
Enrollment Period Eligibility
Check all that apply if you're enrolling outside of the October 15 – December 7 period:
☐ I am new to Medicare
☐ I'm changing plans during MA OEP

☐ I moved, and this plan is new to me. Date: \_\_\_\_\_



An Independent Licensee of the Riue Cross and Riue Shield Association

☐ I was released from incarceration. Date:
☐ I returned from living abroad. Date:
☐ I gained lawful presence. Date:
☐ I had a Medicaid change. Date:
☐ I had a change in Extra Help. Date:
☐ I have both Medicare and Medicaid
☐ I moved into/out of long-term care. Date:
☐ I left a PACE program. Date:
☐ I lost creditable drug coverage. Date:
☐ I left employer/union coverage. Date:
☐ I'm in a state pharmacy assistance program
☐ My plan contract is ending with Medicare
☐ I lost SNP eligibility. Date:
☐ I was affected by a FEMA-declared emergency
☐ My current plan is in receivership
☐ My current plan has the low-performing icon (LPI)
If none apply or unsure, call Capital Health Plan: 850-523-7441 or 1-877-247-6512
For Office Use Only
Agent/Broker Name:
• Agent/Broker/NP Number:
• Date:/
<ul> <li>Date://</li></ul>
• Effective Date of Coverage:

#### **Privacy Act Statement:**

CMS collects this information under sections 1851 and 1860D-1 of the Social Security Act. Data may be used to track enrollment, improve care, and support payment. You are not required to provide this information, but failure to do so may impact your enrollment. Full details are in the Medicare Advantage Prescription Drug (MARx) System of Records.