OMB No. 0938-1378
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Exhibit 1: MODEL INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C)

Who can use this form?

People with Medicare who want to join a 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

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 January1)
- 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?

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. Or call Medicare at 1-800-633-4227.
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 oprima el 8 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.

Section 1 – All fields on this page are required (unless marked optional)

Select the plan you want to join: ☐ Silver Advantage (HMO) $0/mo. ☐ Preferred Advantage (HMO) $96/mo. ☐ Advantage Plus (HMO) $34/mo. ☐ Giveback Advantage (HMO) $0/mo

FIRST name:	LAST name:	[Optional: Middle Initial]:
Birth date: (MM/DD/YYYY) (/ /)	Sex: ☐ Male ☐ Female	Phone number: ( )

Permanent Residence street address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):

City:	[Optional: County]:	State:	ZIP Code:

Mailing address, if different from your permanent address (PO Box allowed):
Street address: City: State: ZIP Code:

Your Medicare information:

Medicare Number: _ _ _ _ - _ _ _ - _ _ _ _

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Capital Health Plan? ☐ Yes ☐ No

Name of other coverage: Member number for this coverage: Group number for this coverage

_____ _____ _____]

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Capital Health Plan.
- By joining this Medicare Advantage, I acknowledge that Capital 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 Capital Health Plan coverage begins, I must get all of my medical and prescription drug benefits from Capital Health Plan. Benefits and services provided by Capital Health Plan and contained in my Capital Health Plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Capital 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:	**Today's date:**
If you're the authorized representative, sign above and fill out these fields:	
Name:	Address:
Phone number:	Relationship to enrollee:

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 one if you want us to send you information in an accessible format.

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact Capital Health Plan at 850-523-7441 or 1-877-247-6512 if you need information in an accessible format other than what's listed above. Our office hours are 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. TTY users can call 850-383-3534 or 1-877-870-8943.

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

List your Primary Care Physician (PCP), clinic, or health center:

I want to get the following materials via email. Select one or more.
☐ Evidence of Coverage ☐ Annual Notice of Change

E-mail address:_____

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or by "Electronic Funds Transfer (EFT) each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

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. DON'T pay Capital Health Plan the Part D-IRMAA.

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): _____

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15th through December 7th of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period. If you are applying outside of the annual enrollment period, please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

☐ New to Medicare ☐ AEP ☐ SEP (please list) _____
☐ Other (please explain): _____
☐ Effective Date of Event: _____/_____/_____

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.

Additional Communication: (Select which applies)

☐ It is the Annual Enrollment Period (October 15 to December 7).

☐ I am new to Medicare.

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

☐ I recently moved outside of the service area for my current plan or I recently moved and have new options available to me.

☐ I moved on.

☐ I recently was released from incarceration. I was released on.

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on.

☐ I recently obtained lawful presence status in the United States. I got this status on.

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on.

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on.

☐ I have Medicare and get full Medicaid benefits.

☐ I want to join or switch to a plan that coordinates coverage between my Medicare and Medicaid managed care plans (called an integrated Dual Eligible Special Needs Plan (D-SNP).

☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved will move into/out of the facility on.

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on.

☐ I am leaving employer or union coverage on

☐ I'm in a qualified State Pharmaceutical Assistance Program, or I'm losing help from a State Pharmaceutical Assistance Program.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan.
My enrollment in that plan started on.

☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on .

☐ I was affected by an emergency or major disaster as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state, or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster. (Be sure to check the other statement that applied to you.)

☐ I signed up for Medicare coverage between January 1 and March 31 during the General Enrollment Period (GEP).

☐ I have a chronic condition(s) and qualify to enroll in a Special Needs Plan (SNP) that serves the condition(s). This is my first enrollment into a chronic care SNP.

☐ I recently left a PACE program on

How would you like to pay? Only choose one. If you don't select an option below, we'll send a monthly bill.

- ☐ Send me a monthly bill
- ☐ Electronic funds transfer (EFT) from your bank account each month.
- ☐ Please enclose a VOIDED check. Take it out of my monthly Social Security check*
- ☐ Take it out of my monthly Railroad Retirement Board (RRB) check*

*It may take at least 2 months for your premium to start coming out of your check. If you choose this option, you may still need to pay Capital Health Plan directly for the first few months.

Please contact Capital Health Plan at 850-523-7441 or 1-877-247-6512 if you need information in an accessible format other than what's listed above. Our office hours are 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. TTY users can call 850-383-3534 or 1-877-870-8943.