OMB No. 0938-1378
Expires: 6/30/2026

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-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Capital Health Plan 1-877-247-6512/TTY: 711 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.

Capital Health PLAN℠

An Independent Licensee of the Blue Cross and Blue Shield Association

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

Select the plan you want to join:

☐Silver Advantage (HMO) $0/mo.	☐Advantage Plus (HMO) $26/mo.	☐Preferred Advantage (HMO) $86/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:	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.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **I choose not to answer.**
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native

Asian:

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

- ☐ Black or African American

Native Hawaiian and Pacific Islander:

- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

- ☐ White
- ☐ **I choose not to answer.**

What is your gender? Select one.

- ☐ Woman
- ☐ Man
- ☐ Non-binary
- ☐ I use a different term: _____
- ☐ **I choose not to answer**

Which of the following best represents how you think of yourself? Select one.

- ☐ Lesbian or gay
- ☐ Straight, that is, not gay or lesbian
- ☐ Bisexual
- ☐ I use a different term: _____
- ☐ I don't know
- ☐ **I choose not to answer**

Select one if you want us to send you information in a language other than English.

☐ Spanish ☐ Other _____

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 850-383-3311 or 1-877-247-6512 if you need information in an accessible format other than what's listed above. Our office hours 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

Email 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 "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. Social Security will notify and bill beneficiaries who are required to pay the IRMAA. The IRMAA can be deducted from your social security benefit checks or paid directly to Medicare.

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.

- ☐ 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 this plan is a new option for me. I moved on (insert date) _____.
- ☐ I recently was released from incarceration. I was released on (insert date) _____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date)_____.
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____
- ☐ I recently had a change in my Medicaid (newly enrolled in Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date)_____.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly enrolled in Extra Help had a change in the level of Extra Help or lost Extra Help) on (insert date) _____.
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.

☐ 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 (insert date) _____.

☐ I recently left a PACE program on (insert date)_____.

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

☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

☐ I am currently enrolled in a plan that is experiencing financial difficulties to such an extent that a state or territorial regulatory authority has placed the organization in receivership.

☐ I am currently enrolled in a plan identified with the low performing icon (LPI)

Please select a premium payment option:

☐ Get a bill.

☐ Electronic funds transfer (EFT) from your bank account each month. **Please enclose a VOIDED check. If you mark this option but do not include a voided check, you will get a paper bill each month.**

☐ Automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefits check. (The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB).

PRIVACY ACT STATEMENT

The Center 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. Section 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.

Office Use Only:

Name of Agent/Broker (if assisted in enrollment):_____ Agent/Broker/NP# _____

Date _____ Effective Date of Coverage: _____.

ICEP/IEP:____ AEP:_____ SEP (type):_____ STAR (R)_____ Not Eligible:_____

If none of these statements apply to you or you're not sure, please contact Capital Health Plan to see if you are eligible to enroll. We can be reached 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.

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.