MOLINA HEALTHCARE

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)

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:
Molina Healthcare
Attn: Enrollment Accounting
PO Box 22800
Long Beach, CA 90801

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

How do I get help with this form?

Call Molina Healthcare at (866) 403-8293. TTY users can call 711 Monday – Sunday, 8 a.m. to 8 p.m., local time.

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

En español: Llame a Molina Healthcare al (866) 403-8293 TTY:711 lunes a domingo, de 8 a.m. a 8 p.m., hora local o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

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

Select the plan you want to join:

☐ ID H5628-009 HMO $0 per month
☐ ID H5628-010 HMO $0 to $20 per month

FIRST name:	LAST name:	Middle Initial:

Birth date: (MM/DD/YYYY)	Sex: ☐ Male ☐ Female	Phone number: ( )

Permanent Residence street address (Don't enter a PO Box):

City:	County:	State:	ZIP Code:

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

Emergency contact:

Phone Number: Relationship to you:

Your Medicare information:

Medicare Number: - -

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Molina Healthcare?
☐ Yes ☐ No
Name of other coverage: Member number for this coverage: Group number for this coverage:

Your State Medicaid Program information:

If you are enrolled in your state Medicaid program, please provide your Medicaid number: _____

If this is a Dual Special Needs plan, I understand that I must remain enrolled in my state Medicaid program to remain eligible in this plan.

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IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Molina Healthcare.
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that Molina Healthcare 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.
- 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.
- I understand that when my Molina Healthcare coverage begins, I must get all of my medical and prescription drug benefits from Molina Healthcare. Benefits and services provided by Molina Healthcare and contained in my Molina Healthcare "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Molina Healthcare 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're the authorized representative, sign above and fill out these fields:

Name:	Address:
Phone number:	Relationship to enrollee:

Office Use Only:

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

Agent Name (Printed): _____

Signature: _____ Agent Writing/NPN #: _____

Agent Receipt Date: _____ /_____ /_____ Agent Phone #: _____

Plan ID# _____ Effective Date of Coverage: _____

P#: _____

Fax# for Agent Use Only – Agents can fax completed enrollment forms and associated documents to (844) 541-6848.

Receipt Date of Enrollment request. This date will be used to determine the election period in which the request was made, which in turn will determine the effective date of coverage.

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Section 2 – All fields on this page 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 a language other than English.
☐ Spanish

Select one if you want us to send you information in an accessible format.
☐ Braille ☐ Large print ☐ Audio CD
Please contact Molina Healthcare at (866) 403-8293 if you need information in an accessible format other than what's listed above. Our office hours are Monday – Sunday, 8 a.m. to 8 p.m., local time. TTY users can call 711.

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

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

PCP Name (Last Name, First Name): _____

*Are you an existing member: ☐ Yes ☐ No

Provider NPI #: _____ Clinic/Medical Group/IPA: _____

PCP Address:

I want to get the following materials via email. Select one or more.
☐ Member Communications/Documents 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 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. 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 Molina Healthcare the Part D-IRMAA.

Please select a premium payment option:

☐ **Get a coupon book**

☐ **Electronic funds transfer** (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following: Account type: ☐ Checking ☐ Savings

Account Holder Name: _____

Bank Routing Number: _____ Bank Account Number: _____

☐ **Automatic deduction** from your monthly Social Security or Railroad retirement Board (RRB) benefit check.
I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

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Molina Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, ethnicity, national origin, religion, gender, sex, age, mental or physical disability, health status, receipt of healthcare, claims experience, medical history, genetic information, evidence of insurability, geographic location.

Molina Medicare Choice Care HMO is a Health Plan with a Medicare Contract. Enrollment in Molina Medicare Choice Care depends on contract renewal.

This information is available in other formats, such as Braille, large print, and audio.

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