PASSPORT BY MOLINA HEALTHCARE

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

# 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 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:
ATTN: MEMBERSHIP ACCOUNTING
Passport by Molina Healthcare
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 Passport by Molina Healthcare at (833) 912-1592 TTY users can call 711.
Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
En español: Llame a Passport by Molina Healthcare at (833) 912-1592 (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.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to 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.

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

Select the plan you want to join:

☐ KY H1799-003-002 HMO D-SNP $0 per month

Effective Date of Coverage: _____

| First name: | Last name: | Middle Initial: |
|---|---|---|
| Birth date: (MM/DD/YYYY)<br>(___/___/_____) | Sex:<br>☐ Male ☐ Female | Phone number:<br><br>Alternative or Mobile 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: |
|---|---|---|

**Emergency Contact Information:**

| First name: | Last name: |
|---|---|
| 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 Passport by Molina Healthcare? ☐ Yes ☐ No

| Name of other coverage: | Member number for this coverage: | Group number for this coverage: |
|---|---|---|
| _____ | _____ | _____ |

Are you enrolled in your state Medicaid program? ☐ Yes ☐ No

Medicaid Number: _____

**IMPORTANT: Read and sign below:**

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Passport by Molina Healthcare.
- By joining this Medicare Advantage, I acknowledge that Passport by 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.
- 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 Passport by Molina Healthcare coverage begins, I must get all of my medical and prescription drug benefits from Passport by Molina Healthcare. Benefits and services provided by Passport by Molina Healthcare and contained in my Passport by Molina Healthcare "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Passport by Molina Healthcare 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: |

Members with a POA or authorized representative should submit their documents to our Passport by Molina Healthcare Service Fulfillment Team via mail or fax.

Address: Passport by Molina Healthcare, Attn: Service Fulfillment, 200 Oceangate, Ste 100, Long Beach, CA 90802
Fax #: (844) 834-2155

| Section 2 | | | |
|---|---|---|---|
| Answering these questions is your choice. You can't be denied coverage because you don't fill them out. | | | |
| Select below if you want us to send you information in a language other than English.<br>☐ Spanish | | | |
| Select one if you want us to send you information in an accessible format<br>☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD<br>Please contact Passport by Molina Healthcare at (833) 912-1592 if you need information in an accessible format other than what's listed above. We are open October 1 to March 31, Monday to Sunday, 8 a.m. ET to 11 p.m. ET, April 1 to September 30, Monday to Friday, 8 a.m. ET to 11 p.m. ET. | | | |
| Do you work? ☐ Yes ☐ No | | Does your spouse work? ☐ Yes ☐ No | |
| List your Primary Care Physician (PCP), clinic, or health center: | | | |
| Are you an existing patient: ☐ Yes ☐ No | | | |
| PCP NPI #: | | | |
| Medical Group/IPA Name: | | | |
| PCP Address: | | | |
| City: | County: | State: | ZIP Code: |
| I want to get the following materials via email or SMS. Select one or more.<br>☐ Member Communications/Documents | | | |
| E-mail address: | | | |
| Mobile Number: | | | |
| By providing your email, you consent to be emailed by Passport by Molina Healthcare, regarding important plan, benefits and healthcare information. Your email address will be handled consistent with our Privacy Policy. By providing your phone number and any future phone numbers, you consent to be texted or called by us, regarding important plan, benefits and healthcare information. Text messages are not encrypted and can be read by unauthorized persons. Message and data rates may apply. Please refer to our SMS Terms and Conditions on our website www.MolinaHealthcare.com for more details. | | | |

## 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 Passport by Molina Healthcare the Part D-IRMAA.

**Please select a premium payment option:**

☐ Get a bill

☐ Automatic deduction from your monthly Social Security benefit check

☐ Automatic deduction from your monthly Railroad Retirement Board (RRB) benefit check

## 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: _____

Agents can fax completed enrollment forms and associated documents to 1-844-541-6848
The receipt date of enrollment will be used to determine the election period in which request was made, which in turn will determine the effective date of coverage.

## Licensed Representative

Name of /Staff Member/Agent/Broker/Licensed Representative (if assisted in enrollment):

_____

National Producer Number (Agents/Brokers only): _____

ICEP/IEP: _____ AEP: _____ Other SEP (type): _____

## 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.