

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.

What happens next?

Send your completed and signed form to:
ATTN: MEMBERSHIP ACCOUNTING
Molina Healthcare
PO Box 22800
Long Beach, CA 90801

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

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.

How do I get help with this form?

Call Senior Whole Health at
(888) 566-3526. TTY users can call 711
Monday – Sunday, 8 a.m. to 8 p.m.
Or, call Medicare at 1-800-MEDICARE
(1-800-633-4227). TTY users can call
1-877-486-2048.

En español: Llame a Senior Whole Health al
(888) 566-3526, TTY: 711 lunes a domingo,
de 8 a.m. a 8 p.m., o a Medicare gratis al
1-800-633-4227 y oprima el
2 para asistencia en español y un
representante estará disponible para
asistirlo.

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:

- ☐ MA H2879-002 (HMO) \$0 per month
☐ MA H2879-004 (HMO) \$0 per month

First name:

Last name:

Birth date (MM/DD/YYYY): Sex: ☐ M ☐ F

Email:

Phone Number*: Is this a mobile number? ☐ Yes ☐ No

*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.

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

City:

State: ZIP Code:

County:

Mailing address, if different from your permanent address (PO Box allowed):

City:

State: ZIP Code:

County:

Emergency contact:

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 Senior Whole Health?

☐ Yes ☐ No

Name of other coverage:

Member number for this coverage:

Group number for this coverage:

Dual Special Needs (HMO DSNP) plans are for those who qualify for Medicare and MassHealth (Medicaid). By enrolling in this plan, you understand that you must remain enrolled in your state MassHealth (Medicaid) program to remain eligible for this plan.

Please provide your MassHealth (Medicaid) Number:

**IMPORTANT: Read and sign below:**

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Senior Whole Health.
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that Senior Whole Health 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).
- 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 Senior Whole Health coverage begins, I must get all of my medical and prescription drug benefits from Senior Whole Health. Benefits and services provided by Senior Whole Health and contained in my Senior Whole Health “Evidence of Coverage” document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Senior Whole Health 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 (MM/DD/YYYY):

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If you're the authorized representative, sign above and fill out these fields:

First name:

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Last name:

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Address:

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City:

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State:

--	--

ZIP Code:

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Phone Number:

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Relationship to enrollee:

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PRIVACY ACT STATEMENT The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 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 staff member/agent/broker (if assisted in enrollment): _____

Agent Name (Printed): _____

Signature: _____

Molina Agent or Broker Writing #: _____

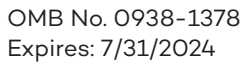
Agent Receipt Date: ____ / ____ / ____ Agent Phone #: _____

Plan ID #: _____ Effective Date of Coverage: _____

Phone #: _____

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.



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

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

☐ No, not of Hispanic, Latino/a, or ☐ Yes, Cuban

What's your race? Select all that apply.

☐ American Indian or Alaska Native ☐ Native Hawaiian

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

☐ Braille ☐ Large print ☐ Audio CD

Please contact Senior Whole Health at (888) 566-3526 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., TTY users can call 711.

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

Does your spouse work? ☐ Yes ☐ No

[illegible][illegible][illegible]

PCP Name:

First name:

Last name:

*Are you an existing member: ☐ Yes ☐ No

Provider NPI #:

Clinic/Medical Group/IPA:						
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PCP Address:

[illegible]

City:

[illegible]

State:

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ZIP Code:

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☐ Member Communications/Documents

E-mail address:

[illegible]