OMB No. 0938-1378
Expires: 7/31/2024

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.

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.

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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.

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., o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

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.

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

Select the plan you want to join:

☐ OH H9955-001 (HMO DSNP) $0 per month
☐ OH H9955-002 (HMO) $0 per month
☐ OH H9955-003 (HMO DSNP) $0 per month
☐ OH H9955-004 (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:

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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 Molina Healthcare?
☐ 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 Medicaid. By enrolling in this plan, you understand that you must remain enrolled in your state Medicaid program to remain eligible for this plan.

Please provide your Medicaid Number:

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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.
- 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 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 (MM/DD/YYYY):

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

First name:

Last name:

Address:

City:

State: ZIP Code:

Phone Number:

Relationship to enrollee:

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.

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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

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, Mexican, Mexican American, Chicano/a
☐ Yes, Cuban
☐ Yes, another Hispanic, Latino/a, or Spanish origin
☐ I choose not to answer

What's your race? Select all that apply.

☐ American Indian or Alaska Native
☐ Asian Indian
☐ Black or African American
☐ Chinese
☐ Filipino
☐ Guamanian or Chamorro
☐ Japanese
☐ Korean
☐ Native Hawaiian
☐ Samoan
☐ Vietnamese
☐ White
☐ Other Asian
☐ Other Pacific Islander
☐ I choose not to answer

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., 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:

First name:

Last name:

*Are you an existing member: ☐ Yes ☐ No

Provider NPI #:

Clinic/Medical Group/IPA:

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Section 2 (continued) – All fields on this page are optional

PCP Address:

City:

State: ZIP Code:

I want to get the following materials via email. Select one or more.

☐ Member Communications/Documents

E-mail address:

Molina Healthcare is a DSNP and HMO plan with a Medicare contract. DSNP plans have a contract with the state Medicaid program. Enrollment depends on contract renewal. 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, and geographic location. English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at (866) 403-8293 (TTY: 711). Someone who speaks English can help you. This is a free service. Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al (866) 403-8293 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.