

# 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](https://www.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:  
CCA Health California  
18000 Studebaker Rd, Suite 150  
Cerritos, CA 90703  
Or Fax to 1-866-207-6650

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

## How do I get help with this form?

Call CCA Health California at 866-333-3530. 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 CCA Health California al 866-333-3530/TTY 711 o a Medicare gratis al 1-800-633-4227 y oprima el 2 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:**

- CCA Medicare Excel (HMO) Santa Clara County- \$0 per month  
 CCA Medicare Excel (HMO) San Joaquin County- \$0 per month

FIRST name: \_\_\_\_\_ LAST name: \_\_\_\_\_ Optional: Middle Initial: \_\_\_\_\_

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

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

City: \_\_\_\_\_ Optional: 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 this 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 CCA Medicare Advantage Plans.
- By joining this Medicare Advantage, I acknowledge that CCA Health California 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 CCA Health California coverage begins, I must get all of my medical and prescription drug benefits from CCA Health California. Benefits and services provided by CCA Health California and contained in my CCA Health California “Evidence of Coverage” document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor CCA Health California 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 on this page 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, Mexican, Mexican American, Chicano/a  
 Yes, Puerto Rican       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  
 Other Asian       Other Pacific Islander       Samoan  
 Vietnamese       White  
 **I choose not to answer.**

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

- Spanish     Chinese     Korean     Vietnamese

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

- Braille     Large print     Audio CD

Please contact CCA Health California at 866-333-3530 if you need information in an accessible format other than what's listed above. Our office hours are 7 days a week, 8 am - 8 pm. 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:

### 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. DON'T pay CCA Part-D IRMAA.**

#### 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.