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APPLICATION FOR ENROLLMENT IN MEDICARE PART C (MEDICARE ADVANTAGE PLAN) or PART D (MEDICARE PRESCRIPTION DRUG PLAN)	EXHIBIT 1: MODEL INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C) OR MEDICARE PRESCRIPTION DRUG PLAN (PART D)	Rev	Revised the title so that this page is included as part of the exhibit in the enrollment guidance, especially as plans might include it in their paper applications.	Cover page, page 1 - top
Headers	Headers	Rev	For legibility, all headers were made sentence case.	Throughout document
WHO CAN USE THIS APPLICATION? • (For MA eligibility) Individuals entitled to Medicare Part A and enrolled in Part B • (For Part D eligibility) Individuals entitled to Medicare Part A and/or enrolled in Part B	Who can use this form? People with Medicare who want to join a Medicare Advantage Plan or Medicare Prescription Drug Plan	Rev	Changed "application" to "form" which is more user-friendly.	Cover page, page 1
In addition, individuals must: • Live in the MA or Part D plan's service area • Be U.S. Citizens or be lawfully present individuals in the United States	**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	Rev	Revised for clarity	Cover page, page 1
	Important: To join a Medicare Advantage Plan, you must also have both: • Medicare Part A (Hospital Insurance) • Medicare Part B (Medical Insurance)	Add	Flagged the special rule for MA enrollment since anyone with Medicare can join a Part D plan.	Cover page, page 1

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WHEN DO YOU USE THIS APPLICATION? **Use this form:** If you are newly eligible for Medicare or otherwise have a valid election period to enroll in either a Medicare Advantage plan OR Prescription Drug Plan. **NOTE:** Your Initial Coverage Election Period (ICEP) lasts for 7 months. It begins 3 months before the month you are newly eligible for Medicare (generally, your 65th birthday or 25th month of disability) and ends 3 months after the month you are newly eligible for Medicare	**When do I use this form?** You can join a plan: • Between October 15–December 7 each year (for coverage starting January1) • 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.	Rev	Simplified collection request due to comments received from PRA package and consumer testing.	Cover page, page 1
WHAT INFORMATION DO YOU NEED TO COMPLETE THIS APPLICATION? **You will need:** • Your Medicare Number • Your current address and phone number	**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 on page 1. The items on page 2 are optional — you can't be denied coverage because you don't fill them out.	Rev	Replaced header. Added (the number on your red, white, and blue Medicare card) at commenters requests. Included details of what's required to process the enrollment as well as clarify that a response to optional items had no effect on enrollment eligibility.	Cover page, page 1

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	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.	Add	Included for informational purposes to help individuals understand the required and optional fields within the form.	Cover page, page 1
WHAT'S INCLUDED WITH THE ENROLLMENT FORM? We have mandatory addenda (to be part of the application), which are optional for the beneficiary to complete; and optional addenda which are optional for the plan to include and the beneficiary to complete.		Del	Removed plan requirements to keep form beneficiary-focused.	Cover page, page 1
THINGS TO REMEMBER? • If you're signing up during open enrollment you can send your form anytime from October 15 but no later than December 7. • You (or your authorized representative) must fill out a separate form for each person enrolling in the plan. • Your plan will bill you. You can choose to sign up to have your premium payments deducted from your bank account.	**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.	Rev	Clarified per public comments that the request must be received by December 7. Added SSA and RRB as other payment options for plan premium deductions.	Cover page, page 1

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WHAT HAPPENS NEXT? Send your completed and signed application to the Medicare Advantage or Prescription Drug plan. If you have questions, call MEDICARE at 1-800-633-4227. TTY users should call 1-877-486-2048. You may call 24 hours a day 7 days per week.	**What happens next?** Send your completed and signed form to: <Plan Name> <Plan address> <Plan address> <Plan address> Once they process your request to join, they'll contact you.	Rev	Provides greater clarity. Revised to add plan specific information.	Cover page, page 1
HOW DO YOU GET HELP WITH THIS APPLICATION? **Phone**: Call MEDICARE at 1-800-633-4227. TTY users should call 1-877-486-2048. **En español:** Llame a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y unrepresentante estará disponible para asistirle.	**How do I get help with this form?** Call <Plan Name> at <phone number>. TTY users can call < phone number >. Or, call Medicare at 1-800-MEDICARE (1-800- 633-4227). TTY users can call 1-877-486-2048. **En español:** Llame a <Plan Name> al <phone number/TTY> o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.	Rev	Updated to include plan contact information. Updated Spanish translation.	Cover page, page 1

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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-NEW. The time required to complete this information is estimated to average 30 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.	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-NEW. 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.	Rev	Updated PRA form number and beneficiary burden to reflect decreased time to complete/submit an application.	PRA Disclosure: Footer on page 1 of the document

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******CMS Disclosure****** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact [Deme Umo, 410-786-8854]	**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 PMB 0939-XXXX) 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.	Rev	Plain language edits to the CMS disclosure section to inform beneficiaries not to send the completed form to CMS.	CMS Disclosure: Footer on page 1 of the document
To Enroll in <plan>, Please Provide the Following Information:	**Section 1 – All fields on this page are required (unless marked optional)**	Rev	Revised header to clarify the data fields on page 2 were required	Top of page 2

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Name of Plan You are Enrolling In:	**Select the plan you want to join:** • Product ABC – $XX per month • Product XYZ – $XX per month	Rev	Accepted comments to Include check boxes to eliminate beneficiary confusion.	Top of page 2
LAST name: FIRST Name:	FIRST name: LAST Name:	Rev	Changed order to list First then last name	Page 2
	Optional: Middle Initial	Add	Included to help plans accurately identify an enrollee	Page 2
Gender: Male Female	Sex: Male Female	Rev	Important change: CMS isnt asking for their gender identity - we're asking for their sex at birth.	Page 2
Home Phone Number:	Phone Number:	Rev	Allow the beneficiary the option to list the best number they can be reached.	Page 2
Permanent Residence Street Address (P.O. Box is not allowed):	Permanent street address (Don't enter a PO Box) :	Rev	PO Box written per USPS styling.	Page 2

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[Optional field: County:]	[Optional: County:]:	Rev	Replaced "Optional field" throughout the form to "Optional"	Page 2 and 3
[Optional field: E-mail Address: _____]		Rev	Moved to the last page of the Enrollment form	Page 3
Please Provide Your Medicare Insurance Information	**Your Medicare information:**	Rev	Revised header	Page 2
Please read and answer these important questions:	**Answer these important questions:**	Rev	Consumer testing indicated invididuals didn't fully understand the ask, so we provided examples of other prescription drug coverge. We also revised the header	Page 2
IMPORTANT: Read and sign below:	**IMPORTANT: Read and sign below:** **1st bullet now reads:** • [MA plans insert: I must keep both Part A and Part B to stay in <Plan Name>.]	Rev	Required to include on any enrollment mechasism: the requirement to keep both Part A and Part B to stay in MA.	Page 2
IMPORTANT: Read and sign below:	**IMPORTANT: Read and sign below:** **2nd bullet now reads:** • [Part D plans insert: I must keep Part A or Part B to stay in <Plan Name>.]	Add	Included the requirement to keep Part A or Part B to stay in a Part D plan.	Page 2

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IMPORTANT: Read and sign below: **2nd bullet:** • **Release of information:** By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that the plan will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that <Plan Name> will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.	**IMPORTANT: Read and sign below:** **3rd bullet:** By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that <Plan Name> will release my information to Medicare, who may use it to track beneficiary enrollment, payment and other purposes applicable to Federal statutes that authorize the collection of this information (see Privacy Act Statement below).	Rev	Revised to meet the requirement in § 422.60(c) and 423.32(b)(1) for that acknowledgement which states: 422.60(c) The election must be completed by the MA eligible individual (or the individual who will soon become eligible to elect an MA plan) and include authorization for disclosure and exchange of necessary information between the U.S. Department of Health and Human Services and its designees and the MA organization. It also includes a note to see the Privacy Act statement on the last page of the enrollment form.	Page 2
IMPORTANT: Read and sign below:	**IMPORTANT: Read and sign below:** **4th bullet now reads:** Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.	Add	The Privacy Act requires that whenever an individual is asked to supply information about himself, herself, or a family member, that the individual be completely informed about the use to be made of the information; which information is mandatory and which is voluntary; and the cost or forfeiture that might be experienced in terms of money, time, lost opportunity or other measure of value if all or some of the information is not supplied.	Page 2

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IMPORTANT: Read and sign below: **7th bullet:** • [MA plans insert: I understand that when my <Plan Name> coverage begins, I must get all of my medical and prescription drug benefits from <Plan Name>. Benefits and services authorized by <Plan Name> and contained in my <Plan Name> "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Without authorization, neither Medicare nor <Plan Name> will pay for benefits or services.]	**IMPORTANT: Read and sign below:** **7th bullet:** • [MA plans insert: I understand that when my <Plan Name> coverage begins, I must get all of my medical and prescription drug benefits from <Plan Name>. Benefits and services provided by <Plan Name> and contained in my <Plan Name> "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor <Plan Name> will pay for benefits or services not covered.]	Rev	Removed bold text as this information is no more important than the other text. Also, updated language and removed "authorized" and "authorization" language.	Page 2
	Section 2 – All fields on this page are optional	Rev	Removed plan requirements to simplify collection instrument.	Top of page 3
[Optional fields: Can you please tell us a little more about yourself. Answering these questions is voluntary and will not be used to process your enrollment. Information provided will only be used to help understand program participation for the purpose of reducing inequalities in certain groups.]	Please tell us a little more about yourself. **Answering these questions is your choice. You can't be denied coverage because you don't fill them out**. Any information you share will only be used to help us understand who joins plans for the purpose of reducing inequalities in certain groups.	Rev	Replaced language. Rather than have the plan instructions that the plan is required to ask them but its optional for the bene to answer, adjusted language so it just speaks to the beneficiary. These changes and formatting should provide enough emphasis and reminders that the info on this page is optional for the bene to complete.	Page 3

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• I decline to provide this information	• I choose not to answer.	Rev	Provides greater clarity.	Page 3
	Select one if you want us to send you information in a language other than English. [• Plans insert the langugages required in your service area.]	Rev	Separated from accessible format preference.	Page 3
Please provide language or accessible format preference: Preferred spoken language _____ Preferred written language _____ Accessible format preference (e.g., Braille, audio tape, or large print) _____ Please contact <plan name> at <phone number> if you need information in an accessible format or language other than what is listed above. Our office hours are <insert days and hours of operation>. TTY users should call <TTY number.>	Select one if you want us to send you information in an accessible format. • Braille • Large print • Audio CD Please contact <plan name> at <phone number> if you need information in an accessible format other than what's listed above. Our office hours are <insert days and hours of operation>. TTY users can call <TTY number.>	Rev	Provides clarity.	Page 3
Do you or your spouse work? 0 Yes 0 No	Do you work? Yes No Does your spouse work? Yes No	Rev	Separated language.	Page 3

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[Optional field: **Please choose the name of a Primary Care Physician (PCP), clinic or health center:**]	List your Primary Care Phsyician (PCP), clinic, or health center:	Rev	Removed bold and Optional Field.	Page 3
[Optional field: **Electronic Delivery of Plan Specific Materials: Choose one** • I opt/choose to receive **all** plan specific • I opt/choose to receive only the following plan related materials electronically: {plans may list those types or categories of materials that are available for electronic delivery} Plans may also include information needed to sign up for portals or other mechanisms to receive materials electronically.]	I want to get the following materials via email. Select one or more. • [Plans may list those types or categories of materials that are available for electronic delivery] E-mail address:	Rev	Updated for plans to include only those materials available for electronic delivery	Page 3

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[Optional field: **Paying Your Plan Premiums:** MA-only, MA-PD plans and Part D plans with premiums insert: **You can pay your monthly plan premium** [MA-PD plans with premiums insert: **(including any late enrollment penalty that you currently have or may owe)] by mail** <insert optional methods: **"Electronic Funds Transfer (EFT)", "credit card"> each month <insert optional intervals, if applicable, for example "or quarterly">. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.]** [MA-PD and PDPs with premiums insert: **If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT pay [insert appropriate plan and/or organization name] the Part D-IRMAA.]**	Paying your plan premiums [Plans with premiums insert: You can pay your monthly plan premium [MA-PD plans with premiums insert: (including any late enrollment penalty that you currently have or may owe)] by mail <insert optional methods: "Electronic Funds Transfer (EFT)", "credit card"> each month <insert optional intervals, if applicable, for example "or quarterly">. **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.**] [MA-PD and PDPs with premiums insert: **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 [insert appropriate plan and/or organization name] the Part D-IRMAA.]	Rev	Provides greater clarity. Replaced bold text to those most important to the beneficiary.	Page 3

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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,	Add	Added to meet HIPAA Privacy Rule requirements which, at a minimum, includes the authority, purpose, routine uses and disclosure.	Page 3- bottom

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