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Exhibit 1: MODEL INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE PRESCRIPTION DRUG PLAN (PART D)

Who can use this form?

People with Medicare who want to join a 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 Prescription Drug Plan, you must also have either, or 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 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.

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:
<Plan Name>
<Plan address>
<Plan address>
<Plan address>

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

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.

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.

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

Select the plan you want to join:

☐ Product ABC – $XX per month ☐ Product XYZ – $XX per month

FIRST name:	LAST name:	[Optional: Middle Initial]:

Birth date: (MM/DD/YYYY) (__ __/__ __/__ __ __ __)	Sex: ☐ Male ☐ Female	Phone number: ( )

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:

[*PDPs insert:*
Will you have other prescription drug coverage (like VA, TRICARE) in addition to < Plan>? ☐ Yes ☐ No

Name of other coverage: _____ Member number for this coverage: _____ Group number for this coverage _____]

[Special Needs Plans] insert question(s) regarding the required special needs criteria]

IMPORTANT: Read and sign below:

- [*Part D plans insert:* I must keep Hospital (Part A) or Medical (Part B) to stay in <Plan Name>.]
- By joining this Medicare Prescription Drug Plan, I acknowledge that <Plan Name> 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 Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another Part D plan.
- [*MA-PD 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 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, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban
- ☐ **I choose not to answer.**

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native

Asian:

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

- ☐ Black or African American

Native Hawaiian and Pacific Islander:

- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

- ☐ White
- ☐ **I choose not to answer.**

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

[☐ Plans insert the languages required in your service area.]

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.>

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

List your Primary Care Physician (PCP), clinic, or health center:

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:

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.**]

[*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.** DON'T pay [*insert appropriate plan and/or organization name]* the 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 1860D-1 of the Social Security Act and 42 CFR §§ 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.