OMB No. 0938-1378
Expires: 7/31/2023

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.
- Your plan will send you a monthly invoice for the plan's premium and any applicable Late Enrollment Penalty and/or Optional Supplemental Benefit (OSB). 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:

BayCarePlus Medicare Advantage
P.O. Box 12487
St. Louis, MO 63132

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

How do I get help with this form?
Call **BayCare**Plus Medicare Advantage at (866) 947-5820 (TTY: 711).

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a **BayCare**Plus Medicare Advantage al (866) 947-5820 (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.

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.

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.

Please contact **BayCare**Plus Medicare Advantage (HMO) Sales at (866) 947-5820 if you need assistance completing this form. TTY users call the national relay service toll free at 711.

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

Select the plan you want to join:

☐ **BayCare**Plus Complete (HMO)–001 (Hillsborough, Pasco, Pinellas, and Polk counties) $0 per month

☐ **BayCare**Plus Rewards (HMO)–002 (Hillsborough, Pasco, Pinellas, and Polk counties) $0 per month

☐ **BayCare**Plus Premier (HMO)–003 (Hillsborough, Pasco, Pinellas, and Polk counties) $34 per month

Optional Supplemental Benefits: Comprehensive Dental ☐ Yes ☐ No

You can add optional supplemental benefits (comprehensive dental services) for an additional $25 per month. The monthly premium for your supplemental benefits will be in addition to your monthly plan premium and/or Late Enrollment Penalty.

FIRST Name:	LAST Name:	Middle Initial (Optional):

Birth Date: (__ __/ __ __/ __ __ __ __) (M M/ D D/ Y Y Y Y)	Sex: ☐ Male ☐ Female	Phone Number (select primary phone number): ☐ Mobile: ( ) ☐ Home: ( )

Permanent Residence street address (Don't enter a PO Box):		County (Optional):
City:	State:	Zip Code:

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

Street Address:

City:	State:	Zip Code:

E-mail address (Optional):

Your Medicare Information

Medicare Number: __ __ __ __- __ __ __ - __ __ __ __

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to **BayCare**Plus Medicare Advantage? ☐ Yes ☐ No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage.

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 **BayCare**Plus Medicare Advantage.
- By joining this Medicare Advantage plan, I acknowledge that **BayCare**Plus will share my information with Medicare, who may use it to track my enrollment, and with other plans 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.
- 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 **BayCare**Plus coverage begins, I must get all of my medical and prescription drug benefits from **BayCare**Plus. Benefits and services provided by **BayCare**Plus and contained in my **BayCare**Plus "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor **BayCare**Plus will pay for benefits or services that are not covered. I will read the Evidence of Coverage document from **BayCare**Plus when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan.
- Once I am a member of **BayCare**Plus, I understand that I have the right to appeal plan decisions about payment or services if I disagree.
- I understand that enrollment in **BayCare**Plus will automatically disenroll me from any other Medicare health plan and/or prescription drug 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.

Optional Supplemental Benefits (OSB) Conditions of Enrollment: If you checked "Yes" to add OSB on page 1, please read the information below. By completing this enrollment application:

- I agree to adding the OSB, which includes comprehensive dental for $25 per month. This amount is in addition to my Medicare premium, **BayCare**Plus plan premiums, and any applicable Late Enrollment Penalty (LEP) that may apply.
- I understand the OSB is only available to members enrolled in a **BayCare**Plus plan and that disenrollment from a **BayCare**Plus plan will result in automatic disenrollment from the optional supplemental benefits.
- I understand that I must get covered care from in-network providers, except for emergency or urgently needed services. If I receive services from an out-of-network provider, I will be responsible for all costs associated with those services.
- I understand that if I disenroll from the OSB, I won't be eligible to enroll again until the next **BayCare**Plus valid OSB enrollment period.
- I understand that if I fail to pay the monthly premium for the OSB, I will lose the OSB but will remain enrolled in **BayCare**Plus.

Signature:	**Today's Date:**

If you are the authorized representative, sign above and fill out these fields:			
Name:	Relationship to Enrollee:	Phone Number:	
Address:	City:	State:	Zip Code:

Section 2 - All fields on this section 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 ☐ French Creole ☐ Vietnamese ☐ Portuguese ☐ Chinese

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

☐ Braille ☐ Large Print

Please contact **BayCare**Plus Medicare Advantage at (866) 947-5820 if you need information in an accessible format or language other than what's listed above. Our office hours are 8am-8pm, seven days a week. You may receive a messaging service on weekends from April 1 through September 30 and holidays. TTY users can call 711.

List your BayCarePlus network primary care physician (PCP), clinic or health center:

Primary Care Physician (PCP): Dr. ____________________ (First Name) (Last Name)	PCP # from Provider Directory: ☐☐☐☐☐☐☐☐☐☐	Is this your current physician? ☐ Yes ☐ No

PLEASE READ THIS IMPORTANT INFORMATION

If you currently have health coverage from an employer or union, joining BayCarePlus Medicare Advantage could affect your employer or union health benefits. You could lose your employer or union health coverage if you join BayCarePlus Medicare Advantage. Read the communications your employer or union sends you. If you have questions, visit their website or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Paying your plan premiums

Whether you are enrolled in a premium or non-premium plan, you may pay your plan premium and any applicable Late Enrollment Penalty and/or OSB that you have or may owe **by automatic deduction from your Social Security (SSA) or Railroad Retirement Board (RRB) benefit check**. You may also choose to pay by Electronic Funds Transfer (EFT) or check via mail 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. 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 **BayCare**Plus Medicare Advantage the Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs, including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you do not select one of the payment options below, you will receive a monthly invoice.

Please select a premium payment option:

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: ___ Social Security ____ RRB

It can take up to 90 days to receive SSA/RRB withhold acceptance. SSA/RRB will begin deducting on the date of acceptance. Members will receive an invoice for any months prior to the withhold acceptance date by SSA/RRB, which will be their responsibility to pay. In limited circumstances, Medicare may not allow for the SSA/RRB deduction option and may instruct the plan to directly bill the member. If this occurs, you will be notified in writing.

☐ Electronic Funds Transfer (EFT) from your bank account each month.

If you choose to have the funds taken directly out of your checking account, this is referred to as Electronic Funds Transfer (EFT). If you elect this method of payment, you will receive a letter from the plan requesting a Voided Check be returned with the letter for account setup. Do not submit a voided check at time of enrollment. Your request will be processed within 60 business days of receipt of returned voided check and letter. Premiums are deducted from your bank account on the 2nd day of the month for the current month's coverage.

☐ Direct Pay

You will receive a monthly invoice containing payment instructions.

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.

FOR OFFICE USE ONLY						
Confirmation # (Quick Entry or Phone Enroll):			**Application Log #**:			
Plan ID #:			**Effective Date of Coverage**:			
Election Periods:	☐ **ICEP (I)**	☐ **IEP (E)**	☐ **2nd IEP (F)**	☐ **AEP (A)**	☐ **OEP (M)**	☐ **OEPI (T)**

Special Election Periods: (Must check all that apply)

SEP (S)
- ☐ SPAP (38)
- ☐ Loss of SNP (35)
- ☐ Retro Entitlement (32)
- ☐ Involuntary Loss/Cred. Coverage (22)
- ☐ Contract/Plan Non-Renewal (12)
- ☐ Contract Violations
- ☐ Contract Term – Immediate (11)
- ☐ Contract Term – MAO (12)
- ☐ Contract Term – CMS (11)
- ☐ CMS Sanction (23)
- ☐ FEMA/Disaster (01)
- ☐ Plan Placed in Receivership (39)
- ☐ CMS Identified Consistent Poor Performing Plan (40)
- ☐ Accessible Format Delay (21)
- ☐ Inv. Dis. – Loss of Part B (25)
- ☐ PACE Transition (27)
- ☐ Cost Plan Non-Renewal (28)
- ☐ Drop Medigap in Trial Period (29)
- ☐ Additional Part D IEP Eligibility (31)
- ☐ Part B General Enrollment (34)
- ☐ Lawfully Present (37)
- ☐ COVID-19 Disaster (02)

SEP (V)
- ☐ Permanent Move

SEP (W)
- ☐ Gain or Loss of Employer Coverage

SEP (L) Allowed once per Quarter
- ☐ Dual Eligible/Has Medicaid
- ☐ Has Non-Dual with LIS

SEP (U)
- ☐ Gain/Loss/Change in Dual Eligible Status
- ☐ Gain/Loss/Change of Medicaid
- ☐ Gain/Loss/Change in Non-Dual LIS

SEP (R)
- ☐ 5-Star SEP

Producer Name:	**Producer NPN:**	**Application Receipt Date**:

Please return completed application to:
BayCarePlus Medicare Advantage
P.O. Box 12487
St. Louis, MO 63132

Please call (866) 947-5820 for more information, including free language translation services, regarding your **BayCare** Select Health Plans. TTY users call the national relay service toll free at 711. Our telephone lines are open 8am-8pm, seven days a week. You may receive a messaging service on weekends from April 1 through September 30 and holidays. Please leave a message and your call will be returned the next business day. **BayCare** Select Health Plans is an HMO plan with a Medicare contract. Enrollment in **BayCare** Select Health Plans depends on contract renewal. You must continue to pay your Medicare Part B premium.