OMB No. 0938-1378
Expires: 02/28/2029

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 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 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?

For Consumers not working with a Broker/Agent send your completed and signed form to:
UCLA Health Medicare Advantage Plan (HMO)
Attn: Medicare Advantage Enrollment & Billing Dept
P O Box 211622
Eagan, MN 55121-3622
Enrollment Fax: (424) 320-8515
Enrollment Email: HPEnrollment@uhmap.com

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

If you are working with a Broker/Agent, please contact them for help and to submit this form. Attention Brokers/Agents – This form should be submitted electronically unless a paper application was completed, in which case it should be faxed.

How do I get help with this form?

Call UCLA Health Medicare Advantage Plan at (833) 627-8252. TTY users can call (800) 735-2929, Voice (800) 735-2922.

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

En español: Llame a UCLA Health Medicare Advantage Plan al (833) 627-8252 TTY 711 Numero gratuito 800-735-2929 Numero de voz 800-735-2922 o a Medicare gratis al 800-633-4227 y oprima el 8 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:

☐ H4647-001 UCLA Health MA Principal Plan $0.00 per month

☐ H4647-002 UCLA Health MA Prestige Plan $45.00 per month

FIRST name:	LAST name:	Middle Initial:
Birth date: (MM/DD/YYYY) (/ /)	Sex: ☐ Male ☐ Female	Home phone number: ( ) Mobile phone number: ( )

Permanent Residence street address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):

City:	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 UCLA Health Medicare Advantage 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 UCLA Health Medicare Advantage Plan.
- By joining this Medicare Advantage Plan, I acknowledge that UCLA Health Medicare Advantage Plan 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 UCLA Health Medicare Advantage Plan coverage begins, I must get all of my medical and prescription drug benefits from UCLA Health Medicare Advantage Plan. Benefits and services provided by UCLA Health Medicare Advantage Plan and contained in my UCLA Health Medicare Advantage Plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor UCLA Health Medicare Advantage Plan will pay for benefits or services that are not covered.
- By providing my phone number and any future phone numbers, I consent to receive automated calls and text messages from or on behalf of UCLA Health Medicare Advantage Plan, including information regarding my plan benefits, treatment, eligibility, renewal, and products or services that may be of interest to me. I acknowledge that text messages are not encrypted and can be read by unauthorized persons. Message frequency varies. Message and data rates may apply. I can opt out at any time by contacting 1-833-627-8252.
- 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 in 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

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

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact UCLA Health Medicare Advantage Plan at (833) 627-8252 if you need information in an accessible format other than what's listed above. Our office hours are 8am - 8pm PT, Monday - Friday, April 1 through September 30, except on all federal holidays. Hours are 8am - 8pm PT, 7 days a week, October 1 through March 31, except Thanksgiving Day and Christmas Day. TTY users can call (800) 735-2929, Voice (800) 735-2922.

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

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

By providing my email, I consent to receiving marketing and communication regarding my plan.

☐ Email address:

☐ By checking this box, I agree to receive automated marketing calls and text messages from or on behalf of UCLA Health Medicare Advantage Plan at the phone number provided. I understand my consent is not a condition of any purchase or service. Message frequency varies. Message and data rates may apply. Reply HELP for help and STOP to cancel. You acknowledge that text messages are not encrypted and can be read by unauthorized persons.

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, "Electronic Funds Transfer (EFT)", "credit card", or "debit card" each month. You can set up monthly payments, including automatic deductions via EFT, credit card, and debit through UCLA Health Medicare Advantage Plan's MyChart Member Portal.

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 UCLA Health Medicare Advantage Plan (HMO) the Part D-IRMAA.

Please select a premium payment option:

☐ Direct Bill - get a monthly invoice

☐ Automatic deduction from your monthly Social Security (SSA) benefit check.

☐ Automatic deduction from your monthly Railroad retirement Board (RRB) benefit check.

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name: _____ Relationship to enrollee: _____

Signature: _____ National Producer Number (Agents/Brokers only): _____

Licensed Representatives/OFFICE USE ONLY

Name of Agent/Broker/License Representative: _____

Agent/Broker Enrollment Receipt Date: _____ Agent/Broker Phone number: _____

Enrollment Proposed Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ SEP(Type): _____

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.

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 and 1860D-1 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.