Clover Health

OMB No. 0938-1378
Expires 7/31/2024

EXHIBIT 1: 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 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 in your completed and signed form:

Mail:
Clover Health
P.O. Box 2090
Jersey City, NJ 07303

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

How do I get help with this form?

Call Clover Health at 1-877-618-8110 (TTY 711).

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

En español: Llame a Clover Health al 1-877-618-8110 (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 shelter, or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

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.

Clover Health

2023 Tennessee Enrollment Form

Section 1 – All fields in this section are required (unless marked optional)			
Select the plan you want to join:			
☐ **033 Clover Health Choice (PPO)**—$0 premium per month (Bledsoe, Davidson, Hamilton, Marion, Polk, Rutherford, Sequatchie, and Williamson counties)			
To enroll with Clover Health, please provide the following information:			
FIRST Name:	**LAST Name:**	**MIDDLE INITIAL** (optional):	
Birth Date (MM/DD/YYYY):		**Sex:** ☐ Male ☐ Female	
Primary Phone Number: ☐ Land Line ☐ Mobile		**Alternate Phone Number:** ☐ Land Line ☐ Mobile	

By providing your mobile number and opting in to receive text communications (message and data rates may apply), you consent to receiving information related to your membership with Clover Health via text message (SMS). Texts may include, but are not limited to, application submission confirmation, health plan materials, notification of programs and services available to you, health reminders and marketing communications.

You may opt out of text messages at any time by texting 'STOP' in response to a text message, or by contacting Clover Health Member Services at 1-888-778-1478.

Permanent Residence Street Address (Don't enter a P.O. Box):			
City:	**State:**	**County** (optional):	**ZIP Code:**
Mailing Address, if different from your permanent address (P.O. Box allowed):			
City:	**State:**	**County** (optional):	**ZIP Code:**
Email Address (optional):			

By providing your email address, you consent to receiving information related to your membership with Clover Health via email. Emails may include, but are not limited to, application submission confirmation, health plan materials, notification of programs and services available to you, health reminders, and marketing communications.

You may opt out of email communications at any time by clicking the 'UNSUBSCRIBE' link within any email message, or by contacting Clover Health Member Services at 1-888-778-1478. You may also request a hard copy of any material that Clover Health delivers via email.

Name: _____ **Date:** _____

Your Medicare Information:
Medicare Number:

Answer these important questions:		
Will you have other prescription drug coverage (like VA, TRICARE) in addition to Clover Health? ☐ Yes ☐ No		
Name of other coverage:	**Member # for this coverage:**	**Group # for this coverage:**
_____	_____	_____

IMPORTANT: Please read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Clover Health.
- By joining this Medicare Advantage plan, I acknowledge that Clover Health 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 Clover Health coverage begins, I must get all of my medical and prescription drug benefits from Clover Health. Benefits and services provided by Clover Health and contained in my Clover Health "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Clover Health 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 are the authorized representative, sign above and fill out these fields:	
Name:	**Address:**
Phone Number:	**Relationship to the Enrollee:**

Clover Health is a Preferred Provider Organization (PPO) and a Health Maintenance Organization (HMO) with a Medicare contract. Enrollment in Clover Health depends on contract renewal. You must continue to pay your Medicare Part B premium.

Name: _____ **Date:** _____

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.

Check the box if you want us to send you information in a language other than English.

☐ Spanish

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
☐ Samoan
☐ White
☐ Other Pacific Islander
☐ I choose not to answer.
☐ Vietnamese

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

☐ Braille ☐ Large Print ☐ Audio CD

Please contact Clover Health at 1-877-618-8110 (TTY 711) if you need information in an accessible format other than what's listed above. Our office hours are 8 am–8 pm local time, 7 days a week.*

Do you work? ☐ Yes ☐ No

Does your spouse work? ☐ Yes ☐ No

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

Street Address **Phone Number**

_____

I want to get the following materials via email. Select one or more.

☐ Evidence of Coverage (EOC) ☐ Provider Directory ☐ Pharmacy Directory ☐ Formulary

Email Address: _____

Name: _____ **Date:** _____

Paying your Plan Premium	
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 Clover the Part D-IRMAA.	
☐ **Get a bill**	☐ **SSA**
☐ **Electronic Funds Transfer** **Account Holder Name:** _____ **Bank Routing Number:** _____ **Bank Account Number:** _____ **Account Type:** ☐ **Checking** ☐ **Savings**	

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.

*Between April 1st and September 30th, alternate technologies (for example, voicemail) will be used on the weekends and holidays.

Section 3 – Office Use Only:			
Name of Staff Member/Agent/Broker (if assisted in enrollment):			
Agent/Broker ID #:		**Received Date:**	
Plan ID:		**Effective Date of Coverage:**	
ICEP/IEP:	**AEP:**	**SEP** (type):	**Not Eligible:**