

## 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](https://www.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.

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.

### 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 Alabama Enrollment Form

Section 1 – All fields in this section are required (unless marked optional)			
<b>Select the plan you want to join:</b>			
<b>052 Clover Health LiveHealthy (PPO)</b> —\$0 premium per month (Chambers, Cherokee, Clay, Cleburne, Macon, Randolph, and Russell counties)			
<b>053 Clover Health LiveHealthy Value (PPO)</b> —\$35.20 premium per month (Chambers, Cherokee, Clay, Cleburne, Macon, Randolph, and Russell counties)			
<b>To enroll with Clover Health, please provide the following information:</b>			
<b>FIRST Name:</b>		<b>LAST Name:</b>	
		<b>MIDDLE INITIAL (optional):</b>	
<b>Birth Date (MM/DD/YYYY):</b>		<b>Sex:</b>	
		Male      Female	
<b>Primary Phone Number:</b>		<b>Alternate Phone Number:</b>	
Land Line	Mobile	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.			
<b>Permanent Residence Street Address (Don't enter a P.O. Box):</b>			
<b>City:</b>	<b>State:</b>	<b>County (optional):</b>	<b>ZIP Code:</b>
<b>Mailing Address, if different from your permanent address (P.O. Box allowed):</b>			
<b>City:</b>	<b>State:</b>	<b>County (optional):</b>	<b>ZIP Code:</b>
<b>Email Address (optional):</b>			
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:	
<ul style="list-style-type: none"><li>• I must keep both Hospital (Part A) and Medical (Part B) to stay in Clover Health.</li><li>• 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.</li><li>• 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).</li><li>• 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.</li><li>• 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.</li><li>• 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:<ul style="list-style-type: none"><li>1) This person is authorized under state law to complete this enrollment, and</li><li>2) Documentation of this authority is available upon request by Medicare.</li></ul></li></ul>	
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: