

EOMB No. 0938-1373 Expires 12/31/2026

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

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)

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 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

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.

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:
West Virginia Senior Advantage
PO Box 3630
Little Rock, AR 72202

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

How do I get help with this form?

Call West Virginia Senior Advantage at (866) 250-6352. TTY/TDD users can call 711.

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

En español: Llame a West Virginia Senior Advantage, al (866) 250-6352, (TTY/TDD 711) 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:
 ISNP

FIRST Name: _____ LAST Name: _____ Optional: Middle Initial: _____

Birth Date: (MM/DD/YYYY) _____ Sex: _____ Phone number: _____
 (/ /) Male Female ()

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 (Optional): _____ 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, pension plan) in addition to West Virginia Senior Advantage? Yes No

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

Are you enrolled in your State Medicaid program? Yes No
 If yes: Medicaid Number: _____

Have you been a resident in or planning to reside in a long term-care facility, such as a nursing home, in West Virginia Senior Advantage network for more than 90 days? Yes No

Name of Facility: _____ Admission Date: _____

IMPORTANT: Read and sign below

- I must keep both Hospital (Part A) and Medical (Part B) to stay in West Virginia Senior Advantage's plan.
- By joining this Medicare Advantage Plan, I acknowledge that West Virginia Senior Advantage 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 or Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA or Part D plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my West Virginia Senior Advantage coverage begins, I must get all of my medical and prescription drug benefits from West Virginia Senior Advantage. Benefits and services provided by West Virginia Senior Advantage and contained in my West Virginia Senior Advantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor West Virginia Senior Advantage 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:

Would you like enrollee's plan mail to be sent to the address listed below?

If other, please note mailing address above.*

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.

Let us know if you want us to send you information in a language other than English

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

Braille Large print Audio CD Data CD

Please contact West Virginia Senior Advantage at (866) 250-6352 if you need information in an accessible format other than what's listed above. Our office hours are 8:00 a.m. to 8:00 p.m. Eastern seven days a week October 1 through March 31 (8:00 a.m. to 8:00 p.m. Eastern Monday through Friday April 1 through September 30). TTY/TDD users can call 711.

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:

Provider Directory Pharmacy Directory Formulary Summary of Benefits
 Evidence of Coverage Non-Discrimination Notice Notice of Privacy Practices

Email address:

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mailing a check 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 West Virginia Senior Advantage the Part D-IRMAA.

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): _____

For Health Plan Use Only

Agent Name: _____ Agent NPI ID _____

Receipt Date of Application: _____ Proposed Effective Date: _____

ICEP/IEP AEP OEPI SEP (Type) _____ Not Eligible

Sales Agent Signature Attestation:

I do hereby attest that the information within this application is true and accurate to the best of my knowledge and that I witnessed the above signed enrollee sign the enrollment application.

Sales Agent Signature

Date

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 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.