Clover Health

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

EXHIBIT 1: 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 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?

Send your completed and signed form to:

By Mail:
Clover Health
PO Box 2090
Jersey City, NJ 07303

By Fax:
1-732-993-6650

By E-Mail:
PO_Box_2090@cloverhealth.com

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

How do I get help with this form?

Call Clover Health at 1-888-778-1478.
TTY users can call 711.
Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Clover Health al 1-888-778-1478, 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.

Clover Health 2021 Arizona Enrollment Form

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

Please check which plan you want to enroll in:	
☐	**040 Clover Health Choice (PPO)**—$0 premium per month (Pima county)

To enroll with Clover Health, please provide the following information:			
FIRST Name:	**LAST Name:**	**MI** (optional):	
Birth Date (MM/DD/YYYY): __ __/__ __/__ __ __ __		**Sex:** ☐ Male ☐ Female	
Home Phone Number: (__ __ __) __ __ __ - __ __ __ __		**Alt Phone Number:** (__ __ __) __ __ __ - __ __ __ __	
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 and phone number(s), you consent to receiving information related to your membership with Clover Health (e.g., benefit information), programs and services offered (e.g., health education materials, reminders), marketing and other communications (e.g., newsletters, surveys) electronically. Communications related to your membership with Clover Health or healthcare may include auto-dialed calls, pre-recorded or electronic voice messages, or text messages. You may opt out of these means of communication at any time by clicking the "opt out" link within any email message, or contacting Clover Health, or responding STOP to a text message. You may also request a hard copy of any material that Clover Health delivers electronically.

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: _____ ID # for this coverage: _____ Group # for this coverage: _____

Please read and sign below:

By completing this enrollment application, I agree to the following:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Clover Health.
- By joining this Medicare Advantage Plan or Medicare Prescription Drug 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.
- 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 county, except for limited coverage near the U.S. border.
- 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.
- 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) plan and a Health Maintenance Organization (HMO) plan 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 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

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

☐ Braille ☐ Large Print ☐ Audio CD
Please contact Clover Health at 1-888-778-1478 if you need information in an accessible format other than what's listed above. Our office hours are 8am-8pm, local time, 7 days a week*. TTY 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: _____

Name/Facility	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: _____

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, "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. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB).
DO NOT 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.

Name: _____ **Date:** _____

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:**