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

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

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.

What happens next?

Send your completed and signed form to:
OneCare (HMO D-SNP)
505 City Parkway West Orange,
CA 92868

Once they process your request to join, they will contact you.

How do I get help with this form?

Call OneCare at **1-877-412-2734**. 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 OneCare al **1-877-412-2734**. TTY al **711** o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en españoly 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

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OneCare
CalOptima Health

OneCare (HMO D-SNP), a Medicare Medi-Cal Plan Individual Enrollment Form

Section 1 – All fields on this page are required (unless marked optional)			
Select the plan you want to join: ☐ OneCare (HMO D-SNP) – $0 per month			
FIRST name:	LAST name:	[Optional: Middle Initial]:	
Birth date: (MM/DD/YYYY) (_____/____/_____)	Sex: ☐ Male ☐ Female	Phone number:	
Permanent residence street address (Do not enter a PO Box):			
City:	[Optional: County]:	State:	ZIP Code:
Mailing address, if different from your permanent address (PO Box allowed): Street address:	City:	State:	ZIP Code:
Emergency Contact: _____ **Phone Number**:_____ **Relationship to You:** _____			
Your Medicare information:			
Medicare Number: _ _ _ _ - _ _ _ - _ _ _ _			
Answer these important questions:			
Will you have other prescription drug coverage (like VA, TRICARE) in addition to OneCare? ☐ Yes ☐ No Name of other coverage: _____ Member number for this coverage: _____ Group number for this coverage _____			
Are you enrolled in your state Medicaid (Medi-Cal) program? ☐ Yes ☐ No If "yes," please provide your Medicaid 9-digit number (Client Index Number (CIN)): _____			

IMPORTANT: Read and sign below:	
• I must keep both Hospital (Part A) and Medical (Part B) to stay in OneCare. • By joining this Medicare Advantage Plan, I acknowledge that OneCare will share my information with Medicare, who may use it to track my enrollment, to make payments, and forother 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 OneCare coverage begins, I must get all of my medical and prescription drug benefits from OneCare. Benefits and services provided by OneCare and contained in my OneCare "Evidenceof Coverage/Member Handbook" document (also known as a member contract or subscriber agreement) will be covered. NeitherMedicare nor OneCare 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:	
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.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban
- ☐ **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
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ **I choose not to answer.**

Select one if you want us to send you information in a language other than English.

☐ Spanish ☐ Vietnamese ☐ Farsi ☐ Arabic ☐ Chinese ☐ Korean

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

☐ Braille ☐ Large print ☐ Audio CD

Please contact OneCare at **1-877-412-2734** if you need information in an accessible format other than what's listed above. Our office hours are Monday through Friday from 8:00 a.m. to 5:00 p.m. 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:

Office Use Only:

Plan ID #: _____

Effective Date of Coverage: IEP: AEP: SEP: ICEP (type): _____

Name of Plan Representative/agent/broker: _____

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.

OneCare (HMO D-SNP), a Medicare Medi-Cal Plan, is a Medicare Advantage organization with a Medicare Contract. Enrollment in OneCare depends on contract renewal. OneCare complies with applicable federal civil rights laws and does not discriminateon the basis of race, color, national origin, age, disability, or sex. Call OneCare Customer Service toll-free at **1-877-412-2734** (TTY **711**), 24 hours a day, 7 days a week. Visit us at **www.caloptima.org/OneCare**.

Enclosures:

- Notice of Nondiscrimination Insert [Material ID: H5433_23MM003_C]
- Multi-Language Insert [Material ID: IR23_MM002_H5433_H7501]