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 your completed and signed form to:

Mail:
Clover Health
P.O. Box 21164
Eagan, MN 55121

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

2024 Pennsylvania Enrollment Form

Section 1 – All fields in this section are required (unless marked optional)

Select the plan you want to join:

☐ **038 Clover Health Choice (PPO)**—$0 premium per month
(Bucks, Delaware, and Philadelphia 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.

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:**

Name: _____ **Date:** _____

IMPORTANT: Please read and sign below:

By completing and submitting this enrollment application for a Clover Medicare Advantage plan, I attest/understand that:

- I am requesting enrollment in a Clover Health Medicare Advantage plan.
- The information on this enrollment form is correct to the best of my knowledge and that if I intentionally provide false information, I will be disenrolled from the plan.
- The plan I have chosen is not a Medicare Supplemental (Medigap) plan.
- Clover Health will share my information with Medicare/CMS, 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 (or my agent, when applicable) reviewed the plan's premium, deductibles, covered benefits, associated copay/coinsurance and determined that the plan selected fits my needs.
- I have received/reviewed the plan's Summary of Benefits.
- I must keep both Hospital (Part A) and Medical (Part B) to stay enrolled in Clover Health.
- I can be enrolled in only one Medicare Advantage (Part C) plan at a time, therefore enrollment in this Clover plan will automatically terminate my enrollment in any other Medicare Advantage plan (exceptions apply for Medicare Advantage Private Fee For Service (PFFS) or Medicare Advantage Medicare Medical Savings Account (MSA) plans).
- My Clover plan will provide my Medicare health and/or prescription drug coverage and I will use my Clover ID card instead of my Medicare card when I require medical services or visit the pharmacy.
- I understand that when my Clover plan coverage begins, I must get all of my medical and prescription drug benefits from Clover. Benefits and services provided by Clover and contained in my Clover "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Clover will pay for benefits or services that are not covered.
- Out-of-network providers are not required by law to accept Clover members (except for emergency or urgently needed services or out-of-area dialysis).
- Any federal or state subsidies I may have or am eligible for is not determined nor governed by Clover. I have been educated about these programs and assisted with enrollment by my agent (when applicable).
- 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 below), 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.

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:
  - ☐ Asian Indian
  - ☐ Chinese
  - ☐ Filipino
  - ☐ Japanese
  - ☐ Korean
  - ☐ Vietnamese
  - ☐ Other Asian
- ☐ Black or African American
- Native Hawaiian or Pacific Islander:
  - ☐ Guamanian or Chamorro
  - ☐ Native Hawaiian
  - ☐ Samoan
  - ☐ Other Pacific Islander
- ☐ White
- ☐ **I choose not to answer.**

Check the box 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 1-877-618-8110 (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 1 and September 30, alternate technologies (for example, voicemail) will be used on the week-ends and holidays.

Section 3			
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:**