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.
- 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:

Solis Health Plans
9250 NW 36 Street, Suite 400
Doral, Florida 33178

By Fax:

305-675-0933

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

How do I get help with this form?

Call Solis Health Plans at 1-844-447-6547. 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 Solis Health Plans al 1-844-447-6547(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 a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

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-NEW. 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.

SOLIS HEALTH PLANS

Proposed Effective Date: _____

2025 Enrollment Request Form

Please contact Solis Health Plans if you need information in another language or format (Braille).

To enroll in Solis Health Plans, please select the plan you'd like to join:

SOUTH FLORIDA

MIAMI-DADE	
☐ **Solis Healthy Living Plan** (HMO) H0982-022	$0 Premium
☐ **Solis Guardian Plan** (HMO D-SNP) H0982-002	$0-$20.30 Premium
☐ **Solis Wellness Plan** (HMO C-SNP) H0982-016	$0 Premium
☐ **Solis Balanced Plan** (HMO C-SNP) H0982-027	$0 Premium
BROWARD	
☐ **Solis Healthy Living Plan** (HMO) H0982-007	$0 Premium
☐ **Solis Guardian Plan** (HMO D-SNP) H0982-012	$0-$20.30 Premium
☐ **Solis Wellness Plan** (HMO C-SNP) H0982-017	$0 Premium
PALM BEACH	
☐ **Solis Healthy Living Plan** (HMO) H0982-008	$0 Premium
☐ **Solis Guardian Plan** (HMO D-SNP) H0982-013	$0-$20.30 Premium
☐ **Solis Wellness Plan** (HMO C-SNP) H0982-018	$0 Premium

CENTRAL FLORIDA

HILLSBOROUGH, PASCO, PINELLAS	
☐ **Solis Healthy Living Plan** (HMO) H0982-009	$0 Premium
☐ **Solis Guardian Plan** (HMO D-SNP) H0982-010	$0-$20.30 Premium
☐ **Solis Wellness Plan** (HMO C-SNP) H0982-019	$0 Premium
POLK	
☐ **Solis Healthy Living Plan** (HMO) H0982-020	$0 Premium
☐ **Solis Guardian Plan** (HMO D-SNP) H0982-023	$0-$20.30 Premium
☐ **Solis Wellness Plan** (HMO C-SNP) H0982-021	$0 Premium
ORANGE, OSCEOLA, SEMINOLE	
☐ **Solis Healthy Living Plan** (HMO) H0982-024	$0 Premium
☐ **Solis Guardian Plan** (HMO D-SNP) H0982-025	$0-$20.30 Premium
☐ **Solis Wellness Plan** (HMO C-SNP) H0982-026	$0 Premium

Section 1 – All fields on this page are required (unless marked optional)

First Name:	Middle Initial:(Optional)	Last Name:	
Birth Date: (MM/DD/YYYY)	Sex: ☐ Male ☐ Female	Phone Number: Email:	
Permanent Residence Street Address: (PO Box only allowed if experiencing homelessness) ☐ Experiencing Homelessness			
City:	County:	State:	Zip Code:
Mailing Street Address: (PO Box is allowed)			
City:	County:	State:	Zip Code:

Your Medicare Information

Medicare Number: _____ - _____ - _____	Effective Date - Part A: Effective Date - Part B:

Your PCP Information

Name of your Primary Care Physician (PCP):

PCP ID (Please include all digits):

Name of Clinic or Health Center:

Are you already a patient of this PCP you chose?
☐ Yes ☐ No ☐ Other:

Answer These Important Questions

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Solis?
☐ Yes ☐ No

If you answered yes to the above, please fill out the information below:

Name of other coverage:

Member number for this coverage:

Group number for this coverage:

For Special Need Plans (SNP) Only

Solis offers two SNPs:

D-SNPs for dual eligible individuals and C-SNPs for individuals with chronic conditions.
D-SNPs are SNPs that restrict enrollment to individuals who are entitled to both Medicare and medical assistance from a state plan under Medicaid.

Do have Medicaid or receive assistance from a state plan under Medicaid?

☐ YES ☐ NO Medicaid ID#: _____

C-SNPs are SNPs that restrict enrollment to special needs individuals with specific severe or disabling chronic conditions.

☐ YES ☐ NO **Have you ever been diagnosed with a cardiovascular disease (CVD), chronic heart failure (CHF), and/or diabetes?**

☐ YES ☐ NO **Have you ever been diagnosed with a bipolar disorder, major depressive disorder, paranoid disorder, schizophrenia, and/or a schizo-affective disorder?**

Election Periods

Typically, you may enroll in a Medicare Advantage plan only during the Annual Enrollment Period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an election period. If we later determine that this information is incorrect, you may be disenrolled.

☐ (IEP/ICEP/IEP2) I am new to Medicare.

☐ (AEP) Annual Enrollment Period (October 15 - December 7).

☐ (MA OEP) I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (January 1 - March 31).

☐ I recently moved outside of the service area for my current plan, or recently moved and this plan is a new option for me. I moved on (insert date) _____.

☐ I recently was released from incarceration. I was released on (insert date) _____.

☐ I recently obtained lawful presence status in the United States.
I obtained this status on (insert date) _____ .

☐ I recently had a change in my Medicaid status (new to Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____ .

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (new to Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____ .

☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.

☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (i.e. a nursing home). I moved/will move into/out of the facility on (insert date)_____ .
If moving in or out, name of facility: _____ .

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.

☐ My plan is ending its contract with Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date)_____ .

☐ I want to join a Special Needs Plan (C-SNP) that tailors its benefits to my chronic condition.

☐ I was enrolled in a Special Needs Plan (D-SNP/C-SNP) but I have lost the special needs qualification required to be in that plan. (insert date) _____ .

☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency, FEMA) or by federal, state, or local government entity. One of the other statements here applied to me, but I was able to make my enrollment request because of the disaster. Election period missed: _____ .

☐ Other: _____

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

What is your gender? Select one:

- ☐ Woman
- ☐ Man
- ☐ Non-Binary
- ☐ I use a different term: _____
- ☐ **I choose not to answer**

Which of the following best represents how you think of yourself? Select one:

- ☐ Lesbian or gay
- ☐ Bisexual
- ☐ Straight, that is, not gay or lesbian
- ☐ I don't know
- ☐ I use a different term: _____
- ☐ **I choose not to answer**

Please check one of the boxes below if you would prefer that we send you information in another language or in an accessible format:

- ☐ Spanish
- ☐ Creole
- ☐ Braille
- ☐ Large Print
- ☐ Audio CD
- ☐ Data CD

Please contact Solis Health Plans at 1-844-447-6547 if you need information in an accessible format other than what's listed above. We're available from October 1 - March 31, 7 days a week; 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday from 8 a.m. to 8 p.m.

Do you or your spouse work? ☐ Yes ☐ No

Do you have other health insurance that will cover medical services? (Examples: other employer coverage, LTD coverage, worker's compensation, auto liability, or VA benefits? If yes, please provide the following information:

Name of Health Insurance Company: _____

Member Number: _____

I want to receive the following materials via email:

Email Address: _____

Select one or more:

☐ Evidence of Coverage ☐ OTC Catalog ☐ Formulary

Paying your plan premium:

You can pay your monthly plan premium (including any late enrollment penalty that you currently or may owe) by mail. 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.

☐ Get a bill ☐ Deduction from Social Security ☐ Deduction from RRB

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. DO NOT pay Solis Health Plans the Part D-IRMAA.

IMPORTANT: Read and Sign Below

- I must keep both Hospital (Part A) and Medical (Part B) to stay enrolled in Solis Health Plans.
- By joining this Medicare Advantage Plan, I acknowledge that Solis Health Plans 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 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 Solis Health Plans coverage begins, I must get all of my medical and prescription drug benefits from Solis Health Plans. Benefits and services provided by Solis Health Plans and contained in my Solis Health Plans "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Solis Health Plans 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:

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.

AUTHORIZED REPRESENTATIVE INFORMATION ONLY

If you're the authorized representative, sign above and fill out these fields.

First Name:	Last Name:

Address:

City:	State:	Zip Code:	Phone:

Email:	Relationship to Enrollee:

☐ **I have submitted Authorized Representative documentation with this application.**

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:

Phone Number:

Relationship to the enrollee:

- ☐ Agent
- ☐ Broker
- ☐ SHIP counselor
- ☐ Authorized Representative
- ☐ Other (third party)
- ☐ Self
- ☐ **I choose not to answer**

Signature:

National Producer Number (NPN - for agents/brokers only):

Received Date:

Please ensure that you submit the Scope of Appointment with the completed Enrollment Application.

You may send the Scope of Appointment with the Enrollment Application via:

- **Fax:** 305-675-0933
- **Email:** sales@solishealthplans.com

If you need information in an accessible format or language other than what is listed above, please contact Solis Health Plans at 1-844-447-6547 (TTY: 711). From October 1 - March 31, we are open 7 days a week; 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday from 8 a.m. to 8 p.m.

Solis Health Plans, Inc. is an HMO plan with a Medicare contract. Enrollment in Solis Health Plans, Inc. depends on contract renewal. ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-447-6547 (TTY: 711).