OMB No. 0938-1378
Expires: 6/30/2026

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 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.

Zing HEALTH™

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:

Zing Health
ATTN: Enrollment Department
225 W. Washington St., Suite 450
Chicago, Illinois 60606

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

How do I get help with this form?
Call Zing Health at 1-866-946-4458. 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 Zing Health al 1-866-946-4458 TTY 711 o a Medicare gratis al 1-800-633-4227 y oprima el 8 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.

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.

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

Select the plan you want to join: **INDIANA**

- ☐ H4624-011 Zing Select Diabetes & Heart IN (HMO C-SNP)
- ☐ H6876-005 Zing Open Choice Diabetes & Heart IN (PPO C-SNP)
- ☐ H4624-026 Zing Elite Select IN (HMO)
- ☐ H4624-024 Zing Select Diabetes & Heart Complete IN (HMO C-SNP)
- ☐ H6876-006 Zing Choice Diabetes & Heart Complete IN (PPO C-SNP)
- ☐ H6876-004 Zing Open Choice IN (PPO)
- ☐ H4624-031 Zing Elite Diabetes & Heart IN (HMO C-SNP)
- ☐ H4624-025 Zing ESRD Select IN (HMO C-SNP)

FIRST name: LAST name: Optional: Middle Initial:

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

Cell phone number: _____

☐ I agree that by checking this box, Zing Health and its agents/affiliates may call or text me on the phone number(s) I have provided to Zing Health for any purpose, including but not limited to healthcare/Medicare-related products or services. I understand and agree that such calls/texts may be made via automated means, that I can opt-out at any time, and that such consent to call/text is not a condition of receipt of any good or service.

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:	Optional: County:	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) in addition to Zing Health? ☐ Yes ☐ No

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

Do you have any chronic conditions, such as cardiovascular disorders, chronic heart failure, diabetes and/or end-stage renal disease (ESRD)? ☐ Yes ☐ No

Are you enrolled in your state Medicaid program? ☐ Yes ☐ No If yes, please provide your Medicaid number. _____

IMPORTANT: Read and sign below:

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

Asian:

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

Native Hawaiian or Pacific Islander:

- ☐ Guamanian or Chamorro
- ☐ Native Hawaaian
- ☐ Samoan
- ☐ Other Pacific Islander

- ☐ White
- ☐ **I choose not to answer**

What's your gender? Select one.

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

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

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

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 ☐ Data CD

Please contact Zing Health at 1-866-946-4458 (TTY: 711) 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. Monday through Friday (April 1 - September 30) and 8:00 a.m. to 8:00 p.m. 7 days a week (from October 1 - March 31).

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

List your Primary Care Physician (PCP), clinic, or health center:

PCP Name: _____ PCP #: _____ PCP Phone Number _____

I want to get the following materials via email. Select one or more.

☐ Evidence of Coverage (EOC) ☐ Provider Directory ☐ Formulary

Paying your plan premiums

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

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment): _____

Agent Name: _____ Agent ID #: _____ Event#/Lead Source: _____

Plan ID #: _____ Plan Name: _____ Effective Date of Coverage: _ _/ _ _/_ _ _ _

Election Type: ☐ ICEP/IEP ☐ AEP ☐ SEP (Type): _____ Date (if applicable): _ _/ _ _/_ _ _ _

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.