OMB No. 0938-1378
Expires: 12/31/2026

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.

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:

Align powered by Sanford Health Plan
P.O. Box 91110
Sioux Falls, SD 57109-1110

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

How do I get help with this form?

Call Align powered by Sanford Health Plan at 1-877-509-4979. 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 Align powered by Sanford Health Plan al 1-877-509-4979/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.

align
powered by
SANFORD HEALTH PLAN

2026 Enrollment Request – Align DUALPartnership HMO D-SNP Plan

FOR OFFICE USE ONLY		
Member ID no.	Effective date (m/d/y)	Election period individual is enrolling in: ☐ AEP ☐ SEP ☐ ICEP ☐ IEP ☐ OEPI

FOR STAFF/AGENT/BROKER USE ONLY		
Name of staff member/agent/broker (if assisted in enrollment)	Agent number	First received date (m/d/y)
Check (✔) one: ☐ Seminar/webinar attendee ☐ Walk-in ☐ Phone consult ☐ Call center ☐ Scheduled appointment		

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

Check (✔) the plan you want to join:

☐ Align DUALPartnership (PPO) - 2026 North Dakota **$0** per month

FIRST name	LAST name	Middle initial (optional)

Birthdate (mm/dd/yyyy)	Sex:
___ ___ /___ ___ / ___ ___ ___ ___	☐ Male ☐ Female
Phone	Alternate phone
(_____) ___ ___ ___ – ___ ___ ___ ___	(_____) ___ ___ ___ – ___ ___ ___ ___

Permanent residence street address (Do not enter a P.O. Box. NOTE: For individuals experiencing homelessness, a P.O. Box may be considered your permanent residence address.)

City	County (optional)	State	ZIP Code

Mailing address, if different from your permanent address (P.O. Box allowed)

Street address	City	State	ZIP code

Emergency contact name (optional)	Relationship to you	Phone

Continue to page 2

Your Medicare Information

Medicare number ___ ___ ___ ___-___ ___ ___-___ ___ ___ ___

Hospital (Part A) effective date _____ Medical (Part B) effective date _____

Attestation of eligibility for an enrollment period

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.

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 enrollment period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare.
- ☐ I had Medicare before, but I am now turning 65.
- ☐ I already have Hospital (Part A) and recently signed up for Medical (Part B). I want to join a Medicare Advantage plan.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I am new to Medicare, and I was notified about getting Medicare after my Part A and/or Part B coverage started. I was notified of getting Medicare on (insert date) _____ /_____ /_____.
- ☐ I recently moved outside of the service area for my current plan or I recently moved and have new options available to me. I moved on (insert date) _____ /_____ /_____ .
- ☐ I recently was released from incarceration. I was released on (insert date) _____ /_____ /_____ .
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____ /_____ /_____ .
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____ /_____ /_____ .
- ☐ I recently had a change in my Medicaid (newly got 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 (newly got Extra Help, had a change in the level of Extra Help or lost Extra Help) on (insert date) _____ /_____ /_____ .
- ☐ I have Medicare and get full Medicaid benefits. I want to join or switch to a plan that coordinates coverage between my Medicare and Medicaid managed care plans [called an integrated Dual Eligible Special Needs Plan (D-SNP)].
- ☐ I am moving into, live in, or recently moved out of a long-term care facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) _____ /_____ /_____ .
- ☐ I recently left a PACE program on (insert date) _____ /_____ /_____ .
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____ /_____ /_____ .
- ☐ I am leaving employer or union coverage on (insert date) _____ /_____ /_____ .
- ☐ I am in a qualified State Pharmaceutical Assistance Program or I am losing help from a State Pharmaceutical Assistance Program.
- ☐ My plan is ending its contract with Medicare or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____ /_____ /_____ .
- ☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____ /_____ /_____ .
- ☐ I was affected by an emergency or major disaster as declared by the Federal Emergency Management Agency (FEMA) or by a federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

Continue to page 3

Attestation of eligibility for an enrollment period (continued)

☐ I am in a plan that was recently taken over by the state because of financial issues. I want to switch to another plan.

☐ I am in a plan that has had a star rating of less than 3 stars for the last three years. I want to join a plan with a star rating of 3 stars or higher.

If none of these statements applies to you or you are not sure, contact Align powered by Sanford Health Plan at 1-877-509-4979 (TTY users should call 711) to see if you are eligible to enroll. We are open 7 days a week, 8 a.m. to 8 p.m., from Oct. 1 – March 31; and Monday through Friday, 8 a.m. to 8 p.m., from April 1 – Sept. 30.

Answer these important questions

1. Will you have other prescription drug coverage (like employer coverage, VA, TRICARE or state pharmaceutical assistance programs) in addition to your Medicare Advantage plan: ☐ Yes ☐ No

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

2. 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 Align DUALPartnership.
- By joining this Medicare Advantage plan, I acknowledge that Align DUALPartnership 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).
- I understand that my 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 or Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA or Part D plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Align DUALPartnership coverage begins, I must get all of my medical and prescription drug benefits from Align DUALPartnership. Benefits and services provided by Align DUALPartnership and contained in my Align DUALPartnership "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Align DUALPartnership 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.

Please retain a copy of this form for your records.

Signature	**Today's date (m/d/y)**

If you are the authorized representative, sign above and fill out these fields:

Name _____

Address _____

Phone (_____) _____–_____

Relationship to enrollee:

☐ Power of Attorney Durable/Financial ☐ Guardian of Estate/Conservator

Name of person helping enrollee fill out form

Name _____ Signature _____

☐ Agent ☐ Broker ☐ SHIP counselor ☐ Other (third party)

Continue to page 4

Section 2 – All fields in this section are optional

Answering these questions is your choice. You cannot be denied coverage because you do not fill them out.

Check (✔) one if you want us to send you information in a language other than English:

☐ Spanish ☐ Oromo ☐ Other _____

Check (✔) one if you want us to send you information in an accessible format:

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Contact Align powered by Sanford Health Plan at 1-877-509-4979 if you need information in an accessible format other than what is listed above. Our office hours are 7 days a week, 8 a.m. to 8 p.m., Oct. 1 – March 31; and Monday through Friday, 8 a.m. to 8 p.m., April 1 – Sept. 30. 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:

Physician first/last name _____

Clinic/health center _____

☐ Phone ☐ Cell ☐ Home

(_____) _____–_____

Optional:

☐ By checking (✔) this box, I agree to receiving plan communication via text messages.

Optional:

Email _____

☐ By checking (✔) this box, I agree to receiving plan materials via email.

Once your coverage is effective, you can sign up for your secure member portal at align.sanfordhealthplan.com. On the portal you can select to receive plan communications electronically.

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Notice of Nondiscrimination/Limited English Proficiency Language Services

Sanford Health Plan and Sanford Health Plan of Minnesota have HMO, PPO, I-SNP and D-SNP plans with a Medicare contract and contracts with state Medicaid programs. Enrollment in these plans depends on contract renewal. Sanford Health complies with applicable federal civil rights laws and does not discriminate, exclude or treat people differently on the basis of race, color, national origin, religion, pregnancy and related conditions, sex (including sexual orientation, gender identity, sex stereotypes, sex characteristics and intersex traits), age, disability, health status, marital status, arrest or conviction record or military participation in the administration of the plan, including enrollment and benefit determinations.

English: Free interpretation services are available to you. Additional services and resources necessary to provide information on accessible formats are also available at no cost. Call 1-877-509-4979 (TTY 711) or speak with your healthcare provider.

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-877-509-4979 (TTY 711) o hable con su proveedor.

Oromo: Yoo afaan Oromoo dubbattu ta'e, tajaajilli gargaarsa afaanii bilisaa siniif ni argama. Gargaarsi gargaaraa fi tajaajilli sirrii ta'ee fi odeeffannoo bifa dhaqqabamaa ta'een kennuunis bilisaan ni argama. Bilbilaa 1- 877-509-4979 (TTY: 711) yookiin dhiyeessaa kee waliin haasa'aa.

Large print – If you require materials in large print, please call 1-877-509-4979 (TTY 711).

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.

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