OMB No. 0938-1378
Expires: 7/31/2023

hmsa

An Independent Licensee of the Blue Cross and Blue Shield Association

HMSA Medicare Advantage

MedicareRx Prescription Drug Coverage

Enrollment Form Instructions

WHO CAN USE THIS FORM?
People with Medicare who want to join an HMSA Medicare Advantage Plan or Medicare Prescription Drug 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 an HMSA 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 three 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 on pages 1-4 unless noted as optional. The items on page 5 are optional — you can't be denied coverage because you don't fill them out.

WHAT HAPPENS NEXT?
Send your completed and signed form back to your employer group as directed in their communications to you.

HOW DO I GET HELP WITH THIS FORM?
Call HMSA Medicare Advantage Sales at 948-6235 on Oahu or toll-free 1 (800) 693-4672. 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 HMSA Medicare Advantage Sales al 948-6235 (Oahu) or toll-free 1 (800) 693-4672/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.

IMPORTANT NOTES:
You can be in only one Medicare contracting plan at a time. Your enrollment in this plan will automatically end your enrollment in another Medicare health or prescription drug plan.

If you currently have an ACA or Medigap plan, be sure to contact your insurance carrier to cancel that plan since it will not be automatically canceled.

If you currently have another health plan (employer or union group, or ACA), joining HMSA Medicare Advantage could affect your employer or union health benefits; please contact your health insurance carrier. You could lose your employer or union health benefits if you join HMSA Medicare Advantage. Read the information your employer or union sends to you. If you have questions, visit their website or contact them. If there isn't any contact information, your benefits administrator or the office that answers questions about your benefits can help.

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HMSA Akamai Advantage (PPO) Group Enrollment Form for CY 2021

Group Name: _____ Group #: _____

SECTION 1: PROVIDE INFORMATION ABOUT YOU

First Name MI

Last Name

Permanent Residence Street Address (Include apartment number. P. O. Box isn't allowed.)

Residence City State ZIP Code County (optional)

/ / Sex ( ) —

Birth Date (MM/DD/YYYY) M or F Daytime Telephone Number

Mailing Address (only if different from your Permanent Residence Address):

Mailing Street Address (include apartment number) P.O. Box allowed

Mailing City State ZIP Code

Current HMSA Member Number (if applicable)

Email Address (optional)
(By providing your email address, you're allowing us to email you important health plan information.)

Primary Care Provider (PCP), clinic, or health center (optional). No titles required.

First Name Last Name

HMSA Use Only

App Rec Date: / / MBI: - - SBM Item #:_____

Sub ID#: A 0 0 0 0 - ☐ Group Sponsored ☐ Individual

HMSA Group#: - Effective Date: / 0 1 / 2 0 2 1

Election Period: ☐ ICEP ☐ IEP-D ☐ AEP (Oct 15-Dec 7) ☐ SEP (type): _____

☐ Not Eligible:_____ ☐ OEP (Jan 1-Mar 31) ☐ Authorization Form

Sales Agent ID:_____ Agent Assisted: ☐ No ☐ Yes_____
(Agent Assist ID & Name)

SOA # _____

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SECTION 2: PROVIDE YOUR MEDICARE INSURANCE INFORMATION

Please take out your red, white, and blue Medicare card to complete this section.

- Fill in these blanks so they match your red, white, and blue Medicare card.

  You must have Medicare Part A and Part B to join a Medicare Advantage plan.

  --------- OR ---------

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Medicare Card First Name (as it appears on your Medicare card) MI

Medicare Card Last Name (as it appears on your Medicare card)

Medicare Number

Is entitled to: Effective Date (MM/DD/YYYY)

HOSPITAL (Part A) / /

MEDICAL (Part B) / /

☐ HMSA Use Only: Card information verified by_____

☐ **Yes** ☐ **No** (Optional) Are you enrolled in QUEST Integration (Medicaid)?
If yes, please provide your Medicaid number:

SECTION 3: MAKE A SELECTION

I understand that the group covering my retiree coverage is offering me the option(s) below. Please enroll me in the following (please check box):

☐ **HMSA Akamai Advantage Prime MA (PPO)**

☐ **HMSA Akamai Advantage Prime MAPD (PPO)**

Check with the group sponsoring your retiree coverage regarding the proposed effective date of enrollment and your share of the monthly premiums payable to your employer/union group, if applicable.

If you wish to decline enrollment, contact the benefits administrator or the office that answers questions about your retiree coverage. If you decline enrollment, you may not be able to re-enroll in your group's plan.

If you're enrolling in a medical plan that doesn't include prescription drug benefits, you're declining enrollment into group-sponsored Part D drug benefits.

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. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). Don't pay HMSA Akamai Advantage the Part D-IRMAA.

If you qualify for Extra Help with your Medicare prescription drug costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we'll bill you for the amount that Medicare doesn't cover.

(continued)

SECTION 4: ANSWER THESE IMPORTANT QUESTIONS

Will you have other prescription drug coverage (like VA, TRICARE) in addition to HMSA Akamai Advantage?

☐ **Yes** ☐ **No**

Name of other coverage

Member number for this coverage

Group number for this coverage

If yes, when did these benefits begin? Month/Year: ☐☐ / ☐☐☐☐

Are you getting these benefits through: ☐ **Yourself** ☐ **Spouse**

Is the person checked above getting these benefits because they're actively employed or is it a retiree plan? ☐ **Actively employed** ☐ **Retiree plan** ☐ **Other**

If actively employed, does the employer have 20 or more employees (full and part time)?

☐ **Yes** ☐ **No**

(continued)

SECTION 5: IMPORTANT: READ AND SIGN BELOW:

By completing this enrollment application, I agree to the following:

I must keep both Hospital (Part A) and Medical (Part B) to stay in HMSA Akamai Advantage.

For HMSA Akamai Advantage Prime or Premier MA ONLY: I understand that if I *don't* have Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.

- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that HMSA Akamai Advantage 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.
- 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 people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my HMSA Akamai Advantage coverage begins, I must get all of my medical and prescription drug benefits from HMSA Akamai Advantage. Benefits and services provided by HMSA Akamai Advantage and contained in my HMSA Akamai Advantage *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor HMSA Akamai Advantage will pay for benefits or services that are not covered.
- 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 or HMSA.

______________________________   __ __ / __ __ / __ __ __ __

Applicant's signature or, if applicant is unable to sign, applicant's legal representative's signature. If applicant's legal representative signs, please complete legal representative's information below:

Today's Date (MM/DD/YYYY)

Name of Legal Representative (please print)

Legal Representative's Mailing Address

Legal Representative's City

State

ZIP Code

( ) -

Legal Representative's Telephone Number

Legal Representative's Relationship to Applicant

For more information, please contact your benefits health plan administrator.

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PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 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.

SECTION 6: ALL FIELDS ON THIS PAGE ARE OPTIONAL. Return with rest of application. Answering these questions is your choice. You can't be denied coverge because you don't fill them out.

What language do you speak most of the time at home? (Choose one.)

- ☐ English
- ☐ Cambodian
- ☐ Cantonese
- ☐ Hawaiian
- ☐ Ilocano
- ☐ Japanese
- ☐ Korean
- ☐ Mandarin
- ☐ Tagalog
- ☐ Vietnamese
- ☐ Other (any language not listed above.)

Select if you want us to send you information in the accessible format ☐ Large print

Please contact HMSA Medicare Advantage at 948-6235 on Oahu or 1 (800) 693-4672 toll-free on the Neighbor Islands and Mainland if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m., seven days a week. TTY users can call 711.

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

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

☐ Provider Directory ☐ Evidence of Coverage ☐ Formulary

Are you a resident in a long-term care facility, such as a nursing home? ☐ **Yes** ☐ **No**
If yes, please provide the following information.

Name of Institution

( ) -

Institution Phone Number

Institution Mailing Address

/

Admission Date

Institution City

State ZIP Code

HMSA Akamai Advantage is a PPO plan with a Medicare contract. Enrollment in HMSA Akamai Advantage depends on contract renewal.

Federal law requires HMSA to provide you with this notice.

HMSA complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. HMSA does not exclude people or treat them differently because of things like race, color, national origin, age, disability, or sex.

Services that HMSA provides

Provides aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages
- If you need these services, please call 1 (800) 776-4672 toll-free; TTY 711

How to file a discrimination-related grievance or complaint

If you believe that we've failed to provide these services or discriminated against you in some way, you can file a grievance in any of the following ways:

- Phone: 1 (800) 776-4672 toll-free
- TTY: 711
- Email: Compliance_Ethics@hmsa.com
- Fax: (808) 948-6414 on Oahu
- Mail: 818 Keeaumoku St., Honolulu, HI 96814

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, in any of the following ways:

- Online: ocrportal.hhs.gov/ocr/portal/lobby.jsf
- Phone: 1 (800) 368-1019 toll-free; TDD users, call 1 (800) 537-7697 toll-free
- Mail: U.S. Department of Health and Human Services, 200 Independence Ave. S.W., Room 509F, HHH Building, Washington, DC 20201

For complaint forms, please go to hhs.gov/ocr/office/file/index.html.

Hawaiian: E NĀNĀ MAI: Inā hoʻopuka ʻoe i ka ʻŌlelo Hawaiʻi, loaʻa ke kōkua manuahi iā ʻoe. E kelepona iā 1 (800) 776-4672. TTY 711.

Bisaya: ATENSYON: Kung nagsulti ka og Cebuano, aduna kay magamit nga mga serbisyo sa tabang sa lengguwahe, nga walay bayad. Tawag sa 1 (800) 776-4672 nga walay toll. TTY 711.

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1 (800) 776-4672。TTY 711。

Ilocano: PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1 (800) 776-4672 toll-free. TTY 711.

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1 (800) 776-4672 をご利用ください。TTY 711。まで、お電話にてご連絡ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1 (800) 776-4672번으로 연락해 주시기 바랍 니다. TTY 711 번으로 전화해 주십시오.

Laotian: ກະລຸນາສັງເກດ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການຊ່ວຍເຫຼືອດ້ານພາສາ, ບໍ່ມີຄ່າໃຊ້ຈ່າຍ, ແມ່ນມີໃຫ້ທ່ານ. ໂທ 1 (800) 776-4672 ฬธิ. TTY 711.

Marshallese: LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk 1 (800) 776-4672 tollfree, enaj ejjelok wonaan. TTY 711.

Pohnpeian: Ma ke kin lokaian Pohnpei, ke kak ale sawas in sohte pweine. Kahlda nempe wet 1 (800) 776-4672. Me sohte kak rong call TTY 711.

Samoan: MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1 (800) 776-4672 e leai se totogi o lenei ʻau'aunaga. TTY 711.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1 (800) 776-4672. TTY 711.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1 (800) 776-4672 toll-free. TTY 711.

Tongan: FAKATOKANGA'I: Kapau ʻoku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea ʻoku nau fai atu ha tokoni ta'etotongi, pea teke lava ʻo ma'u ia. Telefoni mai 1 (800) 776-4672. TTY 711.

Trukese: MEI AUCHEA: Ika iei foosun fonuomw: Foosun Chuuk, iwe en mei tongeni omw kopwe angei aninisin chiakku, ese kamo. Kori 1 (800) 776-4672, ese kamo. TTY 711.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1 (800) 776-4672. TTY 711.

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