



An Independent Licensee of the Blue Cross and Blue Shield Association

HMSA Medicare Advantage

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

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](https://www.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.

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

(continued)



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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 # _____

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):

 Please make selection Not applicable

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.

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 coverage because you don't fill them out.

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

- | | | | |
|------------------------------------|-----------------------------------|-----------------------------------|---|
| <input type="checkbox"/> English | <input type="checkbox"/> Hawaiian | <input type="checkbox"/> Korean | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Cambodian | <input type="checkbox"/> Ilocano | <input type="checkbox"/> Mandarin | <input type="checkbox"/> Other (any language not listed above.) |
| <input type="checkbox"/> Cantonese | <input type="checkbox"/> Japanese | <input type="checkbox"/> Tagalog | |

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.

<input type="text"/>	(<input type="text"/>)	<input type="text"/>	-	<input type="text"/>
Name of Institution	Institution Phone Number			
<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>
Institution Mailing Address	Admission Date			
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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 ho'opuka 'oe i ka 'Ōlelo Hawai'i, loa'a ke kōkua manuahi iā 'oe. 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 llocano, 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 바랍니다. TTY 711 번으로 전화해 주십시오.

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

Marshallese: LALE: Ñe kwōj kōnono Kajin Majōl, kwomaroñ bōk jerbal in jipañ ilo kajin ñe am ejjelok wōñāān. Kaalok 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 totoi, mo oe, Telefoni mai: 1 (800) 776-4672 e leai se totoi o lenei 'au'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 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea teke lava 'o 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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