OMB No. 0938-1378
Expires: 7/31/2024

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 Oct. 15–Dec. 7 each year (for coverage starting Jan. 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 (808) 948-6235 or 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 (808) 948-6235 or 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:
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 0938-1378. 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 2024

Group Name: RCUH AA PRIME MA Group #: 83181-6-4

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) optional

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 4

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

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

Sales Agent ID & Name:_____ Agent Assisted: ☐ No ☐ Yes_____

(Agent Assist ID & Name)

SOA Doc: _____

OMB No. 0938-1378
Expires: 7/31/2024

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 Number

Is entitled to:	Effective Date (MM/DD/YYYY)
HOSPITAL (Part A)	☐☐ / ☐☐ / ☐☐☐☐
MEDICAL (Part B)	☐☐ / ☐☐ / ☐☐☐☐

☐ **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)**

☐ **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 reenroll in your group's plan.

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)

OMB No. 0938-1378
Expires: 7/31/2024

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.
- 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 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.
- 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 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.

(continued)

OMB No. 0938-1378
Expires: 7/31/2024

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.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **I choose not to answer.**

What's your race? Select all that apply.

- ☐ Alaska Native
- ☐ American Indian
- ☐ Asian Indian
- ☐ Black
- ☐ Chamorro
- ☐ Chinese
- ☐ Chuukese
- ☐ Fijian
- ☐ Filipino
- ☐ I-Kiribati
- ☐ Japanese
- ☐ Korean
- ☐ Kosraean
- ☐ Marshallese
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Palauan/Belauan
- ☐ Pohnpeian
- ☐ Samoan
- ☐ Tahitian
- ☐ Tokelauan
- ☐ Tongan
- ☐ Vietnamese
- ☐ White
- ☐ Yapese
- ☐ Other _____
- ☐ **I choose not to answer.**

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

- ☐ English
- ☐ Cantonese
- ☐ Chuukese
- ☐ French
- ☐ German
- ☐ Hawaiian
- ☐ Ilocano
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Mandarin
- ☐ Marshallese
- ☐ Palauan
- ☐ Samoan
- ☐ Spanish
- ☐ Tagalog
- ☐ Tongan
- ☐ Vietnamese
- ☐ Visayan
- ☐ Other _____

Do you need an interpreter? ☐ **Yes** ☐ **No**

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

Please contact HMSA Medicare Advantage at (808) 948-6235 or 1 (800) 693-4672 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 by email. Select one or more.

☐ Provider Directory ☐ Evidence of Coverage ☐ Formulary

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

(continued)

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

Form Approved
OMB# 0938-1421

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Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1 (800) 660-4672 (TTY: 711). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1 (800) 660-4672 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1 (800) 660-4672 (TTY: 711)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1 (800) 660-4672 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1 (800) 660-4672 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1 (800) 660-4672 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1 (800) 660-4672 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1 (800) 660-4672 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1 (800) 660-4672 (TTY: 711)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1 (800) 660-4672 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إنني أقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لديني. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1 (800) 660-4672 (TTY: 711). هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1 (800) 660-4672 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1 (800) 660-4672 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um inté-rprete, contacte-nos através do número 1 (800) 660-4672 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen kon-sènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1 (800) 660-4672 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1 (800) 660-4672 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1 (800) 660-4672 (TTY: 711) にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。