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

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.

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 HMSA Akamai Advantage Dual Care, you must also have all of the following:

- Medicare Part A (hospital insurance)
- Medicare Part B (medical insurance)
- HMSA QUEST (Medicaid)

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.

REMINDERS:

- If you want to join a plan during fall open enrollment (Oct. 15–Dec. 7), we must get your completed form by Dec. 7.
- HMSA 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 (RRB) benefit.

WHAT HAPPENS NEXT?

Send your completed and signed form to:
HMSA Medicare Advantage Sales
P.O. Box 3500
Honolulu, HI 96811-9983

Once we process your request to join, we'll contact 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] toll-free. TTY users can call 1 (877) 486-2048 toll-free.

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 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 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.

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HMSA Akamai Advantage® Dual Care (PPO D-SNP) Enrollment Form for CY 2025

SECTION 1: PROVIDE INFORMATION ABOUT YOU

First Name MI

Last Name

Permanent Residence Street Address
(P.O. Box isn't allowed, except for individuals experiencing homelessness)

Residence City State ZIP Code County (optional)

Birth Date (MM/DD/YYYY) Sex M or F Primary Phone Number

( ) —
Secondary Phone 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)

☐ I give HMSA permission to email me important health plan information.

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 5

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

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

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

SOA Doc: _____

Primary care provider (PCP), clinic, or health center (optional). No titles required.
(Example: John Smith)

First Name

Last Name

I'd like HMSA Akamai Advantage Dual Care to begin on the first day of the month of (M M / Y Y Y Y) ___ / 2025

I understand that this is my HMSA Akamai Advantage Dual Care proposed start date.

Please check the box below: Monthly Premium

☐ I'm enrolling in HMSA Akamai Advantage Dual Care (PPO D-SNP). $0
Available to residents of the state of Hawaii. This plan is available to most individuals who have both HMSA QUEST (Medicaid) and Medicare. Premium may vary based on the level of Extra Help you receive.

Alternate Person's Contact Information:

First Name

Last Name

Relationship to Enrollee

( ) ___ — ___ Primary Phone Number

( ) ___ — ___ Secondary Phone Number

Email Address

SECTION 2: PROVIDE YOUR MEDICARE INSURANCE INFORMATION

___ - ___ - ___
Medicare Number

☐ **Yes** ☐ **No** Are you enrolled in HMSA QUEST (Medicaid)? To be enrolled in this Dual Special Needs plan, you must be enrolled in HMSA QUEST (Medicaid).

If yes, please provide your HMSA QUEST number:

(continued)

SECTION 3: PAYING YOUR PLAN PREMIUMS (OPTIONAL)

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or Electronic Funds Transfer (EFT) 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.** Other payment options are available; ask us for more information.

Choose a premium payment option. If you don't, you'll receive a bill each month.

- ☐ HMSA will mail you a bill each month.
- ☐ Electronic funds transfer (EFT) from your checking or savings account each month.
  - ☐ New (Please complete the enclosed HMSA Dues Payment Authorization Form.)
  - ☐ Existing HMSA Akamai Advantage member with EFT – authorize HMSA to retain same EFT.
- ☐ Automatic deduction from your monthly Social Security or RRB benefit.
  I get monthly benefits from:
  - ☐ Social Security
  - ☐ Railroad Retirement Board

  (The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit will include all premiums due from the point withholding begins, which could correspond to your enrollment start date. If Social Security or RRB doesn't approve your request or approves it for a later date, we'll send you a paper bill for your monthly premiums.)

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.

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:

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

- By joining this Medicare Advantage 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 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 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

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. Section 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.

(continued)

SECTION 6: ALL FIELDS IN THIS SECTION 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.

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

What language do you speak most of the time at home? Select 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

Plan information is available for free in Ilocano, Vietnamese, Chinese, and Korean. Please contact HMSA Medicare Advantage at (808) 948-6235 or 1 (800) 693-4672 if you need information in one of these languages, in email or an accessible format. Our office hours are 8 a.m. to 8 p.m., seven days a week. TTY users can call 711.

(continued)

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

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

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)

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。