REQUEST FOR IDENTITY PASSWORD FORM

ALL SECTIONS MUST BE COMPLETED UNLESS OTHERWISE SPECIFIED. ONE FORM PER PERSON.

PART A: MEMBER INFORMATION

Last Name	First Name	MI

Street Address	City	State	ZIP Code

Email	Home Phone #	Cell Phone #
	( )	( )

HMSA Subscriber Number(s) (Located on your HMSA membership card)	Birth Date
	_ _ /_ _/_ _ _ _

PART B: PASSWORD INSTRUCTIONS

Do not fill out this form if you have forgotten your password. Contact HMSA directly at (808) 948-6111 on Oahu instead.

1. Please select from the options below:

☐ Create Password

Password: | | | | | | | | | | | | | | | |

Acceptable characters are letters, numbers or special characters as found on a U.S. keyboard.

☐ Change Password

Current Password: | | | | | | | | | | | | | | | |

New Password: | | | | | | | | | | | | | | | |

☐ End Password as of: _ _ /_ _/_ _ _ _

2. This restriction will expire on the lesser of five years from the date on which it was signed or as specified below (choose only one):

One year   Until _ _ /_ _/_ _ _ _ (must be less than five years)

Three years   Event described here: ______________________________
(must occur in less than five years)

(Continued on next page)

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PART C: DUTIES AND OBLIGATIONS

I understand that **(please read):**

- By completing this form, I am requesting HMSA to require additional verification of my identity whenever I contact HMSA.
- HMSA is under no obligation to agree to my request, but HMSA will accommodate my request to the extent possible.
- This request will enhance and not replace HMSA's existing process for identity verification. The password I indicate in part B of this form will be used in addition to HMSA's standard identity verification process.
- Notwithstanding this agreement, my request for additional verification will only apply when I or my authorized representative contacts HMSA; this additional verification will not be required if HMSA is contacted by health care entities involved in my treatment, payment, or health care operations.
- At HMSA's discretion, HMSA may use or release my restricted information as necessary for my treatment in an appropriate medical emergency, or when the use or disclosure without my written permission is authorized or required by law.
- This request will only apply to me; HMSA will not require additional verification from other members on this account unless they submit similar, individual requests for identity passwords.
- If I have reason to suspect my password has been compromised, I will contact HMSA immediately.
- I may end this request at any time by notifying HMSA in writing.
- HMSA may end this agreement at any time by notifying me in writing.
- Upon request, I am entitled to receive a copy of this signed form.
- If I have questions about this form, I may contact HMSA at (808) 948-6111 on Oahu.

PART D: SIGNATURE:

I, (print your name) ____ request that you require additional verification of my identity as specified in part B above. I understand HMSA is under no obligation to agree to my request and that I may revoke this request at any time by notifying HMSA in writing.

Member/Authorized Signature: _______________________________ **Date:** _ _ /_ _/_ _ _ _
If signed by other than the member or parent of minor child, please print your name below and indicate your relationship. Provide a copy of verification of your legal right (e.g., power of attorney documentation) to make this authorization.

Authorized Representative Name: ____

Relationship to Member: ____

INCOMPLETE FORMS WILL NOT BE PROCESSED
ALL FIELDS ARE REQUIRED UNLESS OTHERWISE SPECIFIED

Please complete, sign, and submit this form to:
HMSA Privacy Office, P.O. Box 860, Honolulu, HI 96808-9988