hmsa

An Independent Licensee of the Blue Cross and Blue Shield Association

# HMSA Akamai Advantage®

MedicareRx Prescription Drug Coverage

## HMSA Akamai Advantage Enrollment Form for CY 2017

## 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 (H I) | ZIP Code

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

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

Mailing Street Address (include apartment number)

Mailing City | State | ZIP Code

Current HMSA Member Number (if applicable)

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

Primary Care Provider. No titles required. (Example: John Smith)

First Name | Last Name

## HMSA Use Only

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

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

HMSA Akamai Advantage Group#: - Effective Date: / 0 1 / 2 0 1 7

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

☐ Not Eligible:_____ ☐ ESRD Group Waiver ☐ Authorization Form

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

SOA # _____

I'd like HMSA Akamai Advantage to begin on the first day of the month of
I understand that this is my HMSA Akamai Advantage proposed start date.

(M M / Y Y Y Y)
[ ][ ] / [2][0][1][7]

**Select the HMSA Akamai Advantage option you wish to enroll in.** (Premiums are per person, per month. Please check only ONE of the four boxes below.)

| | Monthly Premium |
|---|---|
| ☐ Complete (PPO) (Available to Oahu residents only.) | $70 |
| ☐ Complete Plus (PPO) (Available to Oahu residents only.) | $158 |
| ☐ Standard (PPO) (Available to residents of Hawaii, Maui, Kauai, and Kalawao counties.) | $153 |
| ☐ Standard Plus (PPO) (Available to residents of Hawaii, Maui, Kauai, and Kalawao counties.) | $202 |

## SECTION 2: PROVIDE YOUR MEDICARE INSURANCE INFORMATION

Please see your Medicare card to complete this section:

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

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ] [ ]
Medicare Card First Name MI

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]
Medicare Card Last Name

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ] [ ] [ ]
Medicare Claim Number Sex M or F

| Is entitled to: | Effective Date (MM/DD/YYYY) |
|---|---|
| HOSPITAL (Part A) | [ ][ ] / [ ][ ] / [ ][ ][ ][ ] |
| MEDICAL (Part B) | [ ][ ] / [ ][ ] / [ ][ ][ ][ ] |

☐ HMSA Use Only: Card information verified by_____

☐ **Yes** ☐ **No** Are you enrolled in your state Medicaid program? If "yes," please provide your Medicaid number:

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]



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**SECTION 3: SELECT YOUR PLAN PREMIUM PAYMENT OPTION**

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 automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

**Please select a premium payment option:**

- ☐ 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 Railroad Retirement Board (RRB) benefit check. (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 check 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 must pay a Part D-Income Related Monthly Adjustment Amount, the Social Security Administration will notify you. You must pay this extra amount in addition to your plan premium. You'll either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT pay HMSA the Part D-Income Related Monthly Adjustment Amount.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75 percent or more of your drug costs, including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify won't be subject to the coverage gap or late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about Extra Help, contact your local Social Security office or call Social Security at 1 (800) 772-1213 toll-free. TTY users should call 1 (800) 325-0778 toll-free. You can also apply for Extra Help online at socialsecurity.gov/prescriptionhelp.

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.

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

**Please read and answer these important questions:**

1. ☐ Yes ☐ No Do you have end-stage renal disease (ESRD)?

   If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis. Otherwise, we may need to contact you for more information.



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2. Some individuals may have other drug benefits, including other private insurance, TRICARE, federal employee health benefits, VA benefits, or state pharmaceutical assistance programs.

Will you have other prescription drug benefits in addition to HMSA Akamai Advantage as of the proposed start date?

☐ **Yes.** Continue the questions below. ☐ **No.** If "no," skip to question 3.

**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**

Insurance Company Name

Insurance Company Member ID No.

Insurance Company Plan/Group No.

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

Name of Institution

( ) - Institution Phone Number

Institution Mailing Address

Institution City State ZIP Code

4. Do you or your spouse work? ☐ **No** ☐ **Yes**

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

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

6. ☐ Please check this box if you prefer that we send you information in large-print format.

Please contact HMSA Akamai Advantage at 948-6235 on Oahu or 1 (800) 693-4672 toll-free on the Neighbor Islands and U.S. Mainland if you need information in large-print format. Telephone hours are 8 a.m. to 8 p.m., seven days a week. TTY users, call 711.



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**SECTION 4: PLEASE READ THIS IMPORTANT INFORMATION**

- **If you currently have another health plan (employer or union group or ACA), please contact your health insurance carrier to cancel the other coverage. You could lose your employer or union health benefits if you join HMSA Akamai Advantage.** Read the information your employer or union sends 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.

**SECTION 5: PLEASE READ AND SIGN ON FOLLOWING PAGE**

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

HMSA Akamai Advantage is a Medicare Advantage plan that has a contract with the federal government. I'll need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. I'm responsible for letting HMSA Akamai Advantage know about any prescription drug benefits that I have or may get in the future.

Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (example: October 15 – December 7 of every year), or under certain special circumstances.

HMSA Akamai Advantage serves a specific service area. If I move out of the area that HMSA Akamai Advantage serves, I need to notify HMSA so I can disenroll and find a new plan in my new area. Once I'm a member of HMSA Akamai Advantage, I have the right to appeal plan decisions about payment or services if I disagree. I'll read the *Evidence of Coverage* from HMSA Akamai Advantage when I get it to know which rules I must follow to get benefits with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited benefits near the U.S. border.

I understand that beginning on the date HMSA Akamai Advantage benefits begin, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, HMSA Akamai Advantage provides refunds for all benefits even if I get services out of network. Services authorized by HMSA Akamai Advantage and other services contained in my HMSA Akamai Advantage *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HMSA AKAMAI ADVANTAGE WILL PAY FOR THE SERVICES.**

I understand that a sales agent, broker, or other individual employed by or contracted with HMSA Akamai Advantage who's helping me may be paid based on my enrollment in HMSA Akamai Advantage.



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**RELEASE OF INFORMATION:**

By joining this Medicare health plan, I acknowledge that HMSA Akamai Advantage will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that HMSA Akamai Advantage will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations. 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 signature of the **person authorized to act on my behalf under the state of Hawaii laws**) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (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 from HMSA Akamai Advantage or from Medicare. This would include a court-appointed legal guardian or a person with general durable power of attorney.

_____ / / 

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:

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 call 948-6235 on Oahu or 1 (800) 693-4672 toll-free on the Neighbor Islands and U.S. Mainland. Telephone hours are 8 a.m. to 8 p.m., seven days a week. TTY users, call 711. Or visit HMSA's website at hmsa.com/advantage. Return HMSA Akamai Advantage application forms to HMSA at P.O. Box 3500, Honolulu, HI 96811-9983.

### HMSA doesn't discriminate

We comply with applicable federal civil rights laws. We don't discriminate, exclude people, or treat people differently because of:

- Race.
- Color.
- National origin.
- Age.
- Disability.
- Sex.

### Services that HMSA provides

To better communicate with people who have disabilities or whose primary language isn't English, HMSA provides free services such as:

- Language services and translations.
- Text Relay Services.
- Information written in other languages.
- Information in other formats, such as large print, audio, and accessible digital formats.

If you need these services, please call 1 (800) 776-4672 toll-free.

### How to file a grievance or complaint

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

- Phone: 1 (800) 776-4672 toll-free
- 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.

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**MULTI-LANGUAGE INTERPRETER SERVICES**

**English**
ATTENTION: If you speak a foreign language, language assistance services, free of charge, are available to you. Call 1 (800) 660-4672 (TTY: 711).

**Ilokano (Ilocano)**
PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1 (800) 660-4672 (TTY: 711).

**Tagalog (Tagalog – Filipino)**
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1 (800) 660-4672 (TTY: 711).

**日本語 (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) 660-4672 (TTY: 711)まで、お電話にてご連絡ください。

**繁體中文 (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) 660-4672 (TTY:711)

**한국어 (Korean)**
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1 (800) 660-4672 (TTY: 711)번으로 전화해 주십시오.

**Español (Spanish)**
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1 (800) 660-4672 (TTY: 711).

**Tiếng Việt (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) 660-4672 (TTY: 711).

**Gagana fa'a Sāmoa (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) 660-4672 (TTY: 711).

**Kajin Ṃajōḷ (Marshallese)**
LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk 1 (800) 660-4672 (TTY: 711).

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**Foosun Chuuk (Trukese)**
MEI AUCHEA: Ika iei foosun fonuomw: Foosun Chuuk, iwe en mei tongeni omw kopwe angei aninisin chiakku, ese kamo. Kori 1 (800) 660-4672 (TTY: 711).

**Hoʻokomo ʻōlelo (Hawaiian)**
E NĀNĀ MAI: Inā hoʻopuka ʻoe i ka ʻōlelo [hoʻokomo ʻōlelo], loaʻa ke kōkua manuahi iā ʻoe.
E kelepona iā 1 (800) 660-4672 (TTY: 711).

**Lokaiahn Pohnpei (Pohnpeian)**
Ni songen mwohmw ohte, komw pahn sohte anahne kawehwe mesen nting me koatoantoal kan ahpw wasa me ntingie [Lokaiahn Pohnpei] komw kalangan oh ntingidieng ni lokaiahn Pohnpei.
Call 1 (800) 660-4672 (TTY: 711).

**Bisaya (Bisayan)**
ATENSYON: Kung nagsulti ka og Cebuano, aduna kay magamit nga mga serbisyo sa tabang sa lengguwahe, nga walay bayad. Tawag sa 1 (800) 660-4672 (TTY: 711).

**Tonga (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) 660-4672 (TTY: 711).

ພາສາລາວ **(Lao)**
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບລໍ ກິ ານຊ ວ ຍ ເ ຫ ຼ ືອ ດ ້ ານ ພ າ ສ າ, ໂ ດ ຍ ບ ເ ສ ັ ຽ ຄ ່ າ, ແ ມ ນ ມ ພ ້ ອ ມ ໃ ຫ ້ ທ ່ ານ. ໂ ທ ຣ 1 (800) 660-4672 (TTY: 711).