

Primary Care Provider. 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)
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)..... \$0
This plan is available to most individuals who have Medical Benefits from both the State and Medicare.

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

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 QUEST Integration (Medicaid) program?
If "yes," please provide your Medicaid number:

SECTION 3: SELECT YOUR PLAN PREMIUM PAYMENT OPTION

If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty assessed), you can pay, 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. Premiums, copayments, coinsurance and deductibles may vary based on the level of Extra Help you receive. Please contact the plan for further details.

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.

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 Dual Care 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

Admission Date

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

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.

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.

HMSA Akamai Advantage Dual Care has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until 2018 based on a review of HMSA Akamai Advantage Dual Care's Model of Care.

SECTION 5: PLEASE READ AND SIGN ON FOLLOWING PAGE

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

HMSA Akamai Advantage Dual Care (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 urgent care or out-of-area dialysis. 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.

Important Information About Your Health Plan

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.





An Independent Licensee of the Blue Cross and Blue Shield Association

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 kenyan. 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 Majōl (Marshallese)

LALE: Ñe kwōj kōnono Kajin Majōl, kwomaroñ bōk jermal in jipañ ilo kajin ñe am ejjeļok wōñān.
Kaalok 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).

Ho’okomo ‘ōlelo (Hawaiian)

E NĀNĀ MAI: Inā ho’opuka ‘oe i ka ‘ōlelo [ho’okomo ‘ōlelo], loa’a ke kōkua manuahi iā ‘oe. 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 ‘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) 660-4672 (TTY: 711).

ພາສາລາວ (Lao)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທສ 1 (800) 660-4672 (TTY: 711).