Change Form for Individual Tobacco Use

Amendment to the tobacco portion of Section C of the Individual Plan Application

Mail to: HMSA, Attn: Membership Services, 818 Keeaumoku St., Honolulu, HI 96814 | **Fax to:** 948-6614 (on Oahu)

The information you include on this form will change the information on your original application. **USE THIS FORM ONLY** if you originally enrolled in a health plan directly with HMSA. If you enrolled in an HMSA plan on the Hawaiʻi Health Connector (the state's health insurance marketplace) and you want to change your tobacco use information, please contact the Hawaiʻi Health Connector.

Name (First and Last): .... Subscriber ID: ....

Address: .... City: .... State: ...... ZIP: ....

Date of Birth: .... Telephone No.: .... Date: ....

Member	**Name (First and Last)** **Date of Birth**	**Have you or your dependents used tobacco?*** (regularly within the last six months*)
Member or Dependent ☐ Subscriber ☐ Spouse ☐ Child	______________________ Date of Birth: ____ /____ /________	☐ Yes ☐ No† † Reason for the change (check all that apply): ☐ I made a mistake on my original application. ☐ I quit. I'm no longer a tobacco user. ☐ I'm using/enrolled in tobacco cessation treatment.** ☐ I completed tobacco cessation treatment.** Treatment method: ______________________ Date completed: ____ /____ /________
Dependent ☐ Spouse ☐ Child	______________________ Date of Birth: ____ /____ /________	☐ Yes ☐ No† † Reason for the change (check all that apply): ☐ I made a mistake on my original application. ☐ He/she quit. He/she is no longer a tobacco user. ☐ He/she is using/enrolled in tobacco cessation treatment.** ☐ He/she completed tobacco cessation treatment.** Treatment method: ______________________ Date completed: ____ /____ /________

* **Have you or your dependents used tobacco?** Check "**Yes**" if you or your dependents (20 years of age and older) have used any tobacco within the last six months regularly (four or more times a week on average), excluding religious or ceremonial use. Check "**No**" if you or your dependents haven't used tobacco.

** **Tobacco cessation treatment** includes nicotine replacement therapies (like Chantix®, Zyban, Nicotrol®, or over-the-counter nicotine patches, gum, and lozenges), QuitNet (www.quitnet.com), and other tobacco cessation counseling.

I agree that the terms of this amendment are in addition to the terms in my Individual Plan Application, all of which still apply. I agree that I am signing this amendment under penalty of perjury, which means I have provided true answers to all of the questions covered by this amendment to the best of my knowledge. I understand and agree that the removal of any surcharge resulting from this amendment will take up to 60 calendar days from the date of HMSA's receipt of this amendment.

By printing, filling out, and signing this form as an amendment, I agree to the terms set forth in the application and I intend to enter into this amendment on my behalf and on behalf of my dependents (my spouse and children), if listed.

______________________	______________________	__________
Subscriber's Signature	Subscriber's Name (Print)	Date