HMSA MEDICAL PLAN ENROLLMENT FORM

PLEASE PRINT OR TYPE IN BLUE OR BLACK INK. REFER TO THE BACK FOR ENROLLMENT INSTRUCTIONS.

Group No. ______________________

Employer ______________________

FOR HMSA USE ONLY

SUB ID NO. ______________________

EFF. DATE __________ GROUP NO. __________

CONT ________ PKG ________ DEPT. NO. ________

APP RCV DATE __________ PROC DATE __________

TRX __________ __________ __________

__________ __________ __________

A EMPLOYEE DATA:

Last Name	First (Legal)	M. I.	Suffix	Gender	Birthdate: (mm/dd/yyyy)	Work Phone No.

Mailing Address (Number & Street or P.O. Box Number)	City	State	Zip Code	Home Phone No.

Social Security Number (SSN) (See Section A on the reverse side for information on submission of SSNs) —	☐ I acknowledge that I'm unable to provide a Social Security number because I'm a non-U.S. citizen.	Present/Former Subscriber ID
		If you are currently the subscriber of an HMSA Individual Plan and wish to cancel that membership, please submit a separate cancellation request in writing.

B SELECTING YOUR COVERAGE: PLEASE CHECK WITH YOUR EMPLOYER REGARDING THE PLAN OPTIONS

Medical Plan (Select one)

Free Choice Medical Plan		*HMO Medical Plan*
☐ Preferred Provider Plan	☐ CompMED	☐ Health Plan Hawaii Plus ****Indicate desired health center and primary care provider (PCP) or PCP number in Section C below**

C ENROLLMENT DATA:

LEGAL NAME				Gender	BIRTHDATE			SOCIAL SECURITY NO. (required) See Sec C on reverse side	By checking the applicable box(es) below, I acknowledge that I'm unable to provide a SSN because:	RELATIONSHIP	**COMPLETE THIS SECTION IF YOU SELECTED AN HMO MEDICAL PLAN		Current PCP?
Last Name	First Name	M. I.	Suffix		mm	dd	yyyy				Health Center	Primary Care Provider (PCP) or PCP Number	
Employee										Self			☐ Yes
								— —	☐ The individual is a non-U.S. citizen. ☐ The number provided is an ITIN.				☐ Yes
								— —	☐ The individual is a non-U.S. citizen. ☐ The number provided is an ITIN.				☐ Yes
								— —	☐ The individual is a non-U.S. citizen. ☐ The number provided is an ITIN.				☐ Yes
								— —	☐ The individual is a non-U.S. citizen. ☐ The number provided is an ITIN.				☐ Yes
								— —	☐ The individual is a non-U.S. citizen. ☐ The number provided is an ITIN.				☐ Yes

D OTHER INSURANCE: DO YOU OR YOUR DEPENDENTS HAVE OTHER COVERAGE (INCLUDING HMSA)? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

Name of Other Policy Holder	Other Policy Holder's ID No.	Name of Other Health Plan	Other Health Plan's Phone Number

E CONDITIONS OF ENROLLMENT: READ, SIGN AND DATE BELOW.

If I am accepted for coverage under a medical plan that requires selection of a primary care provider, all benefits must be provided or arranged by my primary care provider. I further understand that as an HMSA member, I agree: (a) to abide by the HMSA's constitution and by-laws, and terms and conditions of the health/dental plan; (b) to provide information to HMSA about my current or future medical treatment or condition; and (c) to appoint my employer or group as my agent for dues payment and for sending and receiving all notices to and from HMSA concerning the health/dental plan.

Signature ______________________________________ Date _____/_____/_____

ENROLLMENT INSTRUCTIONS

Complete all applicable fields to minimize delay in processing. You may not be entitled to all of the plans shown on this enrollment form. Only select plans that your employer states are available. See your employer if you have any questions.

SECTION A - EMPLOYEE DATA: Complete your legal name (last name, first name, middle initial, generational suffix such as Jr, III), gender (M, F, or U), birth date, work phone number, mailing address, home phone number, and Social Security number. Your Social Security number is needed because the Internal Revenue Service (IRS) requires all health plans, including HMSA, to collect members' Social Security numbers. The IRS uses this information to verify that our members have health insurance as required by law. If you are not a U.S. citizen, you can provide an individual taxpayer identification number (ITIN) in place of a Social Security number. Section 111 of the Medicare, Medicaid and SCHIP Extension Act (MMSEA) of 2007 (P.L. 110-173) and 42 U.S.C. 1395y(b)(7) requires HMSA to report Social Security numbers for anyone on this plan who is eligible to receive Medicare benefits regardless of age.

Enter your present or former HMSA number, if any. If you're currently enrolled in an HMSA individual plan, and would like that coverage canceled, please submit a signed letter (include your Subscriber Number) stating you wish to cancel your individual plan coverage to: Hawaii Medical Service Association; P.O. Box 860; Honolulu, HI 96808-0860. The cancellation will be effective on the first of the month following the receipt of the letter.

SECTION B - SELECTING YOUR COVERAGE: Select one of the medical plan options from HMSA's Choice Medical Plan. If you select an HMO Medical Plan, enter a Health Center and a Primary Care Provider in Section C.

If your employer offers a dental plan, select one of the dental plan options from HMSA's Choice Dental Plan.

SECTION C - ENROLLMENT DATA: List the legal name (last name, first name, middle initial, generational suffix such as Jr, III), gender (M, F, or U), birth date, and Social Security number for your spouse or domestic partner and each dependent child or domestic partner dependent who you wish to cover under your selected plan. Social Security numbers are required for your spouse or domestic partner and any dependent who is one year of age or older. If your spouse, domestic partner, or dependent is not a U.S. citizen, you can provide an individual taxpayer identification number (ITIN). Select the relationship (spouse, domestic partner, child, or DP dependent) as appropriate. Section 111 of the Medicare, Medicaid and SCHIP Extension Act (MMSEA) of 2007 (P.L. 110-173) and 42 U.S.C. 1395y(b)(7) requires HMSA to report Social Security numbers for anyone on this plan who is eligible to receive Medicare benefits regardless of age.

If you selected an HMO Medical Plan in Section B, such as Health Plan Hawaii Plus, you must enter a Health Center and the full name of a Primary Care Provider (PCP), or the PCP number, for yourself, your spouse or domestic partner, and each dependent child or domestic partner dependent. In the Current PCP box, check "Yes" for you, your spouse or domestic partner, and each dependent child or domestic partner dependent if the provider you selected is the current PCP. Some doctors may not be accepting new patients. For a current list, go to hmsa.com and click Find a Doctor. You can also view the current Directory of Health Centers and Providers.

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