hmsa

An Independent Licensee of the Blue Cross and Blue Shield Association

HMSA MEDICAL/DENTAL PLAN ENROLLMENT FORM

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

Group No. _____ **Sub Group No.** _____

Employer _____

A EMPLOYEE DATA:

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

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

Email Address	Social Security No. (See Section A on reverse side for additional information on submission of SSN) – –	Cell Phone No.

Employee Status Active Retiree COBRA

My Present or Former HMSA No.

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.

FOR HMSA USE ONLY

SUB ID NO. _____

EFF. DATE _____ GROUP NO. _____

CONT _____ PKG _____ DEPT. NO. _____

APP RCV DATE _____ PROC DATE _____

TRX _____ _____ _____

_____ _____ _____

B SELECTING YOUR COVERAGE: PLEASE CHECK WITH YOUR EMPLOYER REGARDING THE MEDICAL AND DENTAL PLAN OPTIONS.

HMSA's Choice Medical Plan (Select one)		HMSA's Choice Dental Plan (Select one)	
Free Choice Medical Plan	***HMO Medical Plan***	***Free Choice Dental Plan***	***HMO Dental Plan***
❑ Preferred Provider Plan ❑ CompMED	❑ Health Plan Hawaii Plus ****If selecting this plan, indicate desired health center, primary care provider (PCP), and PCP number in Section C below**	❑ Participating Provider Dental Program	❑ Dental Network Program

C ENROLLMENT DATA: IF YOU SELECTED AN HMO MEDICAL PLAN, ENTER A HEALTH CENTER AND PRIMARY CARE PROVIDER FOR YOU AND YOUR DEPENDENTS.

LEGAL NAME				GENDER	BIRTHDATE			SOCIAL SECURITY NO. See Sec C on reverse side	RELATIONSHIP (circle one)	COMPLETE THIS SECTION IF YOU SELECTED AN HMO MEDICAL PLAN			Current Provider?
Last Name	First Name	M. I.	Suffix	M / F	mm	dd	yyyy			Health Center	Primary Care Provider	PCP Number	
Employee (Self)													☐ Yes
Spouse/Domestic Partner								– –	Spouse / Domestic Partner				☐ Yes
Child/DP Dependent								– –	Child / DP Dependent				☐ Yes
Child/DP Dependent								– –	Child / DP Dependent				☐ Yes
Child/DP Dependent								– –	Child / DP Dependent				☐ Yes
Child/DP Dependent								– –	Child / DP Dependent				☐ Yes
Child/DP Dependent								– –	Child / DP Dependent				☐ 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/dental 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 medical/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 medical/dental plan.

Signature _____ Date _____/_____/_____

SEE REVERSE SIDE

White - *HMSA* Yellow - *HMSA/OPL* Pink - *GROUP*

ENROLLMENT INSTRUCTIONS

Please complete all applicable fields to minimize delays in processing. You may not be eligible for all of the plans shown on this enrollment form. Select plans that are available to you according to your employer. 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 or F), birth date, work phone number, mailing address, home phone number, and Social Security number. Important note: 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) require HMSA to report Social Security numbers for anyone on this plan age 45 and over or for anyone on this plan who is otherwise eligible to receive Medicare benefits regardless of age.

Enter your present or former HMSA number, if any. If you are currently enrolled in an HMSA Individual Plan, and would like to cancel that coverage, please submit a signed letter (include your subscriber number) stating you wish to cancel your individual plan coverage to: HMSA, P.O. Box 3500, Honolulu, HI 96811-3500. The cancellation will be effective on the first day of the month after HMSA receives your letter.

SECTION B - SELECTING YOUR COVERAGE: Select one of the medical plan options from HMSA's Choice Medical Plan.

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 or F), 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. Circle the relationship (spouse, domestic partner, child, or DP dependent) as appropriate. Important note: Section 111 of MMSEA (P.L. 110-173) and 42 U.S.C. 1395y(b)(7) require HMSA to report a Social Security number for anyone on this plan age 45 and over or for anyone on the plan who is eligible to receive Medicare benefits.

If you selected Health Plan Hawaii Plus as your HMO plan in Section B, you must enter a health center and the full name of a primary care provider for yourself, your spouse or domestic partner, and each dependent child or domestic partner dependent. Be sure to also include the PCP number for each primary care provider and indicate if you are currently seeing the selected provider. In the Current Provider box, check "Yes" for you, your spouse, or domestic partner and each dependent child or domestic partner dependent if the provider you selected is your current provider. Note: Some primary care providers are not accepting new patients. For a list of participating providers and their PCP numbers, see the current *Directory of Health Centers and Providers* or visit our website at hmsa.com and click on Find a Doctor.

SECTION D - OTHER INSURANCE: Check "Yes" to indicate if you, your spouse or domestic partner, or any of your dependents are also covered by any other group health plan (including HMSA or Medicare). If you check "Yes," enter the other policy holder's name, the other policy holder's ID number, the name of the other health plan, and a phone number for the other health plan.

SECTION E - CONDITIONS FOR ENROLLMENT: Sign and date the enrollment form.