



An Independent Licensee of the Blue Cross and Blue Shield Association

## HMSA MEDICAL PLAN ENROLLMENT FORM

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

Group No. \_\_\_\_\_

Employer \_\_\_\_\_

A EMPLOYEE DATA:							FOR HMSA USE ONLY					
Last Name	First (Legal)	M. I.	Suffix	Gender <b>M / F</b>	Birthdate: (mm/dd/yyyy)	Work Phone No.	SUB ID NO.	EFF. DATE	GROUP NO.	CONT.	PKG.	DEPT. NO.
Mailing Address (Number & Street or P.O. Box Number)			City	State	Zip Code	Home Phone No.	APP. RCV. DATE	PROC. DATE		TRX		
Social Security No. (See Section A on reverse side for additional information on submission of SSN)			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.							

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

**HMSA's Medical Plan**  
 **Free Choice Medical Plan**  
 **CompMED**

C ENROLLMENT DATA:										
	LEGAL NAME				Gender	BIRTHDATE			Full Time Student (over age 18)	SOCIAL SECURITY NO. See Sec C on reverse side
	Last Name	First Name	M. I.	Suffix		mm	dd	yyyy		
Spouse					M / F					- -
Child					M / F				Y / N	- -
Child					M / F				Y / N	- -
Child					M / F				Y / N	- -
Child					M / F				Y / N	- -
Child					M / F				Y / N	- -

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

If I am accepted for coverage under a medical plan that requires selection of a personal care physician, all benefits must be provided or arranged by my personal care physician. 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 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 plan.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_