

HMSA MEDICAL PLAN ENROLLMENT FORM

Group No. _____

PLEASE PRINT OR TYPE. REFER TO THE BACK FOR ENROLLMENT INSTRUCTIONS.

A EMPLOYEE DATA: THE "SUBSCRIBER (SELF)" LINE IN SECTION C BELOW MUST ALSO BE COMPLETED.	FOR HMSA USE ONLY																		
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%;">Last Name</td> <td style="width:15%;">First</td> <td style="width:15%;">Middle Initial or Name</td> <td style="width:20%;">Employer</td> <td style="width:15%;">Employment Date</td> <td style="width:20%;">Work Phone No.</td> </tr> <tr> <td colspan="3">Mailing Address (Number & Street or P.O. Box Number)</td> <td>City</td> <td>State</td> <td>ZIP Code</td> </tr> <tr> <td colspan="2">Home Phone No.</td> <td colspan="4"></td> </tr> </table>	Last Name	First	Middle Initial or Name	Employer	Employment Date	Work Phone No.	Mailing Address (Number & Street or P.O. Box Number)			City	State	ZIP Code	Home Phone No.						SUB ID NO. _____ EFF. DATE _____ GROUP NO. _____ CONT _____ PKG _____ DEPT. NO. _____ APP RCV DATE _____ PROC DATE _____ TRX _____ _____
Last Name	First	Middle Initial or Name	Employer	Employment Date	Work Phone No.														
Mailing Address (Number & Street or P.O. Box Number)			City	State	ZIP Code														
Home Phone No.																			
My Present or Former HMSA No. _____ If you are the subscriber of an HMSA Individual Plan now, do you wish to cancel that membership if this application is accepted? <input type="checkbox"/> Yes <input type="checkbox"/> No																			
B SELECTING YOUR COVERAGE: PLEASE CHECK WITH YOUR EMPLOYER REGARDING THE MEDICAL PLAN OPTIONS.																			

Medical Plan

Indicate desired Participating Health Center AND Personal Care Physician in Section C below.

Health Plan Hawaii Plus

C ENROLLMENT DATA: BE SURE TO COMPLETE ALL ITEMS FOR YOURSELF; IF APPLYING FOR A FAMILY CONTRACT, LIST SPOUSE AND DEPENDENT CHILDREN.								
	SEX	BIRTHDATE			REQUIRED FOR HMO MEMBERS			Current Physician? <input type="checkbox"/> Yes
		Mo.	Day	Year	Health Center	Personal Care Physician	PCP Number	
Subscriber (Self)								<input type="checkbox"/> Yes
Spouse								<input type="checkbox"/> Yes
Child								<input type="checkbox"/> Yes
Child								<input type="checkbox"/> Yes
Child								<input type="checkbox"/> Yes
Child								<input type="checkbox"/> Yes
Child								<input type="checkbox"/> Yes

D OTHER INSURANCE: DO YOU OR YOUR DEPENDENTS HAVE OTHER COVERAGE (INCLUDING HMSA)? <input type="checkbox"/> YES <input type="checkbox"/> 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 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 constitution, bylaws, and terms and conditions of the health/dental plan; (b) to provide information to HMSA about my 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. I also agree that HMSA shall set the date on which my health/dental plan coverage shall begin and agree to abide by any waiting periods in my health/dental plan which must be satisfied before any benefits can be paid for specified illness, injuries, or conditions.
Signature of Applicant _____ Date ____/____/____

ENROLLMENT INSTRUCTIONS APPLYING FOR HMSA MEMBERSHIP IS EASY!

NOTE: You may not be entitled to all of the coverage shown on this enrollment form. Please select and complete only those options that are available to you. Please see your group leader if you have any questions.

In **SECTION A - EMPLOYEE DATA**, complete your name, employer, employment date, work phone number, mailing address, and home phone number.

Enter your present or former Health Plan Hawaii/HMSA number. If you are currently enrolled in an HMSA Individual plan (Conversion Plan, Individual Business Plan, Plan 6, Student Plan 19, or HPH Individual Conversion Plan), and would like that coverage canceled when your new coverage begins, check "YES".

In **SECTION B - SELECTING YOUR COVERAGE**, choose the coverage that you want from the medical plan options that are available to you.

If you select Health Plan Hawaii Plus, you must select a participating Health Center and a Personal Care Physician in Section C.

In **SECTION C - ENROLLMENT DATA**, list the name, sex, and birthdate for yourself, your spouse, and each eligible dependent child who you wish to cover under this plan. A participating Health Center and Personal Care Physician must be selected for yourself, your spouse and, each eligible dependent child you wish to enroll in Health Plan Hawaii Plus. Be sure to also include the PCP number for each Personal Care Physician listed and indicate if you are currently seeing the selected physician.

In **SECTION D - OTHER INSURANCE**, provide the requested information if you, your spouse, or any of your dependents covered by your HMSA Plan are also covered by any other group health plan (including HMSA) or Medicare.

Read **SECTION E - CONDITIONS FOR ENROLLMENT**, then sign and date the enrollment form.

REMEMBER - ALL ITEMS ON THIS FORM MUST BE COMPLETED OR YOUR ENROLLMENT MAY BE DELAYED.