



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. _____

Employer _____

A EMPLOYEE DATA:	FOR HMSA USE ONLY							
Last Name	First (Legal)	M. I.	Suffix	Gender M / F	Birthdate: (mm/dd/yyyy)	Work Phone No.	SUB ID NO. _____	
Mailing Address (Number & Street or P.O. Box Number)			City		State	Zip Code	Home Phone No.	EFF. DATE _____ GROUP NO. _____
Social Security Number (SSN) (See Section A on the reverse side for information on submission of SSNs)				<input type="checkbox"/> I acknowledge that I'm unable to provide a Social Security number because I'm a non-U.S. citizen.		My Present or Former HMSA No. _____		CONT _____ PKG _____ DEPT. NO. _____
<div style="text-align: center;"> - - </div>				<input type="checkbox"/> 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.				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)
<i>Free Choice Medical Plan</i>	<i>Free Choice Dental Plan</i>
<input type="checkbox"/> Preferred Provider Plan	<input type="checkbox"/> Participating Provider Dental Program

C ENROLLMENT DATA: IF YOU SELECTED AN HMO MEDICAL PLAN, ENTER A HEALTH CENTER AND PERSONAL CARE PHYSICIAN FOR YOU AND YOUR DEPENDENTS.														
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 (circle one)	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)	PCP Number	
Employee (Self)														<input type="checkbox"/> Yes
Spouse / Domestic Partner				M / F				— —	<input type="checkbox"/> The individual is a non-U.S. citizen. <input type="checkbox"/> The number provided is an ITIN.	Spouse / Domestic Partner				<input type="checkbox"/> Yes
Child / DP Dependent				M / F				— —	<input type="checkbox"/> The individual is a non-U.S. citizen. <input type="checkbox"/> The number provided is an ITIN.	Child / DP Dependent				<input type="checkbox"/> Yes
Child / DP Dependent				M / F				— —	<input type="checkbox"/> The individual is a non-U.S. citizen. <input type="checkbox"/> The number provided is an ITIN.	Child / DP Dependent				<input type="checkbox"/> Yes
Child / DP Dependent				M / F				— —	<input type="checkbox"/> The individual is a non-U.S. citizen. <input type="checkbox"/> The number provided is an ITIN.	Child / DP Dependent				<input type="checkbox"/> Yes
Child / DP Dependent				M / F				— —	<input type="checkbox"/> The individual is a non-U.S. citizen. <input type="checkbox"/> The number provided is an ITIN.	Child / DP Dependent				<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.
<p>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.</p> <p>Signature _____ Date ____/____/____</p>

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 or F), 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 (PPO Conversion Plan, Individual Business Plan, Individual Care Plan, Plan 6, Student Plan 19, HPH Conversion Plan or 65C Plus), 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 3500; Honolulu, HI 96811-3500. 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 Personal Care Physician 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 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. 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). Circle 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) 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 listed and indicate if you are currently seeing the selected PCP. 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.