hmsa

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. _____

- ☐ Painting Industry Health & Welfare Trust Fund
- ☐ Hawaii Tapers Health & Welfare Trust Fund
- ☐ Carpet Layers Health & Welfare Trust Fund
- ☐ Hawaii Glaziers Health & Welfare Trust Fund

A EMPLOYEE DATA:

Last Name	First (Legal)	M. I.	Suffix	Gender	Birthdate: (mm/dd/yyyy)

Mailing Address (Number & Street or P.O. Box Number)	City	State	Zip Code	Employee Status

Work Phone No.	Home Phone No.	Cell Phone No.	Email Address

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.

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 PLAN AND RIDER OPTIONS.

Medical Plan

Free Choice Plan

☐ Preferred Provider Plan & Drug Rider	☐ Vision Care	☐ Chiropractic Care

C ENROLLMENT DATA:

LEGAL NAME					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:
Last Name	First Name	M. I.	Suffix	Gender	mm	dd	yyyy		
Spouse									☐ The individual is a non-U.S. citizen. ☐ The number provided is an ITIN.
Child									☐ The individual is a non-U.S. citizen. ☐ The number provided is an ITIN.
Child									☐ The individual is a non-U.S. citizen. ☐ The number provided is an ITIN.
Child									☐ The individual is a non-U.S. citizen. ☐ The number provided is an ITIN.
Child									☐ The individual is a non-U.S. citizen. ☐ The number provided is an ITIN.

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 bylaws 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

ENROLLMENT INSTRUCTIONS

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. Your Social Security number is needed because the Internal Revenue Service 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 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 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 860, Honolulu, HI 96808-0860. The cancellation will be effective on the first day of the month after HMSA receives your letter.

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 and each dependent child who you wish to cover under your selected plan. Social Security numbers are required for your spouse and any dependent who is one year of age or older. If your spouse or dependent is not a U.S. citizen, you can provide an individual taxpayer identification 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.

SECTION D - OTHER INSURANCE: Check "Yes" to indicate if you, your spouse, 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.