hmsa

FOR HMSA USE ONLY

SUB ID NO.: _____
EFF. DATE: _____
GROUP NO.: _____
CONT.: _____ PKG.: _____
APP RCV DATE: _____ PROC. DATE: _____
NOTES: _____
_____

REP Name: _____

INDIVIDUAL PLAN APPLICATION

A. Subscriber Information: The information you provide may be used to contact you about health management programs that you're eligible for.

Last Name	First Name (Legal)		M.I.	Suffix	Home Phone No.
Mailing Address (Number & Street or P.O. Box Number)	City	State	ZIP Code		Work Phone No.
Billing Address (Number & Street or P.O. Box Number)	City	State	ZIP Code		Cell Phone No.
Email Address					

Person responsible financially:
☐ Subscriber ☐ Other: Name: _____ Relationship to Subscriber: _____

B. Enrollment Information

I'm enrolling during (choose one):

☐ Annual open enrollment period ☐ A special enrollment period (SEP)
Enter SEP number from Section G attached: _____ Date of event: _____

I'd like to enroll in the following medical plan:

☐ Bronze PPO ☐ Bronze HMO ☐ Bronze HSA
☐ Silver 2500 Direct ☐ Silver PPO 2500 ☐ Silver PPO 3500 ☐ Silver HMO
☐ Gold PPO ☐ Gold PPO 1000 ☐ Gold HMO
☐ Platinum PPO ☐ Platinum HMO

☐ Catastrophic Plan (Single coverage only, up to age 29 or hardship exemption.)

If you've received a hardship or statutory exemption on the Health Insurance Marketplace, please provide the certificate of exemption number: _____

I'd like to enroll in the following stand-alone dental plan:

☐ Dental PPP High ☐ Dental PPP Basic ☐ Dental PPP Basic II ☐ Dental HMO Basic ☐ Dental PPP Pediatric Essential

Have you had HMSA dental coverage in the past 12 months? ☐ Yes ☐ No ☐ Unsure
Do you have HMSA group dental coverage? ☐ Yes ☐ No When will your coverage end? _____

The Affordable Care Act (ACA) requires you to have pediatric (children's) dental with your health plan as an essential health benefit.

☐ I've selected a dental plan above.
☐ I don't wish to include pediatric (children's) dental with my health plan option above.

I attest that I've enrolled in an exchange-certified dental plan that includes pediatric dental benefits as required by the ACA. I acknowledge that the ACA requires that pediatric dental be included as an essential health benefit for individual health insurance policies.

Dental insurance carrier: _____ Dental plan name and policy number: _____

To apply for this coverage, you must meet at least one of the following requirements:

- You're a resident of the state of Hawaii.
- You intend to reside in the state of Hawaii (HMSA reserves the right to request documentation verifying that you've moved into and reside in the state of Hawaii. If we determine you have not fulfilled your intent to reside in Hawaii, HMSA may retroactively rescind your coverage).
- You've entered the state of Hawaii with a job commitment.

☐ **I certify that I'm a resident of or intend to reside in the state of Hawaii or I live with a parent/caretaker who meets the requirements stated above.**

I'm an American Indian or Alaska Native.

☐ Yes ☐ No

My most recent coverage was through:

☐ My employer ☐ COBRA ☐ QUEST Integration ☐ An individual plan ☐ No recent coverage

Name of insurance carrier: ☐ HMSA ☐ Blue Cross Blue Shield ☐ Other carrier

Name of other carrier or Blue Cross Blue Shield plan: ______________________________ Policy number: ________________

Coverage end date: ____________________________ If applicable, was COBRA exhausted? ☐ Yes ☐ No

I or my dependent lost coverage because of:

☐ Failure to pay premiums on a timely basis, including COBRA premiums ☐ Intentional misrepresentation or fraud ☐ Other

I currently have an HMSA individual plan and would like to cancel that membership if this application is accepted.

☐ Yes ☐ No

If yes, complete: Medical subscriber number: ________________________ Dental subscriber number: ________________

C. Personal Information

Complete all items for anyone applying for coverage. Under current law, you can add or keep your children on your health plan until they are 26 years old. If you have additional dependents you wish to enroll, please complete Section C on another application and staple it to this application. **If you're enrolling in an HMO plan, please indicate name of a primary care provider or PCP number. Check yes if this is your current provider. Also, indicate the participating health center.**

***Tobacco use applies to anyone 21 years of age or older:** Check yes if you have used any tobacco within the last six months regularly (four or more times per week on average, excluding religious or ceremonial use). If you checked yes, circle the time period that you used tobacco regularly: a = within the last month; b = 2-3 months ago; c = 4-5 months ago.

If you currently participate in any of the following tobacco dependence treatment options—NRT, Chantix, Wellbutrin/Zyban or counseling—please check yes under Tobacco Dependence Treatment. Under Tobacco Cessation Options, check yes if you'd like to be contacted for information and/or assistance in tobacco cessation options.

	Name (First, Middle Initial, and Last)	Gender	Birth Date	Social Security No.	*Tobacco Use and Time Period	*Tobacco Dependence Treatment	*Tobacco Cessation Options
Subscriber (Self)					☐ Yes a b c	☐ Yes	☐ Yes
Spouse					☐ Yes a b c	☐ Yes	☐ Yes
Child					☐ Yes a b c	☐ Yes	☐ Yes
Child					☐ Yes a b c	☐ Yes	☐ Yes
Child					☐ Yes a b c	☐ Yes	☐ Yes

Subscriber (Self):
Primary care provider (PCP) ________________ PCP Number ________________ Current provider? ☐ Yes
Health center ______________________________

Spouse:
Primary care provider (PCP) ________________ PCP Number ________________ Current provider? ☐ Yes
Health center ______________________________

Child:
If your child is 26 years old or older, are they disabled? ☐ Yes ☐ No
Primary care provider (PCP) ________________ PCP Number ________________ Current provider? ☐ Yes
Health center ______________________________

Child:
If your child is 26 years old or older, are they disabled? ☐ Yes ☐ No
Primary care provider (PCP) ________________ PCP Number ________________ Current provider? ☐ Yes
Health center ______________________________

Child:
If your child is 26 years old or older, are they disabled? ☐ Yes ☐ No
Primary care provider (PCP) ________________ PCP Number ________________ Current provider? ☐ Yes
Health center ______________________________

Name (First and Last)	Gender	Birth Date	Social Security No.	*Tobacco Use and Time Period	*Tobacco Dependence Treatment	*Tobacco Cessation Options
Child _____	_____	_____	_____	☐ Yes ☐a ☐b ☐c	☐ Yes	☐ Yes

If your child is 26 years old or older, are they disabled? ☐ Yes ☐ No
Primary care provider (PCP) _____ PCP Number _____ Current provider? ☐ Yes
Health center _____

Child _____	_____	_____	_____	☐ Yes ☐a ☐b ☐c	☐ Yes	☐ Yes

If your child is 26 years old or older, are they disabled? ☐ Yes ☐ No
Primary care provider (PCP) _____ PCP Number _____ Current provider? ☐ Yes
Health center _____

D. Other Insurance

Will you or anyone listed in Section C have other insurance in addition to this coverage (including HMSA and Medicare)?
☐ Yes ☐ No

Name of other policy holder: _____ Name of insurance carrier: _____

Policy number: _____ Type of coverage: ☐ Medical ☐ Dental ☐ Drug ☐ Medicare Part A ☐ Medicare Part B

Name of other policy holder: _____ Name of insurance carrier: _____

Policy number: _____ Type of coverage: ☐ Medical ☐ Dental ☐ Drug ☐ Medicare Part A ☐ Medicare Part B

E. Payment

☐ Electronic funds transfer (EFT) from my checking or savings account each month.
☐ I'd like to continue my existing EFT under HMSA subscriber number: _____
☐ I'd like to set up a new EFT. Please complete the Automatic Payments Form and return to HMSA. **Note:** You won't receive a paper bill once EFT is set up.

F. Conditions of Enrollment

Please read carefully. If you agree, sign and date below.

- I understand that if the individuals listed on this application are accepted, I agree: (a) to abide by the constitution, bylaws, and terms and conditions of the plan, and (b) to provide information about my child's and/or my treatment or condition.
- I agree to the terms set forth in this application and acknowledge that I am signing this application under penalty of perjury, which means I have provided true answers to all the questions on this form to the best of my knowledge.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed).
- I agree that HMSA will set the date that my coverage will begin. I understand that I must pay my monthly premiums in advance.
- I understand that if I'm applying for coverage under a dental plan, there are certain dental services under the plan that may be subject to waiting periods, and I won't have coverage for those dental services until the waiting periods have been met.
- I understand that HMSA may, at its sole discretion and in accordance with applicable law and regulatory guidance, decline to accept premium or cost-sharing payments made directly or indirectly on my behalf by certain third party payers. These third parties include commercial entities with potential financial interests, health care providers or suppliers, and other entities from whom HMSA is not required by law to accept payment. I confirm that neither I nor my dependents identified in this application will allow premiums or cost-sharing payments to be made on our behalf by the third party payers identified herein.

I attest to the fact that:

- The dependents (spouse and children) listed on this application are my legal dependents. I understand that HMSA may request proof of this relationship at any time. HMSA may request the following documents: marriage certificate, civil union certificate, birth certificate, adoption documents, legal guardianship papers, or medical power of attorney.
- I understand that HMSA may also request proof of prior or current coverage start and end dates at any time.
- I have enrolled in an exchange-certified dental plan that includes pediatric (children's) dental benefits as outlined by the ACA.

Consent to Conduct Electronic Transactions. If I'm submitting this Individual Plan Application electronically, then by doing so, I consent to electronic transactions with HMSA generally and consent to electronically enroll myself in an HMSA plan as set out in this agreement specifically. I understand I can withdraw this consent to electronic transactions at any time by so informing HMSA in writing, and thereafter transactions with me will be conducted by paper. Withdrawing consent will not affect the validity of this Individual Plan Application or any other transactions conducted electronically prior to my withdrawal of consent to electronic transactions.

By printing, filling out, and signing this form for a hard copy application, I agree to the terms set forth in this Individual Plan Application and enter into this contract on my behalf and on behalf of my dependents such as my spouse and children, if listed.

By signing this Individual Plan Application electronically, it means I acknowledge and agree to the terms of this Individual Plan Application and enter into this contract on my behalf (and on behalf of my dependents [spouse and children] if listed) and so indicate by typing my name below as my electronic signature, executed and adopted by me with the intent to sign this document. In other words, typing my name as an electronic signature indicates I acknowledge and agree to the terms of this Individual Plan Application just as a handwritten signature would on a traditional paper form.

F1. _____ _____
Signature of subscriber (18 years old or older) or parent or legal guardian for minors — Print name

_____ _____
Relationship — Date

F2. _____ _____
Signature of other authorized parent or legal guardian for minors — Print name

_____ _____
Relationship — Date

G. Special Enrollment Period (SEP) Reasons

You must apply within 60 days of a qualifying event below. HMSA, at its sole discretion, may request documentation from you to verify your SEP eligibility.

1. A qualified individual or dependent loses minimum essential coverage. Loss of minimum essential coverage doesn't include termination or loss due to failure to pay premiums on a timely basis, including COBRA premiums before the expiration of COBRA coverage, or situations allowing for a rescission for fraud or intentional misrepresentation.
2. A qualified individual gains a dependent or becomes a dependent through marriage.
3. A qualified individual gains a dependent or becomes a dependent through birth, adoption, or placement for adoption.
4. An individual who wasn't previously a citizen, national, or lawfully present individual gains such status.
5. A qualified individual or enrollee gains access to new qualified health plans (QHP) as a result of a permanent move.
6. An American Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a QHP or change to another QHP one time per month.

(00) 2000-37338 9.18 LE

Federal law requires HMSA to provide you with this notice.

HMSA complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. HMSA does not exclude people or treat them differently because of things like race, color, national origin, age, disability, or sex.

Services that HMSA provides

Provides aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages
- If you need these services, please call 1 (800) 776-4672 toll-free; TTY 711

How to file a discrimination-related grievance or complaint

If you believe that we've failed to provide these services or discriminated against you in some way, you can file a grievance in any of the following ways:

- Phone: 1 (800) 776-4672 toll-free
- TTY: 711
- Email: Compliance_Ethics@hmsa.com
- Fax: (808) 948-6414 on Oahu
- Mail: 818 Keeaumoku St., Honolulu, HI 96814

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, in any of the following ways:

- Online: ocrportal.hhs.gov/ocr/portal/lobby.jsf
- Phone: 1 (800) 368-1019 toll-free; TDD users, call 1 (800) 537-7697 toll-free
- Mail: U.S. Department of Health and Human Services, 200 Independence Ave. S.W., Room 509F, HHH Building, Washington, DC 20201

For complaint forms, please go to hhs.gov/ocr/office/file/index.html.

Hawaiian: E NĀNĀ MAI: Inā hoʻopuka ʻoe i ka ʻŌlelo Hawaiʻi, loaʻa ke kōkua manuahi iā ʻoe. E kelepona iā 1 (800) 776-4672. TTY 711.

Bisaya: ATENSYON: Kung nagsulti ka og Cebuano, aduna kay magamit nga mga serbisyo sa tabang sa lengguwahe, nga walay bayad. Tawag sa 1 (800) 776-4672 nga walay toll. TTY 711.

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1 (800) 776-4672。TTY 711.

Ilocano: PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1 (800) 776-4672 toll-free. TTY 711.

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1 (800) 776-4672 をご利用ください。TTY 711.まで、お電話にてご連絡ください.

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1 (800) 776-4672번으로 연락해 주시기 바랍 니다. TTY 711 번으로 전화해 주십시오.

Laotian: ກະລຸນາສັງເກດ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການຊ່ວຍເຫຼືອດ້ານພາສາ, ບໍ່ມີຄ່າໃຊ້ຈ່າຍ, ແມ່ນມີໃຫ້ທ່ານ. ໂທ 1 (800) 776-4672 ຟຣີ. TTY 711.

Marshallese: LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk 1 (800) 776-4672 tollfree, enaj ejjelok wonaan. TTY 711.

Pohnpeian: Ma ke kin lokaian Pohnpei, ke kak ale sawas in sohte pweine. Kahlda nempe wet 1 (800) 776-4672. Me sohte kak rong call TTY 711.

Samoan: MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1 (800) 776-4672 e leai se totogi o lenei ʻau'aunaga. TTY 711.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1 (800) 776-4672. TTY 711.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1 (800) 776-4672 toll-free. TTY 711.

Tongan: FAKATOKANGA'I: Kapau ʻoku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea ʻoku nau fai atu ha tokoni ta'etotongi, pea teke lava ʻo ma'u ia. Telefoni mai 1 (800) 776-4672. TTY 711.

Trukese: MEI AUCHEA: Ika iei foosun fonuomw: Foosun Chuuk, iwe en mei tongeni omw kopwe angei aninisin chiakku, ese kamo. Kori 1 (800) 776-4672, ese kamo. TTY 711.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1 (800) 776-4672. TTY 711.

hmsa

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