COBRA ASSIST ENROLLMENT FORM

An Independent Licensee of the Blue Cross and Blue Shield Association

To: **Hawai'i Medical Service Association**
Membership Services
P.O. Box 860
Honolulu, HI 96808-0860
Ph: 948-5555

Date: _____

From: _____ Group / Subgroup Number: _____
(Name of Company or Group)

Address: _____ Phone Number: _____

HMSA Number (Present or Former)	Name of Eligible Employee or Dependent*	Monthly Rate or Amount Being Remitted	Qualifying Event	Membership Termination Date	Date Election Form Sent	COBRA Election Date	Other Carrier**	Billing Address and Remarks
						0.00%		
	TOTAL							

***List spouse or dependent's name here if application is being made in their own name.**
****Refer to additional instructions on back of form.**

Signed _____
(Report must be signed by group leader or authorized person.)

See reverse side for enrollment instructions.

INSTRUCTIONS

HMSA Number (Present or Former)
Provide the complete 13-digit membership number belonging to the employee. (R0000.....)

Name of Eligible Employee or Dependent
List the individual who has elected extended group coverage under an HMSA plan, e.g., employee, spouse, or dependent.

Monthly Rate or Amount Being Remitted
If applicable, indicate the amount being remitted with this form.

Qualifying Event
Describe which event qualifies the individual for extended coverage under COBRA, e.g., termination, reduction in work hours, layoff for economic reasons, death of employee, divorce or legal separation, employee covered under Medicare, or dependent too old to be covered under family plan.

Membership Termination Date
Include the date that the individual's group coverage ended or will end.

Date Election Form Sent
Indicate the date "Notification of COBRA Election" form was mailed.

COBRA Election Date
Include the date that the individual elected to extend coverage under COBRA.

****Other Carrier**
Indicate the carrier the individual is switching from. If the inidividual is switching from another carrier, a new HMSA enrollment form must accompany this form.

Billing Address and Remarks
Include the billing address of the individual. Also, use this section to report any information pertinent to the COBRA enrollee.

All items on this form must be completed or COBRA enrollment may be delayed.
COBRA enrollment is subject to eligibility requirements.