hmsa

FOR HMSA USE ONLY
SUB ID NO.:
EFF. DATE:
GROUP NO.:
CONT.: PKG.:
APP RCV DATE: PROC. DATE:
NOTES:

EUTF PART-TIME/TEMPORARY EMPLOYEE PLAN APPLICATION

REP Name:

A. Subscriber Data

Last Name	First (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 Data

I'm enrolling during (choose one): ☐ Annual open enrollment period ☐ New hire - Date of hire

I'm enrolling within 30 days of receiving notification of my eligibility: ☐ Yes ☐ No

I'd like to enroll in the EUTF medical and drug plan and I am an EUTF employee: ☐ Yes ☐ No

My most recent coverage was through EUTF: ☐ Yes ☐ No

If yes, through which insurance carrier? ☐ HMSA ☐ Other

C. Personal Information

Complete all items for anyone applying for coverage. Maximum age for dependent children is through 25 years of age. If you have additional dependents you wish to enroll, please complete Section C on another application and staple it to this application.

	Name (First and Last)	Gender	Birth Date	Social Security No. (required)
Subscriber (Self)				
Child				
	If your child is 26 years old or older, are they disabled? ☐ Yes ☐ No			
Child				
	If your child is 26 years old or older, are they disabled? ☐ Yes ☐ No			
Child				
	If your child is 26 years old or older, are they disabled? ☐ Yes ☐ No			
Child				
	If your child is 26 years old or older, are they disabled? ☐ Yes ☐ No			
Child				
	If your child is 26 years old or older, are they disabled? ☐ Yes ☐ No			
Child				
	If your child is 26 years old or older, are they disabled? ☐ Yes ☐ No			

D. Other Insurance

Will you 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

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 will not receive a paper bill once EFT is set up.

F. Conditions of Enrollment

PLEASE READ CAREFULLY, THEN 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 become a full-time EUTF employee, it's my responsibility to cancel this EUTF Part-Time/Temporary Employee Plan. HMSA will not automatically terminate my membership in this plan.

I attest to the fact that:

- The dependents (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: 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.

Consent to Conduct Electronic Transactions. If I am submitting this EUTF Part-Time/Temporary Employee 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 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 EUTF Part-Time/ Temporary Employee Plan Application and enter into this contract on my behalf (and on behalf of my dependents [children], if listed).

By signing this EUTF Part-Time/Temporary Employee Plan Application electronically, it means I acknowledge and agree to the terms of this EUTF Part-Time/Temporary Employee Plan Application and enter into this contract on my behalf (and on behalf of my dependents [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 EUTF Part-Time/Temporary Employee 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 | Print name | Relationship | Date

G. Qualifying Events for Coverage

You must apply within 30 days of a qualifying event below.

- Adoption
- Birth
- Guardianship
- New Eligible Student
- New Hire
- Newly Eligible
- Placement for Adoption
- Reinstatement in Employment
- Return from Authorized Leave of Absence (if not currently enrolled)

(00) 4000-2051 3.15 LE