hmsa

An Independent Licensee of the Blue Cross and Blue Shield Association

HMSA MEDICAL PLAN ENROLLMENT FORM

PLEASE PRINT IN BLACK INK. SEE REVERSE SIDE FOR ENROLLMENT INSTRUCTIONS.

Group No.: ____________________

Employer: ____________________

A EMPLOYEE DATA:

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

Mailing Address (Number & Street or P.O. Box Number)	Apt No.	City	State	Zip Code

Social Security Number (SSN)
See reverse side for more information

If unable to provide a SSN, I acknowledge that:
☐ I am not a U.S. citizen.
☐ The number provided is my Individual Tax Payer Identification number (ITIN)

Work Phone No.

Home Phone No.

Email Address

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:

Medical Plan

Free Choice Medical Plan		***HMO Medical Plan***
☐ Preferred Provider Plan	☐ CompMED	☐ Health Plan Hawaii Plus ****Provide Primary Care Provider (PCP) number or PCP name in Section C**

C ENROLLMENT DATA:

LEGAL NAME: Last Name	First Name	M. I.	Suffix	GENDER (Select one)	BIRTHDATE (mm-dd-yyyy)	SOCIAL SECURITY NUMBER (SSN) See reverse side for more information	If unable to provide a SSN, I acknowledge that:	RELATIONSHIP (Select one)	**COMPLETE THIS SECTION IF YOU SELECTED AN HMO MEDICAL PLAN: Health Center	Primary Care Provider (PCP) or PCP Number	Current PCP? Yes
Employee								Self			☐
Dependent							☐ The individual is a non-U.S. citizen. ☐ The number provided is an ITIN.				☐
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D OTHER INSURANCE:
If you and/or your dependents have other insurance coverage (including another HMSA plan), complete and submit the separate Coordination of Benefit form. See reverse side for more information.

E INDIVIDUAL INSURANCE:
If you have a HMSA Individual plan and wish to cancel that membership, submit a separate cancellation request in writing. See reverse side for more information.

F CONDITIONS OF ENROLLMENT:
Read, sign, and date below.

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.

Signature ______________________________ Date _____/_____/_____

ENROLLMENT INSTRUCTIONS

Complete all applicable fields to minimize delay in processing. See your employer if you have any questions regarding your plan options.

SECTION A - EMPLOYEE DATA: Complete your legal name (last name, first name, middle initial, generational suffix such as Jr, III), gender (M, F, or U), birth date, mailing address, work phone number, home phone number, email address, and Social Security number. The Internal Revenue Service (IRS) requires all health plans, including HMSA, to collect members' Social Security numbers so they can verify health insurance coverage, 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. Check boxes of appropriate statements(s) if a Social Security number cannot be provided. 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 B - SELECTING YOUR COVERAGE: Select desired plan coverage from the options provided in Section B. If you select an HMO Medical Plan, provide the Primary Care Provider information in Section C.

SECTION C - ENROLLMENT DATA: List the legal name (last name, first name, middle initial, generational suffix such as Jr, III), gender (M, F, or U), birth date, and Social Security number for your dependents who you wish to cover under your selected plan. Social Security numbers are required for any dependent who is one year of age or older. If any of your dependents is not a U.S. citizen, you can provide an individual taxpayer identification number (ITIN). Check boxes of appropriate statement(s) if a Social Security number cannot be provided. Select the relationship 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 provide the Health Center name and eight digit Primary Care Provider (PCP) number or the full name of the PCP for each member under your plan. The PCP number can be found by visiting Find a Doctor on hmsa.com and clicking on View Details of the selected provider. Viewing the details will also indicate whether that PCP is accepting new patients. This information can also be found in the current provider directory. Please note that if a Health Center or PCP number is not provided, and only a PCP name is provided, we will assign you to the Health Center that's closest to you. This is important because the Health Center will determine the network of providers available for referrals and coordination of your care. In the Current PCP box, check "Yes" if the provider you have identified is that enrollee's current PCP. If a PCP is not identified, one will be automatically assigned to you based on previous visits or by zip code.

SECTION D - OTHER INSURANCE: If you and/or your dependents have other insurance coverage with another carrier, please complete and submit in the required information identified on the separate Coordination of Benefits form. This will help to process your claims properly. See form for submission options.

SECTION E - INDIVIDUAL PLAN: If you are currently enrolled in an HMSA individual plan, and would like that coverage canceled, please submit a signed letter (include your individual plan subscriber ID number) stating you wish to cancel your individual plan coverage to: Hawaii Medical Service Association, P.O. Box 860, Honolulu, HI 96808-0860. The cancellation will be effective on the first of the month following the receipt of the letter.

SECTION F - CONDITIONS FOR ENROLLMENT: Sign and date the enrollment form.