hmsa

An Independent Licensee of the Blue Cross and Blue Shield Association

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

INDIVIDUAL PLAN APPLICATION

REP Name and ID#: _____

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. ( )
Physical Address (Number & Street or P.O. Box)	City	State	ZIP Code		☐ Same as Mailing Address
Mailing Address (Number & Street or P.O. Box)	City	State	ZIP Code		Work Phone No. ( )
Billing Address (Number & Street or P.O. Box)	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
Enter SEP number from Section G attached: _____ Date of event: _____

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

☐ Platinum PPO ☐ Gold PPO I ☐ Gold PPO II ☐ Silver PPO Direct ☐ Silver PPO ☐ Bronze PPO I ☐ Bronze PPO II HSA

☐ Catastrophic Plan (Single coverage only for individuals under 30 years of age or hardship exemption.)

If you've received a hardship or statutory exemption on HealthCare.gov, please provide the certificate of exemption number: _____

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

☐ PPO Gold ☐ PPO Silver ☐ HMO Silver ☐ PPO Bronze ☐ Dental PPO Pediatric Essential ☐ Dental PPO Platinum
Note: You must be 65 years or older to enroll in this plan.

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 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 are 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 have moved to and reside in Hawaii. If HMSA determines, in its sole discretion, that such documentation does not verify that you have fulfilled your intent to reside in Hawaii, HMSA may rescind your coverage.
- You have entered the State of Hawaii with a job commitment
- You are seeking employment in the State of Hawaii
- Your parent or caretaker resides in Hawaii and you reside with the parent or caretaker

☐ **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.**

We reserve the right to request, at any time, documentation that demonstrates in our sole discretion and to our satisfaction that you meet the above criteria. Your refusal to provide such documentation or to provide documentation that in HMSA's sole discretion demonstrates the criteria have been met shall result in immediate termination of this coverage.

I'm a Native American or Alaska Native.
☐ Yes ☐ No

My most recent coverage was through:
☐ My employer ☐ COBRA ☐ QUEST (Medicaid) ☐ An individual plan ☐ No recent coverage

Name of insurance carrier: ☐ HMSA ☐ Other Blue Cross and/or Blue Shield company ☐ Other carrier

Name of other carrier or other Blue Cross and/or Blue Shield company: _____ 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 plan subscriber number:_____ Dental plan 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, complete Section C on another application and staple it to this application. **Please indicate the name of the 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 — check yes under Tobacco Dependence Treatment. Under Tobacco Cessation Options, check yes if you'd like to be contacted for information about and/or assistance with 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
Primary care provider: _____ PCP Number: _____ Current provider? ☐ Yes						
Health center: _____						
Spouse:				☐ Yes a b c	☐ Yes	☐ Yes
Primary care provider: _____ 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 Number: _____ Current provider? ☐ Yes						
Health center: _____						

Name (First, Middle Initial, 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 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 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 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 Number: ____________ Current provider? ☐ Yes						
Health center: ____________						

D. Other Insurance

Important Note: Will you or anyone listed in Section C have other insurance in addition to this coverage (including HMSA and Medicare)?
Note: Federal law prohibits HMSA from selling new ACA Individual health plans to individuals who are currently enrolled in Medicare.
If you have Original Medicare, you have the option to enroll in an HMSA Medicare Advantage plan.

☐ Yes ☐ No

Name of other policyholder: ____________ Name of insurance carrier: ____________

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

Name of other policyholder: ____________ Name of insurance carrier: ____________

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

E. Payment

☐ Electronic funds transfer 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.

You can also pay through eInvoiceConnect. Go to hmsa.com, click My Account Login, and register for an online account.

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 on paper. Withdrawing consent will not affect the validity of this Individual Plan Application or any other transactions conducted electronically before 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 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 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 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 qualified health plan or change to another QHP one time per month.

Mail the completed application to:

Hawaii Medical Service Association
8 AMS
P.O. Box 860
Honolulu, HI 96808-9988

Fax (808) 948-6343

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