HMSA
Blue Cross Blue Shield of Hawaii
An Independent Licensee of the Blue Cross and Blue Shield Association

HMSA MEDICAL/DENTAL PLAN ENROLLMENT FORM

PLEASE PRINT OR TYPE IN BLUE OR BLACK INK. REFER TO THE BACK FOR ENROLLMENT INSTRUCTIONS.

Group No. _____

Employer _____

A EMPLOYEE DATA:

Last Name	First (Legal)	M. I.	Suffix	Gender M / F	Birthdate: (mm/dd/yyyy)	Work Phone No.

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

Social Security No. (See Section A on reverse side for additional information on submission of SSN) — —	My Present or Former HMSA No.	If you are currently the subscriber of an HMSA Individual Plan and wish to cancel that membership, please submit a separate cancellation request in writing.

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: PLEASE CHECK WITH YOUR EMPLOYER REGARDING THE MEDICAL AND DENTAL PLAN OPTIONS.

HMSA's Choice Medical Plan (Select one)

Free Choice Medical Plan	*HMO Medical Plan*
❑ Preferred Provider Plan	❑ Health Plan Hawaii Plus ****If selecting this plan, indicate desired Health Center AND Personal Care Physician in Section C below**

HMSA's Choice Dental Plan (Select one)

Free Choice Dental Plan	*HMO Dental Plan*
❑ Participating Provider Dental Program	❑ Dental Network Program

C ENROLLMENT DATA: IF YOU SELECTED AN HMO MEDICAL PLAN, ENTER A HEALTH CENTER AND PERSONAL CARE PHYSICIAN FOR YOU AND YOUR DEPENDENTS.

LEGAL NAME					BIRTHDATE			Full Time Student (over age 18)	SOCIAL SECURITY NO.	**COMPLETE THIS SECTION IF YOU SELECTED AN HMO MEDICAL PLAN**		Current
Last Name	First Name	M. I.	Suffix	Gender	mm	dd	yyyy		See Sec C on reverse side	Health Center	Personal Care Physician	Physician?
Employee (Self)												☐ Yes
Spouse				M / F					– –			☐ Yes
Child				M / F				Y / N	– –			☐ Yes
Child				M / F				Y / N	– –			☐ Yes
Child				M / F				Y / N	– –			☐ Yes
Child				M / F				Y / N	– –			☐ Yes
Child				M / F				Y / N	– –			☐ Yes

D OTHER INSURANCE: DO YOU OR YOUR DEPENDENTS HAVE OTHER COVERAGE (INCLUDING HMSA)? ❑ YES ❑ NO IF YES, COMPLETE THE FOLLOWING:

Name of Other Policy Holder	Other Policy Holder's ID No.	Name of Other Health Plan	Other Health Plan's Phone Number

E CONDITIONS OF ENROLLMENT: READ, SIGN AND DATE BELOW.

If I am accepted for coverage under a medical plan that requires selection of a personal care physician, all benefits must be provided or arranged by my personal care physician. 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. You may not be entitled to all of the plans shown on this enrollment form. Only select plans that your employer states are available. See your employer if you have any questions.

SECTION A - EMPLOYEE DATA: complete your legal name (last name, first name, middle initial, generational suffix such as Jr, III), gender (M or F), birth date, work phone number, mailing address, home phone number, and social security number. Important Note: 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 age 55 and over or for anyone on this Plan who is otherwise eligible to receive Medicare benefits regardless of age. Effective January 1, 2011, HMSA is required to include anyone on this Plan age 45 and over.

Enter your present or former HMSA number, if any. If you are currently enrolled in an HMSA Individual Plan (PPO Conversion Plan, Individual Business Plan, Individual Care Plan, Plan 6, Student Plan 19, HPH Conversion Plan or 65C Plus), and would like that coverage canceled, please submit a signed letter (include your Subscriber Number) stating you wish to cancel your individual plan coverage to: Hawaii Medical Service Association; P.O. Box 3500; Honolulu, HI 96811-3500. The cancellation will be effective on the first of the month following the receipt of the letter.

SECTION B - SELECTING YOUR COVERAGE: select one of the medical plan options from HMSA's Choice Medical Plan. If you select an HMO Medical Plan, enter a Health Center and a Personal Care Physician in Section C.

If your employer offers a dental plan, select one of the dental plan options from HMSA's Choice Dental Plan.

SECTION C - ENROLLMENT DATA: list the legal name (last name, first name, middle initial, generational suffix such as Jr, III), gender (M or F), birth date, and social security number for your spouse and each dependent child who you wish to cover under your selected plan. If a dependent child is a full-time student over the age of 18, circle "Y"; if not, circle "N". Important Note: Section 111 of MMSEA (P.L. 110-173) and 42 U.S.C. 1395y(b)(7), requires HMSA to report a social security number for anyone on this Plan age 55 and over or for anyone on the Plan who is eligible to receive Medicare benefits. Effective January 1, 2011, HMSA is required to include anyone on this Plan age 45 and over or anyone on this Plan who is otherwise 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 enter a Health Center and the full name of a Personal Care Physician for yourself, your spouse, and each dependent child. In the Current Physician box, check "Yes" for you, your spouse, and each dependent child if the physician you selected is the current physician. Note: some Personal Care Physicians are not accepting new patients. For a current list, reference the current *Directory of Health Centers and Providers* or on the Internet at www.HMSA.com and click on "Find a Doctor".

SECTION D - OTHER INSURANCE: Check "Yes" to indicate if you, your spouse, or any of your dependents are also covered by any other group health plan (including HMSA or Medicare). If you check "Yes", enter the other policy holder's name, the other policy holder's ID number, the name of the other health plan, and a phone number for the other health plan.

SECTION E - CONDITIONS FOR ENROLLMENT: sign and date the enrollment form.