HMSA's Catastrophic Care Plan Application

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(Please print or type. Refer to the back for enrollment instructions.)

① Last Name | First (Legal) | Middle Initial

Phone Numbers
Home: ____________________
Work: ____________________
Cell: ____________________

Mailing Address (Number & Street or P.O. Box Number) | City | State | ZIP Code

② Other Medical coverage?
❑ Yes ❑ No

____
Name of Carrier(s)

③ If you currently have an HMSA individual plan, do you understand that your membership will be canceled if this application is approved? ❑ Yes ❑ No (Refer to instructions on back.)

④ My present or former HMSA subscriber ID:

FOR HMSA USE ONLY

SUB ID NO. ____________________
EFF. DATE ____________________
GROUP NO. ____________________
CONT ______ PKG ________ DEPT NO ________
APP RCV DATE ____________________
PROC DATE ____________________
TRX ______________ ______________
______________ ______________
HIPAA WAIVER Y___ N ___ CERT___ REP VERIF___

⑤ Applicant Information

	Sex	Birth Date	Social Security Number	*(HMSA Use Only)* Family Code
Subscriber ____________________	_____	______________	______ - ______ - ______	______________

⑥ If applying for family contract, list spouse and dependent children:

Spouse ____________________	_____	______________	______ - ______ - ______	______________
Son or Daughter ____________________	_____	______________	______ - ______ - ______	______________
Son or Daughter ____________________	_____	______________	______ - ______ - ______	______________
Son or Daughter ____________________	_____	______________	______ - ______ - ______	______________
Son or Daughter ____________________	_____	______________	______ - ______ - ______	______________
Son or Daughter ____________________	_____	______________	______ - ______ - ______	______________

⑦ I understand that if I am accepted as an HMSA member, I agree: (a) to abide by the constitution, bylaws, and terms and conditions of the health plan, and (b) to provide information to HMSA about my treatment or condition. I also agree that HMSA shall set the date on which my health plan coverage shall begin and agree to abide by any annual plan deductibles and any waiting periods for this plan, which must be satisfied before any benefits may be paid for specific illness, injuries or conditions.

____ ____________________
Signature of Applicant Date

Enrollment Instructions
Applying for HMSA membership is easy!

① Write your name, address and phone numbers.

② Check "yes" if you have other medical coverage. Write the name of your carrier(s).

③ If you are currently enrolled in an HMSA individual medical plan, that coverage will be canceled upon enrollment into this plan.

If you are currently enrolled in an employer-sponsored HMSA plan, please contact the group to cancel your acceptance into this plan.

Please note: This plan does not coordinate benefits with any other medical insurance plan, including Medicare. Once accepted into this plan, members cannot have any other medical insurance coverage.

④ Enter your present or former HMSA subscriber ID.

⑤ Fill in your name, sex, birth date, and Social Security number.

⑥ If you are applying for a family plan, list information for your spouse and each eligible dependent child.

⑦ Read the agreement, then sign and date the application form.

REMEMBER — ALL ITEMS ON THIS APPLICATION, THE INDIVIDUAL PLAN AUTHORIZATION FOR MEDICAL RECORDS, AND HEALTH HISTORY FOR SUBSCRIBER AND ALL DEPENDENT(S) MUST BE COMPLETED OR YOUR ENROLLMENT MAY BE DELAYED. YOUR APPLICATION IS SUBJECT TO APPROVAL BY HMSA.

Please refer to the brochure for waiting periods, limitations and exclusions that apply to the plan. You may also request a *Guide to Benefits* prior to joining the plan by calling your local HMSA office. The *Guide to Benefits* provides a more detailed explanation of plan benefits, limitations and exclusions.

You must be a Hawaii resident to subscribe to this plan.

IMPORTANT NOTE: Section 111 of the Medicare, Medicaid and SCHIP Extension Act (MMSEA) of 2007 (P.L. 110-173) and 42 U.S.C. 1395 y(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 Jan. 1, 2011, HMSA is required to include anyone on this plan age 45 and over.