



An Independent Licensee of the Blue Cross and Blue Shield Association

# The HMSA Children's Plan Application

(Please print or type. Please refer to the enrollment instructions on the other side.)

<p>① Parent or Guardian's Last Name _____</p> <p>First (Legal) _____ Middle Initial _____</p> <p>Phone Numbers Home: _____ Work: _____ Cell: _____</p> <p>Mailing Address (Number &amp; Street or P.O. Box Number) _____ City _____ State _____ ZIP Code _____</p> <p>Billing Address (if Different) _____</p>	<p style="text-align: center;"><b>FOR HMSA USE ONLY</b></p> <p>SUB ID NO. _____</p> <p>EFF. DATE _____</p> <p>GROUP NO. _____</p> <p>CONT _____ PKG _____ DEPT NO. _____</p> <p>APP RCV DATE _____</p> <p>PROC DATE _____</p> <p>TRX _____</p> <p>Waiver Y _____ N _____ Verified by: _____</p>
<p>② Other Medical Coverage for Child? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Name of Carrier(s) _____</p> <p>③ Child's Present or Former HMSA Subscriber ID.: _____</p>	<p>④ Child Applicant Information</p> <p>First (Legal), M.I., Last Name _____</p> <p>Sex _____ Birth Date _____</p> <p>Social Security Number _____</p> <p>Participating Health Center _____</p> <p>Primary Care Provider _____</p> <p>Current Provider? <input type="checkbox"/> Yes</p>
<p>⑤ I understand that if my child is 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 child's treatment or condition. I also agree that HMSA will set the date on which my child's health plan coverage will begin and agree to abide by any waiting periods for this plan that must be satisfied before any benefits may be paid for specific illnesses, injuries, or conditions.</p> <p style="text-align: right;">Signature of Parent, Legal Guardian, or 18-year-old Applicant _____ Date _____</p> <p style="text-align: center;">(If you are the legal guardian, you must provide a copy of your guardianship papers with this application.)</p>	

## **Enrollment Instructions** **Applying for The HMSA Children's Plan is easy!**

- ① Write your name, address, and phone numbers.
- ② Check "yes" if your child has other medical coverage. Write the name of the carrier. Please note: This plan does not coordinate benefits with any other medical insurance plan. Members cannot have any other medical insurance coverage.
- ③ Enter your child's present or former HMSA subscriber ID.
- ④ List the child's name, sex, birth date, and Social Security number. Then choose a health center and primary care provider that participates with The HMSA Children's Plan. Under "Current Provider?", check "Yes" if the provider you selected is your child's current provider. If box is not checked and provider is not accepting new patients or is a specialist, we will not be able to enroll your child with that provider.
- ⑤ Read the agreement, then sign and date the application on behalf of your minor child.

**REMEMBER: All items on this application must be completed or enrollment may be delayed. Be sure to include the first month's payment with your application. Membership in The HMSA Children's Plan is subject to approval by HMSA.**

Please refer to the brochure for 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 and your child must be residents of the state of Hawaii to enroll in 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.**