

HMSA



An Independent Licensee of the Blue Cross and Blue Shield Association

HMSA's Individual Care Plan Application

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

HMSA's Individual Care Plan Application

① Last Name First (Legal) Middle Initial			Phone Numbers Home: _____ Work: _____ Cell: _____		FOR HMSA USE ONLY				
Mailing Address (Number & Street or P.O. Box Number) City State ZIP Code				② <input type="checkbox"/> High Option <input type="checkbox"/> Basic Option		SUB ID NO. _____ EFF DATE _____ GROUP NO. _____ CONT _____ PKG _____ DEPT NO. _____ APP RCV DATE _____ PROC DATE _____ TRX _____ HIPAA Waiver Y ___ N ___ Verified by: _____			
③ Other Medical Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Name of Carrier(s)		④ If you have an HMSA individual plan now, do you wish to cancel that membership if this application is approved? (Refer to instructions on back.) <input type="checkbox"/> Yes <input type="checkbox"/> No		⑤ My present or former HMSA subscriber ID: _____					
Please indicate desired participating health center and primary care provider for each applicant.									
⑥ Applicant Information		Sex	Birth Date	Social Security Number	Participating Health Center	Primary Care Provider	Current Provider?	Family Code	PCP No.
Subscriber _____			____/____/____	____-____-____	_____/_____	_____	<input type="checkbox"/> Yes	_____	_____
⑦ If applying for family contract, list spouse and dependent children:									
Spouse _____			____/____/____	____-____-____	_____/_____	_____	<input type="checkbox"/> Yes	_____	_____
Son or Daughter _____			____/____/____	____-____-____	_____/_____	_____	<input type="checkbox"/> Yes	_____	_____
Son or Daughter _____			____/____/____	____-____-____	_____/_____	_____	<input type="checkbox"/> Yes	_____	_____
Son or Daughter _____			____/____/____	____-____-____	_____/_____	_____	<input type="checkbox"/> Yes	_____	_____
Son or Daughter _____			____/____/____	____-____-____	_____/_____	_____	<input type="checkbox"/> Yes	_____	_____
Son or Daughter _____			____/____/____	____-____-____	_____/_____	_____	<input type="checkbox"/> Yes	_____	_____
⑧ 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 will set the date on which my health plan coverage will begin and agree to abide by any annual plan deductibles and waiting periods for this plan, which must be satisfied before any benefits may be paid for specific illnesses, injuries, or conditions.									
_____ Signature of Applicant							_____ Date		

Enrollment Instructions

Applying for HMSA's Individual Care Plan is easy!

- ① Write your name, address, and phone numbers.
- ② Select either the High or Basic Option. (Rate and benefit information for each option may be found in the accompanying brochure.)
- ③ Check "yes" if you have other medical coverage. Write the name(s) of your carrier(s).
- ④ If you are currently enrolled in an HMSA Individual Plan, (PPO Conversion Plan, Conversion Plan 10, Plan 6, Student Plan 19, or HPH Conversion Plan), are accepted for coverage in this plan, and would like your current coverage canceled when your new coverage begins, simply check "yes." You may be required to complete a plan waiver form at the time of acceptance.
- ⑤ Enter your present or former HMSA subscriber ID.
- ⑥ Please fill in your name, sex, birth date, Social Security number, participating health center, and primary care provider. The primary care provider must be with the participating health center specified in the directory of HMSA health centers and providers for individual plans. Under "Current Provider?", check "Yes" if the provider you selected is your 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 you with that provider. For a list of participating providers, see the *Directory of Health Centers and Providers* or visit HMSA's website at hmsa.com and click on "Find a Doctor."
- ⑦ If applying for the family plan, list information for your spouse and each eligible dependent child.
- ⑧ Read the agreement, then sign and date the application.

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.