

## HMSA's Individual Dental Plan Application

<b>A SUBSCRIBER DATA:</b>					<b>FOR HMSA USE ONLY</b>	
Last Name	First Name (Legal)	Middle Initial	Phone Numbers Home: _____ Work: _____ Cell: _____		SUB ID NO. _____	
Mailing Address (Number & Street or P.O. Box Number)			City	State	ZIP Code	EFF. DATE _____ GROUP NO. _____
My Present HMSA Medical Plan Subscriber ID (Required)		I currently have an HMSA individual dental plan and would like to cancel that membership if this application is accepted. <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide HMSA Dental Subscriber # _____				CONT _____ PKG _____ DEPT NO. _____
					APP RCV DATE _____ PROC DATE _____	
					TRX _____	
<b>B SELECT YOUR DENTAL OPTION</b>						
<input type="checkbox"/> <b>HMSA Dental Plus Plan</b> (Monthly dues)		<input type="checkbox"/> <b>HMSA PPP Individual Dental</b> (Annual dues)		<input type="checkbox"/> <b>Dental Network Program</b> <b>Hawaii Family Dental Centers</b> (Annual dues)		
<b>C ENROLLMENT DATA: BE SURE TO COMPLETE ALL ITEMS FOR YOURSELF. IF APPLYING FOR A FAMILY CONTRACT, LIST EACH INDIVIDUAL AND COMPLETE ALL ITEMS.</b>						
APPLICANT INFORMATION				SEX	BIRTH DATE	SOCIAL SECURITY NUMBER
SUBSCRIBER (SELF) _____				_____	_____	- - -
SPOUSE _____				_____	_____	- - -
SON OR DAUGHTER _____				_____	_____	- - -
SON OR DAUGHTER _____				_____	_____	- - -
SON OR DAUGHTER _____				_____	_____	- - -
SON OR DAUGHTER _____				_____	_____	- - -
<b>D OTHER INSURANCE: DO YOU OR YOUR DEPENDENTS HAVE OTHER DENTAL COVERAGE (INCLUDING HMSA)?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>IF YES, COMPLETE THE FOLLOWING.</b>						
Name of Other Policy Holder		Name of Other Dental Plan		Other Policy Holder's ID No.		Other Dental Plan's Phone No.
<b>E CONDITIONS OF ENROLLMENT: PLEASE READ CAREFULLY, THEN SIGN AND DATE BELOW.</b>						
<p><i>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 plan, and (b) to provide information to HMSA about my treatment or condition. I agree that HMSA shall set the date on which my dental plan coverage shall begin. Based on the dental plan I have selected, I understand that: (a) If I enroll in the HMSA Dental Plus Plan, I must pay monthly dues in advance. If I cancel this plan, I will have a 24-month waiting period from the effective date of the cancellation before I can reapply; and (b) If I enroll in HMSA PPP Individual Dental or Dental Network Program, I will pay plan dues annually prior to the plan year. If I disenroll from either of these plans, the dues paid are non-refundable. I also understand that my dependent(s) and I must have an active HMSA medical plan to qualify for initial and continued enrollment in these plans.</i></p>						
Signature of Applicant _____					Date _____	
					RELATIONSHIP _____	
					PRINT NAME _____	

# ENROLLMENT INSTRUCTIONS

## APPLYING FOR HMSA MEMBERSHIP IS EASY!

**NOTE:** You must currently have an HMSA medical plan to qualify for enrollment in an HMSA individual dental plan.

### SECTION A - SUBSCRIBER DATA

Complete your name, mailing address, and phone numbers. Enter your present HMSA medical plan subscriber ID. If you currently have an individual dental plan, please indicate if you would like that membership canceled if this application is accepted. If yes, enter your dental plan subscriber ID.

### SECTION B - SELECT YOUR DENTAL OPTION

The HMSA Dental Plus Plan and the HMSA PPP Individual Dental give you the freedom to see your own dentist. For the Dental Network Program, you must use dentists within Hawaii Family Dental Centers.

### SECTION C - ENROLLMENT DATA

List your name, sex, birth date, and Social Security number. If applying for the family plan, list information for your spouse and each eligible dependent child who you wish to cover under this plan.

### SECTION D - OTHER INSURANCE

Provide the requested information if you, your spouse, or any of your dependents covered by your HMSA plan are also covered by any other dental plan (including HMSA).

### SECTION E - CONDITIONS OF ENROLLMENT

Read, sign, and date the enrollment form. Only the signature of the applicant will be accepted unless you are enrolling a minor child. If signing for a minor, please print your name and relationship to that child.

REMEMBER - ALL ITEMS ON THIS FORM MUST BE COMPLETED OR YOUR ENROLLMENT MAY BE DELAYED.

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Send your completed application with the appropriate dues payment payable to HMSA to:

HMSA  
Attn: 6-AMS  
P.O. Box 860  
Honolulu, HI 96808-0860

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**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.