HMSA's Dental Plus Plan Application

hmsa

An Independent Licensee of the Blue Cross and Blue Shield Association

HMSA's Dental Plus Plan Application (For seniors 65 or better)

A SUBSCRIBER DATA:

Last Name	First Name	Middle Initial

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

Email Address

Phone Numbers

Home: _____

Work: _____

Cell: _____

Present HMSA medical plan subscriber ID number if you have an HMSA medical plan.

_____

I currently have an HMSA individual dental plan and would like to cancel that membership if this application is accepted. ❑ Yes ❑ No

If yes, please provide HMSA dental plan subscriber number: _____

FOR HMSA USE ONLY

SUB ID NO. _____

EFF. DATE _____ GROUP NO. _____

CONT _____ PKG _____ DEPT NO. _____

APP RCV DATE _____ PROC DATE _____

TRX _____ _____ _____ _____

_____ _____ _____ _____

B ENROLLMENT DATA: *ALL APPLICANTS MUST BE AT LEAST 65 YEARS OF AGE.*

APPLICANT INFORMATION	SEX (CIRCLE ONE)	BIRTH DATE	SOCIAL SECURITY NUMBER	FOR HMSA USE ONLY Family Code
SUBSCRIBER (SELF) _____	M / F	_____	_____ - _____ - _____	_____
SPOUSE _____	M / F	_____	_____ - _____ - _____	_____

C OTHER INSURANCE: *DO YOU OR YOUR SPOUSE (IF APPLICABLE) HAVE OTHER DENTAL COVERAGE (INCLUDING HMSA)?* ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING.

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

D CONDITIONS OF ENROLLMENT: *PLEASE READ CAREFULLY, THEN SIGN AND DATE BELOW.*

I understand that if the individuals listed on this application are accepted, 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 spouse and/or my treatment or condition. I agree that HMSA will set the date on which my dental plan coverage will begin. I understand that there are certain services under this plan that may be subject to waiting periods, and that I will not have coverage for those services until the waiting periods have been met. I understand that I must pay monthly premiums in advance. If I cancel this plan, I'll have a 24-month waiting period from the effective date of the cancellation before I can reapply.

_____ _____ _____ _____

*SIGNATURE OF APPLICANT OR LEGAL AUTHORIZED REPRESENTATIVE** | *PRINT NAME* | *RELATIONSHIP* | *DATE*

*If you're completing this application as a legal authorized representative on behalf of an applicant, please submit a copy of your legal documentation (e.g., power of attorney) with this application for our records.

SEE REVERSE SIDE FOR INSTRUCTIONS

(00) 2000-6010 07:16 cs

ENROLLMENT INSTRUCTIONS

NOTE: All applicants must be at least 65 years of age or better.

SECTION A - SUBSCRIBER DATA

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

SECTION B - ENROLLMENT DATA

List your name, sex, birth date, and Social Security number. If you'd like to enroll your spouse, fill in spouse's information.

SECTION C - OTHER INSURANCE

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

SECTION D - CONDITIONS OF ENROLLMENT

Read, sign, and date the enrollment form. If you're a legal authorized representative for the applicant, please print your name and relationship and submit a copy of your legal documentation (e.g., power of attorney) with the application.

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

Send your completed application to:

HMSA
Attn: 8-AMS
P.O. Box 860
Honolulu, HI 96808-0860

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.