HMSA's PPO Conversion Plan Application

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

① Last Name | First (Legal) | Middle Initial

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

Phone Numbers
Home: ______________________
Work: ______________________
Cell: ______________________

② Other Medical Coverage?
❑ Yes ❑ No
____
Name of Carrier(s)

③ 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 ____________ ____________
____________ ____________

④ Applicant Information

	Name	Sex	Birth Date	Social Security Number	*(HMSA Use Only)* Family Code
Subscriber	______	____	______	____ - ____ - ____	______

⑤ If applying for family contract, list spouse and dependent children:

	Name	Sex	Birth Date	Social Security Number	Family Code
Spouse	______	____	______	____ - ____ - ____	______
Son or Daughter	______	____	______	____ - ____ - ____	______
Son or Daughter	______	____	______	____ - ____ - ____	______
Son or Daughter	______	____	______	____ - ____ - ____	______
Son or Daughter	______	____	______	____ - ____ - ____	______
Son or Daughter	______	____	______	____ - ____ - ____	______

⑥ 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 illnesses, 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 Enter your present or former HMSA subscriber I.D.

④ Fill in your name, sex, birth date and Social Security Number.

⑤ If you are applying for a family plan, list information for your spouse and each eligible dependent child.

⑥ Read the agreement, then sign and date the application.

REMEMBER — ALL ITEMS ON THIS APPLICATION MUST BE COMPLETED OR YOUR ENROLLMENT MAY BE DELAYED. BE SURE TO INCLUDE FIRST TWO MONTHS DUES PAYMENT WITH YOUR APPLICATION. ADDITIONAL DUES MAY BE REQUIRED IF APPLYING AFTER THE 10TH OF THE CURRENT MONTH. YOUR APPLICATION 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 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.