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# Enrollment Application

Please print in **black ink** or complete online at [www.hmaa.com](http://www.hmaa.com).

Applications must be received by the 10<sup>th</sup> of the coverage month.

HMAA USE ONLY				
Policy #	Div #	Eff Date		
Med	Den	Vis	Rx	Life

**REV: 01/12**

## Enrollment and Qualifying Event Information *(Members must enroll within 30 days of a Qualifying Event)*

<b>I am enrolling because: (Please check the appropriate statement)</b> <input type="radio"/> This is my company's annual open enrollment with HMAA <input type="radio"/> I am a new employee <input type="radio"/> I just began working 20+ hours a week - on ___/___/___ <input type="radio"/> I have involuntarily lost my health coverage <i>(please attach HIPAA certificate)</i> My company is now enrolling with HMAA and: <input type="radio"/> I am actively working <input type="radio"/> I am on COBRA. Coverage began ___/___/___ and will end on ___/___/___	<b>I am adding my:</b> <input type="radio"/> Newborn child <i>(attach proof of birth)</i> <input type="radio"/> Newly adopted dependent <i>(attach proof of adoption)</i> <input type="radio"/> New spouse or civil union partner <i>(attach proof of marriage/partnership)</i> <input type="radio"/> Dependent who involuntarily lost his/her health coverage <i>(attach HIPAA certificate)</i> <input type="radio"/> OTHER <i>(specify):</i> _____
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Last Name		First Name		M.I.	SSN		
Mailing Address				City	State	Zip Code	
Home Phone #	E-Mail Address		<input type="radio"/> Male <input type="radio"/> Female	Weight (lbs)	Height (ft. in.)	Status <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Civil Union	Birthdate / /
Employer Name		Policy #	Employer Phone #	Job Title/Description		Date of Hire / /	Hours Worked (per week)
Div #							
Name of Current or Most Recently Visited Doctor			Doctor's Phone #		Other Coverage? If Yes, Other Carrier and Policy #: <input type="radio"/> YES <input type="radio"/> NO		
<b>Life Insurance Beneficiary</b> <i>(if coverage included with plan):</i>		Last Name		First Name		M.I.	Relationship

## Dependent Enrollment Information *(Child coverage available up to age 26)*

Dependent Name	Relationship to Member	SSN	Birthdate	Gender	Height	Weight	(X) if Disabled	Other Coverage?	If Yes, Other Carrier and Policy #
	<input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Civil Union Partner		/ /	<input type="radio"/> M <input type="radio"/> F				<input type="radio"/> Yes <input type="radio"/> No	
	<input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Civil Union Partner		/ /	<input type="radio"/> M <input type="radio"/> F				<input type="radio"/> Yes <input type="radio"/> No	
	<input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Civil Union Partner		/ /	<input type="radio"/> M <input type="radio"/> F				<input type="radio"/> Yes <input type="radio"/> No	

## Medical History Disclosure, Certification, & Authorization

Within the past five (5) years, have you or anyone included in this application for coverage:

- Experienced symptoms; received medical advice; or been tested, diagnosed, or treated for any medical conditions?
- Contemplating, planning, or considering any elective procedures or treatments causing you or your dependents to seek medical advice?

**YES, initial here** \_\_\_\_\_ **and list the details on Page 2.**       **NO, initial here** \_\_\_\_\_

I certify that the disclosures in this application are true and complete for all medical conditions. I understand that HMAA uses this information for rating purposes and that any claims for benefits related to any undisclosed medical conditions may materially affect HMAA's risk. Between the time I sign this disclosure to the effective date of coverage, if there are changes to, or development of, any medical conditions disclosed or not disclosed, I will immediately disclose those changes in writing to HMAA's underwriting department for rate review. Benefits for any undisclosed conditions known and unreported as of the effective date of coverage may be denied, or coverage may be rescinded or terminated, or premium may increase retroactively or on a forward going basis at the sole discretion of HMAA. I will make full restitution of claims paid if coverage is rescinded due to a material non-disclosure of medical conditions. Intentional falsification of material facts or non-disclosure of conditions to secure medical benefits on this application seeking benefits coverage is a violation of Federal and State law and may be punishable by both civil and criminal sanctions.

I authorize HMAA to contact the treating physicians or other health care providers or facilities (collectively called "doctors"), or insurance organizations, for myself and any enrolled dependent(s) about any medical conditions, or obtain records (except psychotherapy notes) so that HMAA may underwrite my enrollment in HMAA plans, to ask my/our doctors about medical conditions that are reported on claims from doctors, to respond to treatment plan requests from doctors, and for other normal health plan operations. A photocopy of this authorization shall be valid as the original.

This authorization is effective from the date noted below until all coverage with HMAA for myself and my enrolled dependent(s) ceases, or any (initial) disputes regarding coverage with HMAA are resolved, whichever date is the later. I understand that the information covered by this authorization may be redisclosed subject to the Federal Privacy Regulations. I understand that I may revoke this authorization where HMAA has not acted in reliance upon it by submitting a written request to HMAA at the address listed on this application. My written statement shall specify which parts of this authorization are revoked and the date the revocation is effective.

	/ /		/ /
<b>Applicant's Signature</b>	<b>Date</b>	<b>Spouse or Partner's Signature (if enrolling)</b>	<b>Date</b>

Last Name of Employee:	First Name of Employee:
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If you answered YES to the Medical History Disclosure question on the first page, please provide details below. Do not provide genetic information.

**Section 1: Full Medical History Disclosure**  
*Please answer questions for yourself and anyone in your family applying for coverage*

	Patient's First Name	Description of Diagnosis/Treatment/Symptoms	Date Began	Date Ended or Ongoing	Physician Name and Phone Number
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

**Section 2: Medication Disclosure**  
*Prescription medications, including over the counter or "OTC" medicine prescribed or recommended by a physician or practitioner for yourself and anyone in your family applying for coverage - attach additional sheets if needed*

	Patient's First Name	Description of Condition(s) Being Treated	Medication Name	Dosage	Frequency	Date Prescribed	Date Ended or Ongoing	Physician Name and Phone Number
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								