HMAA
HAWAII MEDICAL ASSURANCE ASSOCIATION

737 Bishop St, Suite 1200
Honolulu, HI 96813
Phone: (808) 941-4622
Fax: (808) 535-8363

Enrollment Application

Please print in **black ink** or complete online at www.hmaa.com.

Applications must be received by the 10th 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)*

I am enrolling because: (Please check the appropriate statement)

- O This is my company's annual open enrollment with HMAA
- O I am a new employee
- O I just began working 20+ hours a week - on ___/___/___
- O I have involuntarily lost my health coverage *(please attach HIPAA certificate)*

My company is now enrolling with HMAA and:

- O I am actively working
- O I am on COBRA. Coverage began ___/___/___ and will end on ___/___/___

I am adding my:

- O Newborn child *(attach proof of birth)*
- O Newly adopted dependent (*attach proof of adoption)*
- O New spouse or civil union partner *(attach proof of marriage/partnership)*
- O Dependent who involuntarily lost his/her health coverage *(attach HIPAA certificate)*
- O OTHER *(specify):* _____

Last Name	First Name	M.I.	SSN

Mailing Address	City	State	Zip Code

Home Phone #	E-Mail Address		Weight (lbs)	Height (ft. in.)	Status	Birthdate
		O Male O Female			O Single O Married O Civil Union	/ /

Employer Name	Policy # / Div #	Employer Phone #	Job Title/Description	Date of Hire	Hours Worked (per week)
				/ /	

Name of Current or Most Recently Visited Doctor	Doctor's Phone #	Other Coverage?	If Yes, Other Carrier and Policy #:
		O YES O NO	

Life Insurance Beneficiary (if coverage included with plan):	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 #
	O Spouse O Child O Civil Union Partner		/ /	O M O F				O Yes O No	
	O Spouse O Child O Civil Union Partner		/ /	O M O F				O Yes O No	
	O Spouse O Child O Civil Union Partner		/ /	O M O F				O Yes O 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.

	/ /		/ /
Applicant's Signature	**Date**	**Spouse or Partner's Signature (if enrolling)**	**Date**

Forms must be dated <u>within sixty (60) days</u> of the coverage effective date. Continued on other side.

Last Name of Employee:	First Name of Employee:

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								

Print & Mail

Send To Human Resources