

HMSA



For Informational Purposes of the Blue Cross and Blue Shield Association

HMSA MEDICAL/DENTAL PLAN ENROLLMENT FORM

Group No. _____

PLEASE PRINT OR TYPE. REFER TO THE BACK FOR ENROLLMENT INSTRUCTIONS.

| A EMPLOYEE DATA: THE "SUBSCRIBER (SELF)" LINE IN SECTION C BELOW MUST ALSO BE COMPLETED. | | | | | | FOR HMSA USE ONLY | | | | |
|---|-------|--|--|-----------------|--|-------------------------|--|----------------------------------|---|------------|
| Last Name | First | Middle Initial or Name | Employer | Employment Date | Work Phone No. | SUB ID NO. | _____ | | | |
| Mailing Address (Number & Street or P.O. Box Number) | | | City | State | ZIP Code | EFF. DATE | GROUP NO. _____ | | | |
| My Present or Former HMSA No. | | | If you are the subscriber of an HMSA Individual Plan now, do you wish to cancel that membership if this application is accepted? | | | CONT | PKG | DEPT. NO. _____ | | |
| | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | APP RCV DATE | PROC DATE _____ | | | |
| | | | | | | TRX | _____ | | | |
| B SELECTING YOUR COVERAGE: PLEASE CHECK WITH YOUR EMPLOYER REGARDING THE MEDICAL AND DENTAL PLAN OPTIONS. | | | | | | | | | | |
| HMSA's Choice Medical Plan (Select one) | | | | | HMSA's Choice Dental Plan (Select one if offered by your employer) | | | | | |
| Free Choice Plan | | HMO Plan: Please indicate desired Participating Health Center AND Personal Care Physician in Section C below if selecting this plan. | | | Free Choice Dental Plan | | HMO Dental Plans | | | |
| <input type="checkbox"/> Preferred Provider Plan | | <input type="checkbox"/> Health Plan Hawaii Plus | | | <input type="checkbox"/> Participating Dental Program | | <input type="checkbox"/> Hawaii Family Dental Centers <input type="checkbox"/> Eugene M. Azuma, DDS, Inc.* <i>*Provider accepting established patients only.</i> | | <input type="checkbox"/> Dental Independent Network** <i>**Indicate desired Primary Care Dentist in Section C below.</i> | |
| C ENROLLMENT DATA: BE SURE TO COMPLETE ALL ITEMS FOR YOURSELF; IF APPLYING FOR A FAMILY CONTRACT, LIST SPOUSE AND DEPENDENT CHILDREN. | | | | | | | | | | |
| | SEX | BIRTHDATE | | | REQUIRED FOR HMO MEDICAL MEMBERS | | | Current Physician? | **Dental Independent Network | |
| | | Mo. | Day | Year | Health Center | Personal Care Physician | PCP Number | | Primary Care Dentist | PCD Number |
| Subscriber (Self) | | | | | | | | <input type="checkbox"/> Yes | | |
| Spouse | | | | | | | | <input type="checkbox"/> Yes | | |
| Child | | | | | | | | <input type="checkbox"/> Yes | | |
| Child | | | | | | | | <input type="checkbox"/> Yes | | |
| Child | | | | | | | | <input type="checkbox"/> Yes | | |
| Child | | | | | | | | <input type="checkbox"/> Yes | | |
| Child | | | | | | | | <input type="checkbox"/> Yes | | |
| Child | | | | | | | | <input type="checkbox"/> Yes | | |
| D OTHER INSURANCE: DO YOU OR YOUR DEPENDENTS HAVE OTHER COVERAGE (INCLUDING HMSA)? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, COMPLETE THE FOLLOWING: | | | | | | | | | | |
| Name of Other Policy Holder | | | Other Policy Holder's ID No. | | Name of Other Health Plan | | | Other Health Plan's Phone Number | | |
| E CONDITIONS OF ENROLLMENT: READ, SIGN AND DATE BELOW. | | | | | | | | | | |
| If I am accepted for coverage under a medical plan that requires selection of a personal care physician, all benefits must be provided or arranged by my personal care physician. I further understand that as an HMSA member, I agree: (a) to abide by the constitution, bylaws, and terms and conditions of the health/dental plan; (b) to provide information to HMSA about my medical treatment or condition; and (c) to appoint my employer or group as my agent for dues payment and for sending and receiving all notices to and from HMSA concerning the health/dental plan. I also agree that HMSA shall set the date on which my health/dental plan coverage shall begin and agree to abide by any waiting periods in my health/dental plan which must be satisfied before any benefits can be paid for specified illness, injuries, or conditions. | | | | | | | | | | |
| Signature of Applicant _____ | | | | | Date ____/____/____ | | | | | |