HMSA
Blue Cross Blue Shield of Hawaii
An Independent Licensee of the Blue Cross and Blue Shield Association

HMSA MEDICAL PLAN ENROLLMENT FORM

Group No. 23917

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.

Last Name	First (Legal)	Middle Initial or Name	Employer	Employment Date	Work Phone No.

Mailing Address (Number & Street or P.O. Box Number)	City	State	ZIP Code	Home Phone 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? ❑ Yes ❑ No

FOR HMSA USE ONLY

SUB ID NO. _____

EFF. DATE _____ GROUP NO. _____

CONT _____ PKG _____ DEPT. NO. _____

APP RCV DATE _____ PROC DATE _____

TRX _____ _____ _____

B

C ENROLLMENT DATA: BE SURE TO COMPLETE ALL ITEMS FOR YOURSELF; IF APPLYING FOR A FAMILY CONTRACT, LIST SPOUSE AND DEPENDENT CHILDREN.

Legal Name	SEX	BIRTHDATE Mo.	Day	Year
Subscriber (Self)				
Spouse				
Child				
Child				
Child				
Child				
Child				

D OTHER INSURANCE: DO YOU OR YOUR DEPENDENTS HAVE OTHER COVERAGE (INCLUDING HMSA)? ❑ YES ❑ 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 _____/_____/_____