HMAA USE ONLY	
Policy #	Div #

737 Bishop Street, Suite 1200
Honolulu, Hawaii 96813
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Fax (808) 535-8363

REV 05/2018

Business Application

Businesses with 50 or fewer Full-Time Equivalent Employees (FTEs) qualify for the Affordable Care Act (ACA) benefit and rating structure. Under the ACA, a full-time employee is one who works at least 30 hours per week during the preceding calendar year. Under the Prepaid Health Care Act, an eligible employee is defined as an employee who works at least 20 hours per week. Please print in **black ink** or complete online at hmaa.com. Failure to answer **every** question may result in delayed coverage. Kindly retain a copy of the submitted application for your files.

Business Information

Business Name as it appears when filing with the Department of Labor, if applicable			
Doing Business as (dba), if applicable *(if your company does business under a different name from above)*			
Street Address	City	State	Zip Code
Billing Address	City	State	Zip Code
Name of Contact Person	Phone ( )	Fax ( )	
Email Address			
Type of Business: ❍ Corporation ❍ Partnership ❍ Sole Proprietor ❍ LLC ❍ Other (specify):	Nature of Business (please be specific)		
Number of FTEs in the preceding calendar year: ❍ 50 or fewer ❍ 51-99 ❍ 100+ *(Example: 3 employees each working 20 hours per week = 2 FTEs)*	Number of Years in Business	Current Health Insurance Carrier(s)	
Federal Tax Identification Number	Department of Labor Number (if applicable)	General Excise Tax Number	
Do you currently have Workers' Compensation Insurance? ❍ Yes – Name of carrier: ❍ No	Will those who own 50% or more of the business be enrolled in HMAA's Plan? ❍ Yes ❍ No If yes, are these owners covered by Workers' Compensation Insurance? ❍ Yes ❍ No If yes, name of carrier (if different from previous section):		

Employee Participation

Requested Coverage Effective Date (month and year)			
# of Active Employees to be Enrolled	# of COBRA Employees to be Enrolled	# of Employees Waiving Coverage	***Participation Requirements***
# of Employees who work **20 or more hours** per week	# of Employees who work **less than 20 hours** per week	# of Employees covered by employer-sponsored HMO plan	

Participation Requirements

- Co-existence is not permitted with other Hawaii PPO plans
- If the business also offers a Hawaii **HMO plan:**
  - Fewer than 5 eligible employees: 100% HMAA participation required
  - 5 or more eligible employees: 50% HMAA participation and minimum of 4 employees required
- Employer must retain a copy (updated annually) of the Dept of Labor **HC-5 waiver** for all eligible employees waiving employer-sponsored health coverage

(continued on reverse)

HMAA
HAWAII MEDICAL ASSURANCE ASSOCIATION

Business Application

(continued)

COBRA / Medicare Information

- A completed enrollment application must be submitted for each current COBRA enrollee.
- Upon enrollment and at each renewal, a copy of the company's prior-year UC-B6 or Quarterly Wage Report must be submitted for continued COBRA eligibility verification and Medicare Coordination of Benefits.
- Misrepresentation and/or false information provided by Group/Employer which results in fines imposed by Centers of Medicare and Medicaid Services (CMS) per MMSEA Section 111 will be charged to the Group/Employer.

Broker Information

Broker Name	Agency

Certification & Acknowledgement

By my signature below:

- I certify the employees enrolling in the plan now and at any time in the future are bona fide employees of this company that receive regular monthly W-2 wages, receive at least the minimum wage required by law, have worked a minimum of 20 hours or more per week for four consecutive weeks, and continue to work at least 20 hours per week. I understand that rates are contingent upon meeting the participation requirements noted in this application.
- I certify the statements and answers contained in this application are complete, true, and accurate.
- I understand that coverage is subject to rating action and/or rescission and cancellation of coverage for non-disclosure or partial disclosure of the business and on the employee enrollment applications. In addition, any person acting with intent to defraud and/or knowingly aiding another to commit fraud against HMAA is in violation of state and/or federal law and therefore liable for both civil and criminal sanctions. I understand that no coverage is in place until Final Rates are issued and accepted by the Owner or Executive of the Employer. I further understand that I am obligated to immediately report changes to the information contained in this application to HMAA in writing.

Name of Group/Employer

Signature of Owner or Authorized Executive

Title

Print Name

Date (mm/dd/yy)

HMAA Association Application

I hereby apply on behalf of my business for membership in HMAA's Benefits and Services Association, which is a requirement for membership with HMAA.

Signature

Date (mm/dd/yy)