HMAA
HAWAII MEDICAL ASSURANCE ASSOCIATION

737 Bishop Street, Suite 1200
Honolulu, Hawaii 96813
(808) 591-0088 | Toll-Free (800) 621-6998
Fax (808) 535-8363

HMAA USE ONLY	
Policy #	Div #

REV 12/2020

Business Application

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 completed application for your files.

Business Information

Legal Business Name

The Legal Business Name above applies to:

- Hawaii Department of Labor's Employer Registration & Filings? ☐ Yes ☐ No; name appears as:
- Hawaii DCCA's Business Registration (BREG)? ☐ Yes ☐ No; name appears as:
- Doing Business As (dba)? ☐ Not applicable ☐ Yes ☐ No; name appears as:

Street Address	City	State	Zip Code
Billing Address	City	State	Zip Code

Name of Contact Person	Phone (include area code)	Fax (include area code)

Email Address

Type of Business: ☐ Corporation ☐ Partnership ☐ Sole Proprietor ☐ LLC ☐ Other (specify):	North American Industry Classification System # (NAICS)
Federal Tax Identification Number	Department of Labor Number

Employer size based on the preceding calendar year in accordance with Internal Revenue Code Section 4980H(c)(2) such that a full-time equivalent employee (FTE) is someone who worked an average of at least 30 hours per week. *Example: 3 employees each working 20 hours per week = 2 FTEs:*

☐ 50 or fewer FTEs ☐ 51 to 99 FTEs ☐ 100 or more FTEs

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:

Requested Effective Date of Coverage

Month and Year

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 UC-B6 or Quarterly Wage Report for the preceding year 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

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Business Application

(continued)

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)

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DOL Name Verified:	DCCA BREG Name Verified: