



HAWAII MEDICAL ASSURANCE ASSOCIATION

737 Bishop Street, Suite 1200 | Honolulu, HI 96813

(808) 941-4622 | Toll-Free (888) 941-4622

Fax (808) 535-8353

Member Change or Termination Form

All terminations must be submitted on or before the last day of the month in which eligibility ends.
If you email us, please send securely. HMAA is not responsible for the security or confidentiality of communications you send by email. HMAA cannot accept retroactive terminations.

Group Information		
Group Name	Policy #	Division # (if applicable)
Name of Requester / Contact Person	Phone ()	Fax ()
Email Address		

Member Change Information

* For the effective date of terminations, indicate last date of employment. For deceased members, indicate date of death.

Action	Member ID #	Applies To (First and Last Name)	Effective Date* (mm/dd/yy)	Updated Status or Contact Information (change in address/phone/email, division, etc.)
<input type="radio"/> Change Info <input type="radio"/> Terminate <input type="radio"/> Deceased		<input type="radio"/> Employee: _____ <input type="radio"/> Dependent(s): _____		
<input type="radio"/> Change Info <input type="radio"/> Terminate <input type="radio"/> Deceased		<input type="radio"/> Employee: _____ <input type="radio"/> Dependent(s): _____		
<input type="radio"/> Change Info <input type="radio"/> Terminate <input type="radio"/> Deceased		<input type="radio"/> Employee: _____ <input type="radio"/> Dependent(s): _____		
<input type="radio"/> Change Info <input type="radio"/> Terminate <input type="radio"/> Deceased		<input type="radio"/> Employee: _____ <input type="radio"/> Dependent(s): _____		

Certification & Acknowledgement

By my signature below, I certify the information contained in this form is complete, true, and accurate.

Signature of Authorized Individual

Title

Print Name

Date (mm/dd/yy)