HMAA
HAWAII MEDICAL ASSURANCE ASSOCIATION

Online Group Administration (OGA)
Agreement, Registration, and User Request/Change Form

Section 1: Company Information

Group Name	Policy #

Section 2: User Information - *Please complete one form for each user. For New User requests, you should expect to receive login information within 3 to 5 business days.*

User's First Name	User's Last Name	Job Title

Type of Request

○ New User: User to access all of group's divisions? ○ Yes ○ No If No, list the division(s) to access _____

_____ User's Phone Number

_____ User's E-mail Address

_____ User's Last 4 digits of SSN (for security purposes)

○ Information Change: _____ Updated Information

○ Delete Access: _____ Reason

Agreement Terms and Conditions

We understand:

- This agreement is non-transferrable.
- Our system requirements have been met.
- It may take 3 to 5 business days to receive login information for a new user.
- A login/password may not be shared.
- This service is only available to groups that meet certain criteria, and failure to meet that criteria will automatically terminate access to this service.
- Termination of employment of any user from the above-named group will result in termination of that user's access.

We hereby agree:

- To notify HMAA when a user terminates his/her employment with the above-named group.
- To abide by HIPAA Privacy Rules and not divulge protected health information to any unauthorized person for any reason, nor directly or indirectly use or allow the use of, protected health information for any purpose other than that directly associated with treatment, payment, or healthcare operations related to plan participants.
- To report any breach of confidentiality as required by state or federal law.
- To ensure all health plan enrollment applications are completed and signed in their entirety, if required by the group, and the information provided is accurate such that only eligible participants and their eligible dependents are enrolled.
- To maintain and be held liable for all completed health plan enrollment applications and/or other eligibility documents submitted by plan participants.
- To provide documentation of eligibility in the format requested by HMAA.

By signing this form, the above-named Company and user agree to the terms and conditions.

_____ User's Signature (not required if deleting access)

_____ Date

_____ Authorizing Company Officer's Name (Print)

_____ Signature

_____ Date

_____ Authorizing Company Officer's Title

_____ Phone Number or e-mail Address

Please submit to HMAA's Billing Department by mail, fax, or email OGAhelpdesk@hmaa.com.

If you email us, please send securely. HMAA is not responsible for the security or confidentiality of communications you send by email.

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