HMAA
HAWAII MEDICAL ASSURANCE ASSOCIATION
220 S KING STREET, SUITE 1200
HONOLULU, HAWAII 96813

Disclosure for Conflict of Interest Evaluation

The following information is provided to ensure that the independent review organization (IRO) assigned to conduct my external review does not have a conflict of interest.

Member name	
Appointed representative, if any	
Member's immediate family members (spouse, reciprocal beneficiary, civil union partner, parents, children)	
Health plan	Hawaii Medical Assurance Association (HMAA)
If your health care coverage is provided by your employer, name of employer	
If you are a union member, name of union and trustees (attach a sheet if needed)	
Plan employees (e.g., benefit plan administrator and staff, if any)	
Health care providers who are treating or have treated you for the condition that is the subject of the external review, and their medical group(s)	
Health care provider and facility where requested health care service or treatment would be provided	
Developer or manufacturer of the principal drug, device, procedure, or other therapy that is the subject of the external review	

I certify that the information I have provided is true and correct.

Signature of Member or Member's Representative

Date