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HMAA USE ONLY	
Policy #	Div #
DOL Name Verified	DCCA BREG Name Verified

# Business Application

Please print in **black ink** or complete online at [hmaa.com](http://hmaa.com). Failure to answer **every** question may result in delayed processing. Kindly retain a copy of the completed application for your files.

Business Information			
Legal Business Name			
Does the Legal Business Name above apply to:			
<ul style="list-style-type: none"> <li>Hawaii Department of Labor Employer Registration and Filings? <input type="radio"/> Yes <input type="radio"/> No; name appears as: _____</li> <li>Hawaii DCCA Business Registration (BREG)? <input type="radio"/> Yes <input type="radio"/> No; name appears as: _____</li> <li>Doing Business As (dba)? <input type="radio"/> Not applicable <input type="radio"/> Yes <input type="radio"/> No; we do business as: _____</li> </ul>			
Street Address	City	State	Zip Code
Billing Address	City	State	Zip Code
Type of Business: <input type="radio"/> Corporation <input type="radio"/> Partnership <input type="radio"/> Sole Proprietor <input type="radio"/> LLC <input type="radio"/> Other (specify): _____	North American Industry Classification System # (NAICS)		
Federal Tax Identification Number	Department of Labor Number		
Employer size based on the <b>preceding calendar year</b> in accordance with Internal Revenue Code Section 4980H(c)(2) whereby a full-time equivalent employee (FTE) is someone who worked an average of at least 30 hours per week. <i>Example: 3 employees each working 20 hours per week = 2 FTEs.</i>			
<input type="radio"/> 50 or fewer FTEs <input type="radio"/> 51 to 99 FTEs <input type="radio"/> 100 or more FTEs			
Will individuals who own 50% or more of the business be enrolled in HMAA's Plan? <input type="radio"/> Yes <input type="radio"/> No			
If yes, are these owners covered by Workers' Compensation Insurance? <input type="radio"/> Yes <input type="radio"/> No			
If yes, name of Workers' Compensation carrier: _____			

Authorized Group Administrators		
First and Last Name	Title	Contact Information
		Phone _____ Email _____
		Phone _____ Email _____
		Phone _____ Email _____

Requested Start Date of Coverage
Month and Year



# Business Application

(continued)

Broker Information	
Broker Name	Agency
Broker Email	Broker Phone

## HMAA Association Application (Employer signature required)

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 of Owner or Authorized Executive

\_\_\_\_\_  
Date (mm/dd/yy)

## Certification & Acknowledgement (Employer signature required)

By my signature below, I certify and acknowledge:

- Upon enrollment and every calendar year, a copy of the company's UC-B6 or Quarterly Wage Report for the preceding year must be submitted for Medicare Coordination of Benefits and continued COBRA eligibility verification.
- 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.
- The employees enrolling in the plan now and at any time in the future are bona fide employees of this company who 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 premium rates are contingent upon meeting the participation requirements noted in this application.
- I understand that coverage is subject to rating action and/or rescission and cancellation of coverage for non-disclosure or partial disclosure of information on this application and 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 Business Owner or Authorized Executive. I further understand that I am obligated to immediately report changes to the information contained in this application to HMAA in writing.
- The statements and answers contained in this application are complete, true, and accurate.

\_\_\_\_\_  
Name of Business/Employer

\_\_\_\_\_  
Signature of Owner or Authorized Executive

\_\_\_\_\_  
Title

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date (mm/dd/yy)