HMAA
HAWAII MEDICAL ASSURANCE ASSOCIATION
220 S King Street, Suite 1200
Honolulu, HI 96813
(808) 591-0088 | Toll-Free (800) 621-6998
Fax (808) 535-8353

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. 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:

- Hawaii Department of Labor Employer Registration and Filings? ○ Yes ○ No; name appears as: _____
- Hawaii DCCA Business Registration (BREG)? ○ Yes ○ No; name appears as: _____
- Doing Business As (dba)? ○ Not applicable ○ Yes ○ No; we do business as: _____

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

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) whereby 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 individuals 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 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

HMAA
HAWAII MEDICAL ASSURANCE ASSOCIATION

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)