HMAA
HAWAII MEDICAL ASSURANCE ASSOCIATION
220 S King 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.)
O Change Info O Terminate O Deceased		O Employee: _____ O Dependent(s): _____		
O Change Info O Terminate O Deceased		O Employee: _____ O Dependent(s): _____		
O Change Info O Terminate O Deceased		O Employee: _____ O Dependent(s): _____		
O Change Info O Terminate O Deceased		O Employee: _____ O 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) _____