HMAA
HAWAII MEDICAL ASSURANCE ASSOCIATION

220 S King Street, Suite 1200
Honolulu, HI 96813
Phone (808) 591-0088
Fax (808) 535-8353
enroll@hmaa.com

Enrollment Application

Please print in **black ink** or complete online at www.hmaa.com/enroll.

HMAA USE ONLY				
Policy #		Div #	Eff Date	
Med	Den	Vis	Rx	Life

Last updated January 2023

This application must be dated within sixty (60) days of the coverage effective date and submitted to HMAA by mail, fax, or online at hmaa.com/enroll.
If you email us, please send securely. HMAA is not responsible for the security or confidentiality of communications you send by email.

Policy Information

Employer/Group Name	Policy #	Div #	Employer Phone #

Enrollment and Qualifying Event Information

Members must enroll within 31 days of Qualifying Event. We reserve the right to request supporting documentation for the Qualifying Event.

I am enrolling because (please check the appropriate statement):

- O This is my company's annual open enrollment with HMAA
- O I am a new employee
- O I just began working 20+ hours a week - on _____
- O I have involuntarily lost my health coverage

*Carrier name*_____*Coverage termination date* _____

My company is now enrolling with HMAA and:

- O I am actively working
- O I am on COBRA. Coverage began _____ and will end on _____

I am adding my:

- O Newborn child
- O Newly adopted child - Adoption date _____
- O New spouse or civil union partner – Marriage/Union date _____
- O Dependent who involuntarily lost his/her health coverage

*Carrier name*_____*Coverage termination date* _____

- O OTHER *(specify):* _____

Last Name	First Name	M.I.	SSN

Mailing Address	City	State	Zip Code

Phone #	Email Address	Gender	Weight (lbs)	Height (ft. in.)	Status	Birthdate (mm/dd/yy)
		O M O F			O Single O Married O Civil Union	

Job Title/Description	Date of Hire (mm/dd/yy)	Hours Worked (per week)	Other Coverage? If Yes, Other Carrier and Policy #
			O Yes O No

Life Insurance Beneficiary (if coverage is included)	Last Name	First Name	M.I.	Relationship

Dependent Enrollment Information *(Child coverage available up to age 26)*

Dependent First and Last Name	Relationship to Enrollee	SSN	Birthdate (mm/dd/yy)	Gender	Height	Weight	(X) if Disabled	Other Coverage?	If Yes, Other Carrier & Policy #
	O Spouse O Child O Civil Union Partner			O M O F				O Yes O No	
	O Spouse O Child O Civil Union Partner			O M O F				O Yes O No	
	O Spouse O Child O Civil Union Partner			O M O F				O Yes O No	

Medical History Disclosure, Certification, & Authorization

Within the past five (5) years, have you or anyone included in this application for coverage:

- Experienced symptoms; received medical advice; or been tested, diagnosed, or treated for any medical conditions?
- Contemplating, planning, or considering any elective procedures or treatments causing you or your dependents to seek medical advice?

☐ **YES - initial here_____ and list details on Page 2.** ☐ **NO - initial here _____**

I certify that the disclosures in this application are true and complete for all medical conditions. I understand that HMAA uses this information for rating purposes and that any claims for benefits related to any undisclosed medical conditions may materially affect HMAA's risk. Between the time I sign this disclosure to the effective date of coverage, if there are changes to, or development of, any medical conditions disclosed or not disclosed, I will immediately disclose those changes in writing to HMAA for rate review. Benefits for any undisclosed conditions known and unreported as of the effective date of coverage may be denied, or coverage may be rescinded or terminated, or premium may increase retroactively or on a forward going basis at the sole discretion of HMAA. I will make full restitution of claims paid if coverage is rescinded due to a material non-disclosure of medical conditions. Intentional falsification of material facts or non-disclosure of conditions to secure medical benefits on this application seeking benefits coverage is a violation of Federal and State law and may be punishable by both civil and criminal sanctions. I understand by providing my email address, I consent to receive communications by this method.

I authorize HMAA to contact the treating physicians or other health care providers or facilities (collectively called "doctors"), or insurance organizations, for myself and any enrolled dependent(s) about any medical conditions, or obtain records (except psychotherapy notes) so that HMAA may underwrite my enrollment in HMAA plans, to ask my/our doctors about medical conditions that are reported on claims from doctors, to respond to treatment plan requests from doctors, and for other normal health plan operations. A photocopy of this authorization shall be valid as the original.

This authorization is effective from the date noted below until all coverage with HMAA for myself and my enrolled dependent(s) ceases, or any (initial) disputes regarding coverage with HMAA are resolved, whichever date is the later. I understand that the information covered by this authorization may be redisclosed subject to the Federal Privacy Regulations. I understand that I may revoke this authorization where HMAA has not acted in reliance upon it by submitting a written request to HMAA at the address listed on this application. My written statement shall specify which parts of this authorization are revoked and the date the revocation is effective.

Applicant's Signature **Date (must be within 60 days of coverage)**

Last Name of Applicant	First Name of Applicant

If you answered YES to the Medical History Disclosure question on Page 1, provide details below to the best of your knowledge.
Do **not** provide genetic information.

Section 1: Full Medical History Disclosure

Information about yourself and anyone in your family applying for coverage. Attach additional sheets if needed.

	Patient's First Name	Description of Diagnosis/ Treatment/Symptoms	Date Began	Date Ended or Ongoing	Physician Name and Phone Number
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Section 2: Medication Disclosure

Prescription medications, including over-the-counter (OTC) medicine prescribed or recommended by a physician or practitioner for yourself and anyone in your family applying for coverage. Attach additional sheets if needed.

	Patient's First Name	Description of Condition(s) Being Treated	Medication Name	Dosage	Frequency	Date Prescribed	Date Ended or Ongoing	Physician Name and Phone Number
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

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