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 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): <input type="radio"/> This is my company's annual open enrollment with HMAA <input type="radio"/> I am a new employee <input type="radio"/> I just began working 20+ hours a week - on _____ <input type="radio"/> I have involuntarily lost my health coverage Carrier name _____ Coverage termination date _____ My company is now enrolling with HMAA and: <input type="radio"/> I am actively working <input type="radio"/> I am on COBRA. Coverage began _____ and will end on _____	I am adding my: <input type="radio"/> Newborn child <input type="radio"/> Newly adopted child - Adoption date _____ <input type="radio"/> New spouse or civil union partner – Marriage/Union date _____ <input type="radio"/> Dependent who involuntarily lost his/her health coverage Carrier name _____ Coverage termination date _____ <input type="radio"/> OTHER (specify): _____
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Last Name	First Name	M.I.	SSN
Mailing Address		City	State
Phone #	Email Address	Gender <input type="radio"/> M <input type="radio"/> F	Weight (lbs)
		Height (ft. in.)	Status <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Civil Union
Job Title/Description		Date of Hire (mm/dd/yy)	Hours Worked (per week)
		Other Coverage? If Yes, Other Carrier and Policy # <input type="radio"/> Yes <input type="radio"/> No	

Birthdate (mm/dd/yy)	Relationship
Life Insurance Beneficiary (if coverage is included)	
Last Name	First Name
	M.I.

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 #
	<input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Civil Union Partner			<input type="radio"/> M <input type="radio"/> F				<input type="radio"/> Yes <input type="radio"/> No	
	<input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Civil Union Partner			<input type="radio"/> M <input type="radio"/> F				<input type="radio"/> Yes <input type="radio"/> No	
	<input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Civil Union Partner			<input type="radio"/> M <input type="radio"/> F				<input type="radio"/> Yes <input type="radio"/> 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
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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					
<i>Information about yourself and anyone in your family applying for coverage. Attach additional sheets if needed.</i>					
	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								
<i>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.</i>								
	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								