

ENROLLMENT INSTRUCTIONS

Complete all applicable fields to minimize delay in processing. You may not be entitled to all of the plans shown on this enrollment form. Only select plans that your employer states are available. See your employer if you have any questions.

SECTION A - EMPLOYEE DATA: complete your legal name (last name, first name, middle initial, generational suffix such as Jr, III), gender (M or F), birth date, work phone number, mailing address, home phone number, and social security number. Important Note: Section 111 of the Medicare, Medicaid and SCHIP Extension Act (MMSEA) of 2007 (P.L. 110-173) and 42 U.S.C. 1395y(b)(7), requires HMSA to report social security numbers for anyone on this Plan age 55 and over or for anyone on this Plan who is otherwise eligible to receive Medicare benefits regardless of age. Effective January 1, 2011, HMSA is required to include anyone on this Plan age 45 and over.

Enter your present or former HMSA number, if any. If you are currently enrolled in an HMSA Individual Plan (PPO Conversion Plan, Individual Business Plan, Individual Care Plan, Plan 6, Student Plan 19, HPH Conversion Plan or 65C Plus), and would like that coverage canceled, please submit a signed letter (include your Subscriber Number) stating you wish to cancel your individual plan coverage to: Hawaii Medical Service Association, P.O. Box 3500, Honolulu, HI 96811-3500. The cancellation will be effective on the first of the month following the receipt of the letter.

SECTION B - SELECTING YOUR COVERAGE: select one of the medical plan options from HMSA's Choice Medical Plan. If you select an HMO Medical Plan, enter a Health Center and a Personal Care Physician in Section C.

If your employer offers a dental plan, select one of the dental plan options from HMSA's Choice Dental Plan.

SECTION C - ENROLLMENT DATA: list the legal name (last name, first name, middle initial, generational suffix such as Jr, III), gender (M or F), birth date, and social security number for your spouse and each dependent child who you wish to cover under your selected plan. If a dependent child is a full-time student over the age of 18, circle "Y"; if not, circle "N". Important Note: Section 111 of MMSEA (P.L. 110-173) and 42 U.S.C. 1395y(b)(7), requires HMSA to report a social security number for anyone on this Plan age 55 and over or for anyone on the Plan who is eligible to receive Medicare benefits. Effective January 1, 2011, HMSA is required to include anyone on this Plan age 45 and over or anyone on this Plan who is otherwise eligible to receive Medicare benefits regardless of age.

If you selected an HMO Medical Plan in Section B, such as Health Plan Hawaii Plus, you must enter a Health Center and the full name of a Personal Care Physician for yourself, your spouse, and each dependent child. In the Current Physician box, check "Yes" for you, your spouse, and each dependent child if the physician you selected is the current physician. Note: some Personal Care Physicians are not accepting new patients. For a current list, reference the current *Directory of Health Centers and Providers* or on the Internet at www.HMSA.com and click on "Find a Doctor".

SECTION D - OTHER INSURANCE: Check "Yes" to indicate if you, your spouse, or any of your dependents are also covered by any other group health plan (including HMSA or Medicare). If you check "Yes", enter the other policy holder's name, the other policy holder's ID number, the name of the other health plan, and a phone number for the other health plan.

SECTION E - CONDITIONS FOR ENROLLMENT: sign and date the enrollment form.



HMSA MEDICAL/DENTAL PLAN ENROLLMENT FORM

Group No. _____

PLEASE PRINT OR TYPE IN BLUE OR BLACK INK. REFER TO THE BACK FOR ENROLLMENT INSTRUCTIONS. **Employer** Hawaii Residency Programs, Inc.

A EMPLOYEE DATA:		FOR HMSA USE ONLY	
Last Name	First (Legal)	M. I.	Suffix
Mailing Address (Number & Street or P.O. Box Number)	City	State	Zip Code
Social Security No. (See Section A on reverse side for additional information on submission of SSN)	My Present or Former HMSA No.	Birthdate: (mm/dd/yyyy)	Work Phone No.
<p>B SELECTING YOUR COVERAGE: PLEASE CHECK WITH YOUR EMPLOYER REGARDING THE MEDICAL AND DENTAL PLAN OPTIONS.</p> <p>HMSA's Choice Medical Plan (Select one)</p> <p><input type="checkbox"/> Free Choice Medical Plan</p> <p><input type="checkbox"/> Preferred Provider Plan</p>		<p>HMSA's Choice Dental Plan (Select one)</p> <p><input type="checkbox"/> Free Choice Dental Plan</p> <p><input type="checkbox"/> HMO Medical Plan</p> <p><input type="checkbox"/> HMO Dental Plan</p>	

<p>C ENROLLMENT DATA: IF YOU SELECTED AN HMO MEDICAL PLAN, ENTER A HEALTH CENTER AND PERSONAL CARE PHYSICIAN FOR YOU AND YOUR DEPENDENTS.</p> <p>Employee (Self)</p>		<p><input type="checkbox"/> Participating Provider Dental Program</p> <p><input type="checkbox"/> Dental Network Program</p>
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LEGAL NAME	BIRTHDATE		Full Time Student (over age 18)	SOCIAL SECURITY NO. (See Sec C on reverse side)	COMPLETE THIS SECTION IF YOU SELECTED AN HMO MEDICAL PLAN	
	Last Name	First Name			Health Center	Personal Care Physician
Employee (Self)						
Spouse						
Child			Y/N			
Child			Y/N			
Child			Y/N			
Child			Y/N			
Child			Y/N			

D OTHER INSURANCE: DO YOU OR YOUR DEPENDENTS HAVE OTHER COVERAGE (INCLUDING HMSA)? YES NO IF YES, COMPLETE THE FOLLOWING:

Name of Other Policy Holder	Other Policy Holder's ID No.	Name of Other Health Plan	Other Health Plan's Phone Number
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E CONDITIONS OF ENROLLMENT: READ, SIGN AND DATE BELOW.

If I am accepted for coverage under a medical plan that requires selection of a personal care physician, all benefits must be provided or arranged by my personal care physician. I further understand that as an HMSA member, I agree: (a) to abide by the HMSA's constitution and by-laws, and terms and conditions of the health/dental plan; (b) to provide information to HMSA about my current or future medical treatment or condition; and (c) to appoint my employer or group as my agent for dues payment and for sending and receiving all notices to and from HMSA concerning the health/dental plan.

Signature _____ Date ____/____/____



An Independent Licensee of the Blue Cross and Blue Shield Association

Coordination of Benefits (COB) Subscriber Questionnaire

It is important that you complete and return this survey. COB is a way to coordinate benefit payments when you or your dependents are covered by more than one health plan. By keeping us informed, we can update your records and provide you with timely and accurate processing of claims. Please answer all questions completely. Thank you.

Are you, your spouse, or any of your dependents covered by your HMSA plan also covered by any other health plan or Medicare?

Yes No

If yes: — For other health insurance plans, please complete sections 1 & 2.
— For Medicare coverage only, please complete sections 1 & 3.
— For other health insurance plans and Medicare, complete sections 1, 2 & 3.

If no: — Please complete section 1 and sign your name.

PLEASE PRINT

SECTION 1—TO BE COMPLETED BY ALL HMSA SUBSCRIBERS			
HMSA Subscriber's Name	Birth Date	Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Retired	Date of Retirement (if Applicable)
HMSA Member Number	Social Security Number	Phone Number	
I certify that the information furnished by me on this form is true and correct at this time, and agree to inform HMSA of any changes.			
HMSA Subscriber's Signature			Today's Date

SECTION 2—OTHER COVERAGE INFORMATION				
Name of Policyholder	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date	Social Security Number	Relationship to You
Name of Other Health Plan	Policyholder Identification Number			
Other Health Plan's Address			Phone Number	
Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Retired	Employer's Name		Date of Retirement (if Applicable)	
Type of Coverage	<input type="checkbox"/> Medical	<input type="checkbox"/> Drug	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision
Effective Date	_____	_____	_____	_____
Cancellation Date	_____	_____	_____	_____
Please list any other dependents covered by this other plan. If there are more than four, please check this box <input type="checkbox"/> and list the rest on the back of this form.				
1. Name (First and Last)	Relationship to You	3. Name (First and Last)	Relationship to You	
2. Name (First and Last)	Relationship to You	4. Name (First and Last)	Relationship to You	

SECTION 3—MEDICARE COVERAGE INFORMATION		
Name of Medicare Beneficiary	Social Security Number	
Medicare Number	Type of Coverage Part A (Hospital) Effective Date _____ Part B (Medical) Effective Date _____ Part D (Drug) Effective Date _____	Medicare Eligibility Due to: <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> End-Stage Renal Disease Initial Dialysis Date: _____
Name of Medicare Beneficiary	Social Security Number	
Medicare Number	Type of Coverage Part A (Hospital) Effective Date _____ Part B (Medical) Effective Date _____ Part D (Drug) Effective Date _____	Medicare Eligibility Due to: <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> End-Stage Renal Disease Initial Dialysis Date: _____