SECTION A: QUALIFYING EVENT (Member Please Check One)

☐ New Hire/Open Enrollment ☐ Termination (Date)____/____/____
Reason for Termination_____

☐ Add/Delete Dependents: (Indicate Date of Qualifying Event) Complete Section C
(Must include documentation) Marriage: ____/____/____ New Birth: ____/____/____
Divorce: ____/____/____ Adoption: ____/____/____
Other: ____/____/____ _____

☐ Address Change ☐ Reinstatement
☐ Decline Coverage ☐ Transfer of Coverage
☐ Name Change ☐ Salary

HMA
Hawaii-Mainland Administrators
1600 West Broadway Road, Suite 300
Tempe, Arizona 85282
Phone: (480) 921-8944
Toll-Free (888) 811-8944
Fax (866) 814-3854
Enrollment@hmatpa.com

SECTION B: MEMBERSHIP INFORMATION

Gender:	Marital Status:	Coverage Selected:	Coverage Desired:
☐ Male ☐ Female	☐ Single ☐ Married ☐ Common Law	☐ Employee Only ☐ Employee & Family ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Dual Spouse	Employee: ☐Medical ☐Dental ☐Vision ☐Life ☐STD Spouse: ☐Medical ☐Dental ☐Vision Child(ren): ☐Medical ☐Dental ☐Vision Plan:_____

Social Security Number | | | | | | | | | | |

Birth Date MO DAY YEAR

Phone Number ( )

Employee Census#

Employer Position/Title

Last Name First Name M.I.

Home Address (Mailing) City State Zip Code

SECTION C: DEPENDENT INFORMATION (All information is MANDATORY)

Add	Change	Delete	Last Name (if different), First, M.I.	Census#	Social Security Number	Gender	Date of Birth	Grand-child
			(Spouse)			M / F		Y / N
			(Child)			M / F		Y / N
			(Child)			M / F		Y / N
			(Child)			M / F		Y / N
			(Child)			M / F		Y / N

If dependent coverage is elected, the Plan must receive a photocopy of Birth Certificate and Social Security card for each dependent within 31 days from date of enrollment to satisfy proof of eligibility and to comply with Medicare laws.

SECTION D: OTHER INSURANCE

Is there any other Group Insurance for your family members? ☐ Yes ☐ No If yes, please list individuals covered and what type of coverage. Please attach certificate of creditable coverage.

Employer:_____ Name of Insurance Company/TPA:_____

Individuals Covered:_____

Type of Coverage: Effective Date:_____

Employee: ☐Medical ☐Dental ☐Vision Address:_____

Spouse: ☐Medical ☐Dental ☐Vision Phone: _____

Child(ren): ☐Medical ☐Dental ☐Vision Plan/Policy Number: _____

SECTION E: DISCLAIMER INFORMATION

I represent that all answers given are full, complete and true to the best of my knowledge, information and belief.
AUTHORIZATION TO RELEASE INFORMATION: For claim purposes, I give my permission to: any physician or other medical practitioner, hospital, clinic, pharmacy, insurance company, reinsurer, or any other drug organization to give my employer or HMA, LLC. all information on my behalf including findings on medical care, dental care, alcohol or drug abuse information, psychiatric or psychological care or examination, or surgery, as they apply to me or my dependents who are to be covered. I know that I have a right to a copy of this authorization. A photocopy will be as valid as the original.
AUTHORIZATION FOR PAYROLL DEDUCTION: I hereby authorize my Employer to deduct any health insurance premium that may be due from my paycheck.

Employee Signature:_____ Date:_____

FOR HR USE ONLY - DO NOT WRITE BELOW THIS LINE

ANNUAL SALARY:	DEPT. CODE:	DATE OF FULL TIME HIRE (MO / DAY / YEAR)	EFFECTIVE DATE:

EMPLOYER/ADMINISTRATOR SIGNATURE_____ DATE:_____

WHITE - HMA YELLOW - HR PINK - EMPLOYEE