



# HMSA MEDICAL PLAN ENROLLMENT FORM

Group No. \_\_\_\_\_



An Independent Licensee of the Blue Cross and Blue Shield Association

PLEASE PRINT OR TYPE IN BLUE OR BLACK INK. REFER TO THE BACK FOR ENROLLMENT INSTRUCTIONS.

Employer NAVY EXCHANGE (NAF)

A EMPLOYEE DATA:							FOR HMSA USE ONLY			
Last Name	First (Legal)	M. I.	Suffix	Gender M / F	Birthdate: (mm/dd/yyyy)	Work Phone No.	SUB ID NO.	EFF. DATE	GROUP NO.	
Mailing Address (Number & Street or P.O. Box Number)			City	State	Zip Code	Home Phone No.	CONT.	PKG.	DEPT. NO.	
My Present or Former HMSA No.		If you are currently the subscriber of an HMSA Individual Plan and wish to cancel that membership, please submit a separate cancellation request in writing.				APP RCV DATE				PROC DATE
TRX										

**B SELECTING YOUR COVERAGE:** PLEASE CHECK WITH YOUR EMPLOYER REGARDING THE MEDICAL PLAN OPTION.

HMSA's Medical Plan  
 HMO Medical Plan  
 Health Plan Hawaii Plus

\*\*Indicate desired Health Center AND Personal Care Physician in Section C below

**C ENROLLMENT DATA:** PLEASE ENTER A HEALTH CENTER AND PERSONAL CARE PHYSICIAN FOR YOU AND YOUR DEPENDENTS.

LEGAL NAME	BIRTHDATE	Full Time Student (over age 18)	COMPLETE THIS SECTION IF YOU SELECTED AN HMO MEDICAL PLAN		Current Physician?
			Health Center	Personal Care Physician	
Employee (Self)					<input type="checkbox"/> Yes
Spouse		Y / N			<input type="checkbox"/> Yes
Child		Y / N			<input type="checkbox"/> Yes
Child		Y / N			<input type="checkbox"/> Yes
Child		Y / N			<input type="checkbox"/> Yes
Child		Y / N			<input type="checkbox"/> Yes

**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 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 plan.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

SEE REVERSE SIDE

White - HMSA Yellow - HMSA/OPL Pink - GROUP