COMPCARE ACTIVE & FIT Enrollment Form

Please print clearly or type. This form must accompany Group Health Plan Enrollment Form

Date Received

EMPLOYER SECTION

Company Name ______________________ Point of Contact ______________________

Phone ______________ Fax ______________ Email ______________

HMSA Group # ______________ HMSA Band ________

Type of Enrollment (select one) ○ Open Enrolllment ○ New Hire ○ Rehire ○ Qualifying Event (MUST Specify) ______________

Effective Date of Coverage ______________ **<-- REQUIRED**

COMPCARE SELECTION

○ COMPCARE with Active & Fit

EMPLOYEE INFORMATION

Employee Last Name ______________ Employee First Name ______________ MI _____ Suffix _____

Employee Social Security Number (required) ______-______-______ Date of Hire __________ Date of Birth __________ Gender ○ M ○ F

Mailing Address ______________________ City ______________ State ______ Zip ______

Email Address (optional) ______________________ Home Phone ______________ Work Phone ______________

AUTHORIZATION

Employee Signature ______________________________ Date ______________

Employer Signature ______________________________ Date ______________

Send completed Change Forms to KIAA | 820 Piilani St., Suite 201 | Hilo, HI 96720 - Fax: 808-935-9740