SUBSCRIBER ENROLLMENT FORM

Please print clearly or type. Please be sure application is completed in full to ensure enrollment.

Election Code

EMPLOYER SECTION

Company Name ______________________ Point of Contact ______________________

Phone ______________ Fax ______________ Email ______________

HMSA Group # ______________ HMSA Band ________ Kaiser Group # ______________ Kaiser Band ________

Type of Enrollment (select one) ◯ Open Enrollment ◯ New Hire ◯ Rehire ◯ COBRA ◯ Qualifying Event (MUST specify) ______________ Effective Date ________

PLAN SELECTION Elect one (1) Health Plan from the following selections

Available Full-Package HMSA Plans
- ◯ [10] Preferred Provider Plan
- ◯ [20] CompMED A
- ◯ [30] Health Plan Hawaii Plus*
- ◯ [60] CompMED B
- ◯ [70] Health Plan Hawaii Basic*

Available Medical Only HMSA Plans
- ◯ [40] Preferred Provider Plan
- ◯ [50] CompMED A
- ◯ [80] CompMED B

Available Full-Package Kaiser Plans
- ◯ [02] Option 2 - HMO
- ◯ [04] Option 4 - HMO Prevalent

Available Medical/Drug Kaiser Plans
- ◯ [01] Option 1 - HMO
- ◯ [03] Option 3 - HMO Prevalent

Available Rider Package
- ◯ [90] ACA Rider Package

Group Life Enrollment forms must be accompanied with all Full-Package and Rider-Package enrollments. Check with your company for the Group Life Enrollment Form

EMPLOYEE SECTION

Last Name ______________ First Name ______________ Middle Initial ____ Suffix ______

Employee Social Security Number (required) ________-______-________ Date of Hire (MM/DD/YYYY) ____/____/____ Date of Birth (MM/DD/YYYY) ____/____/____ Gender ◯ M ◯ F

Mailing Address ______________________ City ______________ State ______ Zip ______

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

Marital Status ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Type of Coverage Requested ◯ [01] Employee Only ◯ [02] Employee + 1 Dependent ◯ [03] Employee + 2or more Dependents

Primary Care Provider (*provide if Electing Health Plan Hawaii Plans) First Name ______________ Last Name ______________ PCP ID# ________ Are you an established patient of this PCP? ◯ Yes ◯ No

Members Enrolling (First name, include last name if different)	Sex M/F	Date of Birth (MM/DD/YYYY)	Social Security Number (required for all members)	Choose a Primary Care Providers for each member (Include first and last name.)	Current PCP? Yes/No	PCP ID#
Spouse	◯ M ◯ F				◯ Y ◯ N	
Child/Dependent	◯ M ◯ F				◯ Y ◯ N	
Child/Dependent	◯ M ◯ F				◯ Y ◯ N	
Child/Dependent	◯ M ◯ F				◯ Y ◯ N	
Child/Dependent	◯ M ◯ F				◯ Y ◯ N	
Child/Dependent	◯ M ◯ F				◯ Y ◯ N	

Please check if you are using additional membership applications for additional dependent children. ☐

Do you or someone else covered under this insurance policy have other insurance coverage at the same time this policy is in effect? ◯ Yes ◯ Yes (Medicare) ◯ No

Name of Health Plan ______________ Name of Plan Holder ______________ Health Plan Number ______________ Effective Date ______________

AUTHORIZATION

Employee Signature ______________________ Date ________ Employer Signature ______________________ Date ________

Send completed Enrollment Forms to KIAA | 820 Piilani St., Suite 201 | Hilo, HI 96720 - Fax: 808-935-9740 - Email: admin@kiaahilo.org