MEMBER ENROLLMENT FORM

UHA HEALTH INSURANCE

REASON FOR ENROLLMENT (One Selection Only)

1

- ☐ Open Enrollment
- ☐ Add a new subscriber (with or without family)
- ☐ Reinstate Subscriber (no break in coverage)
- ☐ Add Dependent(s) / Spouse / Civil Union Partner

(See Page 2)

GROUP INFORMATION

2

Group Name: _____

Group/Division #: ☐☐☐☐ / ☐☐☐☐

BENEFIT INFORMATION

3

Plan Type: ☐ 1 Party ☐ 2 Party ☐ Family

Medical Plan: ☐ UHA 600 ☐ UHA 3000

Other Benefits: ☐ Drug ☐ Vision ☐ Dental

Effective Date: (First day of the month) ☐☐ / 01 / ☐☐☐☐ (MM / YYYY)

SUBSCRIBER INFORMATION

Please provide all information requested

4

Social Security: ☐☐☐-☐☐-☐☐☐☐ Birth Date: ☐☐ / ☐☐ / ☐☐☐☐ Gender: ☐ Female ☐ Male

Last Name:

First Name:

Mailing Address:

City: State: ☐☐ Zip Code: ☐☐☐☐☐

☐ Physical Address: same as mailing

City: State: ☐☐ Zip Code: ☐☐☐☐☐

Contact Number: ☐☐☐-☐☐☐-☐☐☐☐ E-mail Address: _____

Other Health plan for you or your family in addition to UHA? ☐ Yes ☐ No Other Plan Effective Date: ☐☐ / ☐☐ / ☐☐☐☐

Choose name of other plan:

- ◯ HMSA
- ◯ Kaiser
- ◯ HMAA
- ◯ Medicare - Part A
- ◯ Medicare - Part B
- ◯ Medicare - Part A&B
- ◯ Other _____

Policy Holder's Name: _____

Copy of other health plan ID card attached: ☐

REQUIRED SIGNATURES

5

PEDIATRIC DENTAL COVERAGE FOR SMALL GROUPS ONLY (1 - 50 Employees): I attest that my employer has purchased stand-alone pediatric dental coverage offered by an Exchange-certified stand-alone dental plan on or off the Exchange, and is therefore eligible to purchase a medical plan that excludes pediatric dental coverage. I acknowledge that the Patient Protection and Affordable Care Act requires that pediatric be included as an essential health benefit for customers of small group and individual health insurance policies.

CONSENT FOR RELEASE OF MEDICAL RECORDS: I certify by signature below that I am 18 years of age and hereby authorize any health care facility, physician, practitioner, counselor, or therapist to provide UHA or its reinsurer, all information pertaining to any medical condition, treatment, confinement, or diagnosis of myself or my dependents who are also covered by UHA. This authorization includes, but is not limited to, mental health conditions, alcohol and drug abuse, and HIV/AIDS information. This consent shall be valid for all medical information throughout the period that I am covered by UHA. This consent shall also include all information pertaining to claims incurred during the coverage period.

Subscriber's Signature: _____ Date: _____

The Group Administrator and subscriber of the above named UHA Member Group certifies by signature below that the above named subscriber is a bona fide employee as defined by the Hawaii Prepaid Healthcare Act. UHA may terminate coverage for any ineligible enrollee upon confirmation of ineligibility. If enrollment of the above named enrollee(s) is found to be based on fraud or intentional misrepresentation of a material fact by the employer, coverage for the Member Group and/or the enrollee(s) may be terminated by UHA. In the event of termination, the above named Member Group agrees that any benefit payments made by UHA on behalf of the ineligible enrollee(s) must be returned in full to UHA by the ineligible enrollee(s) and/or the employer. UHA shall return all premiums paid by the employer with respect to the ineligible enrollee(s) upon termination of coverage and reimbursement of benefit payments made by UHA. By signing below, the Group Administrator also confirms that they have provided the above named subscriber with a copy of their Summary of Benefits & Coverage and Uniform Glossary.

Group Administrator Signature: _____ Date: _____

Prepared By: _____ Contact Number: _____

MEMBER ENROLLMENT FORM

UHA HEALTH INSURANCE

SUBSCRIBER NAME: ______________________________

ADD SPOUSE OR CIVIL UNION PARTNER INFORMATION

Complete only if enrolling Spouse, Civil Union Partner and/or Dependent(s)

6 Reason to Add: ☐ Marriage ☐ Civil Union Partnership

Social Security: ___-__-____ Effective Date: __/__/____

Last Name:

First Name:

Birth Date: __/__/____ Gender: ☐ Female ☐ Male

Living outside of Hawaii? ☐ Yes ☐ No If Yes, Enter address: ______________________________

ADD DEPENDENT(S) INFORMATION

7 Reason to Add: ☐ Newborn ☐ Adoption/Stepchild ☐ Court Order ☐ Disabled ☐ Loss of other medical coverage

Social Security: ___-__-____ Effective Date: __/__/____

Last Name:

First Name:

Birth Date: __/__/____ Gender: ☐ Female ☐ Male

Living outside of Hawaii? ☐ Yes ☐ No If Yes, Enter address: ______________________________

Reason to Add: ☐ Newborn ☐ Adoption/Stepchild ☐ Court Order ☐ Disabled ☐ Loss of other medical coverage

Social Security: ___-__-____ Effective Date: __/__/____

Last Name:

First Name:

Birth Date: __/__/____ Gender: ☐ Female ☐ Male

Living outside of Hawaii? ☐ Yes ☐ No If Yes, Enter address: ______________________________

Reason to Add: ☐ Newborn ☐ Adoption/Stepchild ☐ Court Order ☐ Disabled ☐ Loss of other medical coverage

Social Security: ___-__-____ Effective Date: __/__/____

Last Name:

First Name:

Birth Date: __/__/____ Gender: ☐ Female ☐ Male

Living outside of Hawaii? ☐ Yes ☐ No If Yes, Enter address: ______________________________

Member Enrollment Instructions

① REASON FOR ENROLLMENT: Select a reason for submitting this form (one selection only).

② GROUP INFORMATION: Enter the group name and the eight-digit group/division number.

③ BENEFIT INFORMATION: Choose benefit selection and enter the effective date of coverage.

④ SUBSCRIBER INFORMATION: Enter all information requested for the subscriber.

⑤ REQUIRED SIGNATURES

-Subscriber Signature: Form must be signed and dated by subscriber of the plan.
-Group Administrator: Form must be signed and dated by an authorized group administrator.

⑥ SPOUSE or CIVIL UNION PARTNER INFORMATION:
The first row is for entering spouse or civil union partner information. If adding spouse or civil union partner outside of open enrollment, please attach supporting documents (i.e., marriage certificate, loss of coverage letter from other carrier, etc.)

⑦ DEPENDENT INFORMATION
Enter all information for dependent(s). If additional rows are needed, please attach another sheet. If adding dependent(s) outside of open enrollment, please attach supporting documents (i.e., court order, birth certificate, etc.)

To ensure proper processing, all required fields must be completed and proper documentation submitted.
Fax or mail completed forms with necessary documentation to:

UHA Employer Services
700 Bishop Street, Suite 300
Honolulu, HI 96813-4100

Toll-free fax: (877)222-3198

If you have any further questions contact Employer Services.
Phone: (808) 532-4007; Toll-free phone: (800) 458-4600 Ext. 299; www.uhahealth.com