Member Enrollment Form

UHA HEALTH INSURANCE

1 Group Name: _____ Group/Division #: ____ / ____

2 REASON FOR ENROLLMENT (One Selection Only)

- ☐ Annual Group Open Enrollment
- ☐ Reinstate Subscriber (no break in coverage)
- ☐ Add Dependent(s) / Spouse / Civil Union Partner (See Page 2)
- ☐ Add a new subscriber (with or without family)

***THIS INFORMATION IS REQUIRED.**

*Status Change from Part-time to 20+ hours/week: ☐ YES ☐ NO

*Date of Hire: __ / __ / ____

3 BENEFIT INFORMATION

Plan Type: ☐ 1 Party ☐ 2 Party ☐ Family

Other Benefits: ☐ Drug ☐ Vision ☐ Dental ☐ **Pediatric Dental

**PEDIATRIC DENTAL COVERAGE FOR SMALL GROUPS ONLY (1 - 50 Employees)

Medical Plan: ☐ UHA 600 ☐ UHA 3000 ☐ UHA One Plan

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

4 SUBSCRIBER INFORMATION

Please provide all information requested

Social Security: ___ - __ - ____ Birth Date: __ / __ / ____ Gender: ☐ Female ☐ Male

Last Name:

First Name:

Mailing Address:

City: State: Zip Code:

☐ same as mailing Physical Address:

City: State: Zip Code:

Contact Number: ___ - ___ - ____ E-mail Address: _____

5 OTHER HEALTH COVERAGE

Does the subscriber or their dependents have other health coverage? ☐ Yes ☐ No

Please provide all information requested if answer is "Yes".

Choose name of other plan:

- ☐ HMSA
- ☐ Kaiser
- ☐ HMAA
- ☐ Medicare - Part A
- ☐ Medicare - Part B
- ☐ Medicare - Part A&B
- ☐ Other: _____

Copy of other health plan ID card attached: ☐

Other Plan Effective Date: __ / __ / ____

Policy Holder's Name: _____

6 REQUIRED SIGNATURES

NOTE: Verifiable digital signatures with date stamp and name of signor accepted as well as certain electronic signatures.

The Group Administrator of the above named UHA Member Group understands that they act as the agent for dues payments and for sending and receiving all health plan notices to and from UHA on behalf of the above named subscriber and they certify 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, 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.

Group Administrator Signature: _____ Date: _____

Prepared By: _____ Contact Number: _____

Optional signature unless the Subscriber is below age of 18, then signatures required.

Subscriber's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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UHA HEALTH INSURANCE

SUBSCRIBER NAME: ____________________

Instructions: Complete Sections 6 & 7 **only** if enrolling Spouse, Civil Union Partner and/or Dependent(s).

7 ADD SPOUSE OR CIVIL UNION PARTNER INFORMATION

Reason to Add: ☐ Marriage ☐ Civil Union Partnership **Date of Reason:** __ __ / __ __ / __ __ __ __

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

Last Name:

First Name:

Birth Date: __ __ / __ __ / __ __ __ __ Living outside of Hawaii?

Gender: ☐ M ☐ F ☐ Yes ☐ No If Yes, Enter address: ____________________

8 ADD DEPENDENT(S) INFORMATION

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

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

Last Name:

First Name:

Birth Date: __ __ / __ __ / __ __ __ __ Living outside of Hawaii?

Gender: ☐ M ☐ F ☐ Yes ☐ No If Yes, Enter address: ____________________

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

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

Last Name:

First Name:

Birth Date: __ __ / __ __ / __ __ __ __ Living outside of Hawaii?

Gender: ☐ M ☐ F ☐ Yes ☐ No If Yes, Enter address: ____________________

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

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

Last Name:

First Name:

Birth Date: __ __ / __ __ / __ __ __ __ Living outside of Hawaii?

Gender: ☐ M ☐ F ☐ Yes ☐ No If Yes, Enter address: ____________________

Member Enrollment Instructions

① **GROUP INFORMATION:** Enter the group name and the eight-digit group/division number.

② **REASON FOR ENROLLMENT:** Select a reason for submitting this form (one selection only).

- "Date of Hire" and "Status Change" are required fields for the subscriber.
- "Status Change" Select YES if the employee is working more than 20 hours per week.
- "Date of Reason" is the applicable date of the reason the member is being added.

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

④ **SUBSCRIBER INFORMATION:** Enter all information requested for the subscriber. In most situations, the employee is the subscriber.

⑤ **OTHER PLAN INFORMATION:** Indicate whether subscriber or dependent(s) have other health coverage. If yes, enter all information requested regarding other health plan information.

⑥ **REQUIRED SIGNATURES:** Form must be signed and dated by an **authorized group administrator**. If the subscriber is under age 18 then the subscriber and parent/guardian signatures are required. Otherwise, the subscriber signature is optional.

⑦ **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.)

⑧ **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. Mail, fax or email completed forms with necessary documentation to:

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

Toll-free fax: (877)222-3198

Email: ES@uhahealth.com

You can also conveniently submit changes for employee information through **UHA's Online Enrollment Services.** Member enrollments take approximately one business day. Please note that retroactive changes **cannot** be added through the Online Enrollment Services System.

To sign up, complete the **Online Employer Access Authorization and Certification Form** (uhahealth.com/wp-content/uploads/online-agreement-auth-cert-form.pdf) or contact us for more information.

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