HMA
HAWAII - MAINLAND ADMINISTRATORS

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# Employee Enrollment Form

Please complete all sections to prevent any delay in enrollment.
For questions regarding this form, email Enrollment@hmatpa.com.

## SECTION A: QUALIFYING EVENT (Please Select One Option)

| Employee | Dependent |
|---|---|
| ☐ **New Hire/Open Enrollment** | ☐ **Add/Delete Dependents** (Must Complete Section C) |
| ☐ **Termination:** (Date) _____/_____/_____ | Please Select Qualifying Event (Must Provide Documentation) |
| Reason for Termination: _____ | ☐ **New Birth** ☐ **Divorce** ☐ **Adoption** ☐ **Marriage** |
| ☐ **Transfer of Coverage:** From _____ | ☐ **Other:** Please explain _____ |
| ☐ **Name Change:** From _____ | Date of Qualifying Event: _____/_____/_____ |
| ☐ **Decline Coverage:** Reason _____ | ☐ **Termination** (Date) _____/_____/_____ |
| ☐ **Dual Coverage** ☐ **Reinstatement** | Reason for Termination: _____ |
| ☐ **New ID Card** ☐ **Salary Change** | ☐ **Address Change** |

## SECTION B: EMPLOYEE INFORMATION

Navajo Technical University _____ _____ _____
Employer Name | Position / Title | Employee Census Number

_____ - _____ - _____ _____ _____
Social Security Number | Employee First Name | Employee Last Name

_____ _____/_____/_____ _____ _____
Employee ID Number | Date of Birth | Phone Number | Email Address

_____ _____ _____ _____
Home Address (Mailing) | City | State | Zip Code

| Gender: | Marital Status: | Coverage Selected: | Coverage Desired: |
|---|---|---|---|
| ☐ Male | ☐ Single | ☐ Employee Only | **Employee:** ☐ Health ☐ Life ☐ Disability |
| ☐ Female | ☐ Married | ☐ Employee & Spouse | **Spouse:** ☐ Health ☐ Life |
| | ☐ Common Law | ☐ Employee & Family | **Child(ren):** ☐ Health ☐ Life |
| | | ☐ Employee & Child(ren) | |
| | | ☐ Dual Spouse | |

## SECTION C: DEPENDENT INFORMATION (ALL INFORMATION IS MANDATORY) ("A" Add, "C" Change, "D" Delete)

| "A" | "C" | "D" | First Name, Last Name, M.I. | Census # | Social Security Number | Date of Birth | Gender | | Grand-Child | |
|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | **Spouse:** | | | | M | F | Y | N |
| ☐ | ☐ | ☐ | **Child:** | | | | M | F | Y | N |
| ☐ | ☐ | ☐ | **Child:** | | | | M | F | Y | N |
| ☐ | ☐ | ☐ | **Child:** | | | | M | F | Y | N |
| ☐ | ☐ | ☐ | **Child:** | | | | M | F | Y | N |

If dependent coverage is elected, a photocopy of the Birth Certificate and Social Security card for each dependent must be submitted within 31 days from date of enrollment.

## SECTION D: OTHER INSURANCE

**Is there any other Group Insurance for you or your family members?** ☐ **Yes** ☐ **No**
*If yes, please list individuals covered and what type of coverage.*

**Employer Name:** _____ **Insurance/TPA Carrier:** _____
**Individuals Covered:** ☐ Employee ☐ Spouse ☐ Child(ren) **Effective Date** _____/_____/_____

**Type of Coverage:**
**Employee:** ☐ Medical ☐ Dental ☐ Vision
**Spouse:** ☐ Medical ☐ Dental ☐ Vision
**Child(ren):** ☐ Medical ☐ Dental ☐ Vision

**Contract Holder Name:** _____
**Contract Holder Date of Birth:** _____/_____/_____
**Plan/Policy Number:** _____

## SECTION E: DISCLAIMER INFORMATION

I represent that all answers given are full, complete and true to the best of my knowledge, information and belief.
**AUTHORIZATION TO RELEASE INFORMATION:** For claim purposes, I give my permission to: any physician or other medical practitioner, hospital, clinic, pharmacy, insurance company, reinsurer, or any other drug organization to give my employer or HMA, LLC. all information on my behalf including findings on medical care, dental care, alcohol or drug abuse information, psychiatric or psychological care or examination, or surgery, as they apply to me or my dependents who are to be covered. I know that I have a right to a copy of this authorization. A photocopy will be as valid as the original.
**AUTHORIZATION FOR PAYROLL DEDUCTION:** I hereby authorize my Employer to deduct any health, life and disability insurance premium from my paycheck.

**Employee Signature:** _____ **Date:** _____/_____/_____

## FOR HR USE ONLY – DO NOT WRITE BELOW THIS LINE

**Annual Salary:** | **Date of Hire:** _____ | **Effective Date:** | **Health:** _____ **Life:** _____ **Disability:** _____

**Employer/Administrator Signature:** _____ **Date:** _____/_____/_____