MEMBER ENROLLMENT FORM

① Reason for submitting form

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

② Group Information

Group/Division Name ________ Group/Division # ________

③ Subscriber Information *Please provide all information requested*

SSN	Last Name	First Name	MI	Birthdate	Gender	Date Employed
					☐ Male ☐ Female	

Mailing Address		City	State	Zip	Work #

Street Address ☐ same as mailing		City	State	Zip	Home/Cell #

Email Address ________

Other health plan 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 ________

④ Benefit Selection

Plan Type

◯ 1 Party ◯ 2 Party ◯ Family

Medical ________

UHA 600 = 06
UHA 3000 = 03

☐ **Drug**
☐ **Vision**
☐ **Dental**

Effective Date

Month ____ Day 1 Year ____

Effective date will be the first day of the month selected

⑤ Spouse & Dependent Information *Complete only if enrolling spouse and/or dependents*

	SSN	Last Name	First Name	MI	Birthdate	Gender	Other Health Plan Name (in addition to UHA)	Reason for add (if other than new subscriber or Open Enrollment)
SPOUSE						☐ Male ☐ Female		◯ Loss of other medical coverage ◯ Marriage (Date) ____
DEPENDENT						☐ Male ☐ Female		◯ Loss of other medical coverage ◯ Legal Guardianship ◯ Disabled ◯ Newborn (Date) ____ ◯ Adoption/Stepchild (Date) ____ ◯ Student (over age 19)
DEPENDENT						☐ Male ☐ Female		◯ Loss of other medical coverage ◯ Legal Guardianship ◯ Disabled ◯ Newborn (Date) ____ ◯ Adoption/Stepchild (Date) ____ ◯ Student (over age 19)
DEPENDENT						☐ Male ☐ Female		◯ Loss of other medical coverage ◯ Legal Guardianship ◯ Disabled ◯ Newborn (Date) ____ ◯ Adoption/Stepchild (Date) ____ ◯ Student (over age 19)
DEPENDENT						☐ Male ☐ Female		◯ Loss of other medical coverage ◯ Legal Guardianship ◯ Disabled ◯ Newborn (Date) ____ ◯ Adoption/Stepchild (Date) ____ ◯ Student (over age 19)

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.

⑥ **Subscriber 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.

UHA
BETTER HEALTH • BETTER LIFE

⑦ **Group Administrator Signature** ________________ **Date** ________

700 Bishop Street, Suite 300
Honolulu, HI 96813.4100
T 808.532.4009
F 866.577.3035
www.uhahealth.com

EMPLOYEE MEDICAL QUESTIONNAIRE

Subscriber Name _____ Social Security Number _____
Address _____ Gender Select one
Zip Code of Residence _____ Name of Employer _____
Date of Birth _____ Home Phone _____

Name of Spouse or Dependent to be covered by UHA	Date of Birth	Gender	(X) if Disabled	Dependent with Other Coverage	Name of Carrier	Effective Date of Coverage
		Select one		☐ Yes ☐ No		
		Select one		☐ Yes ☐ No		
		Select one		☐ Yes ☐ No		

Please check one:

1. Are you an employee working at least 20 hours per week with the above employer and receiving at least minimum wage? ☐ YES ☐ NO
   If No, please explain: _____

2. Have you or any of your dependents ever been admitted to a hospital or other medical facility during the past 3 years? ☐ YES ☐ NO

Please Specify Self, Spouse or Child	Explanation of Medical Service Rendered

3. Have you or any of your dependents been advised to have any diagnostic testing, treatment or surgery performed in the next 12 months? ☐ YES ☐ NO

Please Specify Self, Spouse or Child	Explanation of Medical Testing, Treatment or Surgery Recommended

4. Have you or any of your dependents been evaluated, tested or treated for infertility or sought counseling regarding In-vitro f ertilization or infertility options during the past 5 years? ☐ YES ☐ NO

5. Are you or any of your dependents currently pregnant? ☐ YES ☐ NO

6. Have you or any of your dependents been advised to have a transplant of any nature, received any transplant, or been listed or scheduled for a transplant, at any time in the past or in the next 12 months? ☐ YES ☐ NO

7. Please check off any of the illnesses listed below that you or any of your dependents have been treated for at any time in the last 3 years.

☐Cancer ☐Stroke ☐Kidney Failure ☐Mental Illness ☐Other
☐Diabetes Mellitus ☐Heart Attack ☐Immuno-Deficiency ☐Emphysema and/or Asthma
☐Elevated Cholesterol ☐Heart Failure ☐High Blood Pressure ☐Substance Abuse (Drug/Alcohol)

If you checked off any of the above illnesses, please provide the following information. (Please attach a separate sheet if more space is needed.)

Illness	Please Specify Self, Spouse or Child	Specific Condition	Are You Under a Doctor's Care?	Date(s) of Illness	Present Condition/ Prognosis	Name of Physician Providing Treatment

8. Are you or any of your dependents currently eligible for or enrolled in Medicare or any other governmental or private healthcare coverage? ☐ YES ☐ NO

Please Specify Self, Spouse or Child	Name of Healthcare Coverage for which Eligible	Effective Date of Coverage

9. Do you or any of your dependents currently live temporarily or permanently in another state or country? ☐ YES ☐ NO

Please Specify Self, Spouse or Child	Reason of non Hawaii Residency	List State or Country

To the best of my knowledge and belief, I certify that the answers and statements provided are true and complete. I understand and authorize representatives of University Health Alliance (UHA) to contact me or any of the physicians listed above if additional information is needed.

By signing this form I authorize UHA to gather my individually identifiable health information, including medical records, lab records, and prescription records from sources including but not limited to physicians, clinics, hospitals, pharmacies, pharmacy benefit managers and health plans. This information will be used for the purpose of evaluating and underwriting my insurance application. This authorization is valid for 180 days from signing unless earlier revoked. I may revoke this authorization by notifying UHA in writing at 700 Bishop Street Suite 300 Honolulu, HI 96813. I understand that this information may be subject to redisclosure, and once redisclosed, may no longer be subject to federal rules governing privacy. I understand that signing this form is voluntary and that I need not sign it to assure treatment.

_____ _____
Date Prospective Subscriber's Signature