Deseret Mutual Benefit Administrators (DMBA)
60 East South Temple ● P.O. Box 45530
Salt Lake City, Utah 84145
Telephone: (801) 578-5600 ● Toll Free 1-800-777-3622 ● Fax Number (801) 578-5903

COMPANY CODE	EFFECTIVE DATE

HAWAII MEDICAL PLAN ENROLLMENT/CHANGE FORM

APPLICANT INFORMATION: Complete the information in full and return to Deseret Healthcare. Any changes to this must be reported immediately.

NEW ENROLLMENT **CHANGE/OTHER:**

NAME OF APPLICANT (LAST, FIRST, MIDDLE)	**APPLICANT'S SOCIAL SECURITY#**	**HOME PHONE**	**WORK PHONE**

GENDER	**DATE OF BIRTH**	**MARITAL STATUS** (MARRIED, WIDOWED, SINGLE DIVORCED, SEPARATED)	**SPOUSE'S NAME AND DATE OF BIRTH**

MAILING ADDRESS	**CITY**	**STATE**	**ZIP**

APPLICATION FOR INSURANCE BENEFITS: I WOULD LIKE MY LEVEL OF INSURANCE COVERAGE TO BE FOR (Choose one):

☐	**MYSELF**	☐	**MYSELF AND ONE DEPENDENT**	☐	**MYSELF AND TWO OR MORE DEPENDENTS**

For dependent coverage, complete the following information in full. Failure to list all dependents or to add new dependents will result in no coverage for the omitted person. Attach a separate sheet if necessary.

NAME OF FAMILY MEMBER (First, Middle, Last)	**SOCIAL SECURITY NUMBER**	**DATE OF BIRTH** MO	DAY	YR	**RELATIONSHIP**	**GENDER**	NAME OF ANY OTHER MEDICAL INSURANCE CARRIER, HEALTH MAINTENANCE PLAN, OR GOVERNMENT PLAN (MEDICARE, ETC.) AND POLICY NUMBER FOR COVERED INDIVIDUAL.	**PHYSICIAN'S LAST NAME & GROUP NUMBER**
APPLICANT (Refer to related information above)					**SELF**			
					SPOUSE			

I hereby choose to participate in the Deseret Choice Plan and authorize my portion of the premium to be deducted from my paycheck. By enrolling in the plan and receiving benefits there under, I understand and agree that in the event of any claim against Deseret Healthcare based upon negligence, breach of contract, or otherwise, the matter will be first submitted to arbitration, pursuant to arbitration provisions set forth in the plan, before resorting to any other form of dispute settlement. Furthermore, I authorize any physician, medical practitioner, hospital, clinic, any other provider of health care, insurance company, or my employer to disclose to DESERET HEALTHCARE or their representatives all information an records about any

DATE: SIGNATURE:

WAIVER OF INSURANCE BENEFITS

I DO NOT WISH TO ENROLL **I WISH TO DISCOUNTINUE MEDICAL COVERAGE**

I certify that I am enrolled for Medical coverage comparable to this Plan through another source. I understand the Medical coverage available to me and choose not to participate with this benefit and hereby waive such coverage. I understand my Employer is not responsible for any costs not covered by my insurance plan and that they will not be responsible in the event my coverage terminates. I hereby release my Employer from any liability for the cost of medical-hospital-surgical care of treatment.

DATE:	**SIGNATURE:**

EMPLOYER USE ONLY

INSURANCE EMPLOYMENTS STATUS	UNDERWRITING STATUS	BENEFIT PACKAGE	CONTRACT TYPE	RISK POPULATION	PREMIUM SPLIT CODE	BILL TO CODE
PT	MO	HM		NM	PH	DD

NEW ENROLLMENT	**TERMINATION**	**CHANGE/OTHER:**

COMMENTS:

DATE:	**EMPLOYER AUTHORIZATION**