



Your Health Is Our Business

HMAA's benefits and rates are customized to your company.
 Fax this for a free quote to see if we can save you money and improve your bottom line!

Please Fax to Larry Santiago at (808) 535-8337

Company Name: _____

Company Information: Type of Business: _____ Contact Person: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Current Plan Information: Carrier: _____ Plan: _____ Single Rate: _____ Renewal Date: _____

Current Plan Benefits: Medical Dental Drug Vision

Please tell us how you heard about us:

Radio/Television Print Internet Tradeshow/Event Other: SBH

Please provide the following information for each Employee working 20+ hours per week.

(Attach a separate sheet if needed)

#	Age or Birthdate (mm/yy)	Gender (circle one)	Coverage Type* (circle one)
1		M F	E S C F
2		M F	E S C F
3		M F	E S C F
4		M F	E S C F
5		M F	E S C F
6		M F	E S C F
7		M F	E S C F
8		M F	E S C F
9		M F	E S C F
10		M F	E S C F

#	Age or Birthdate (mm/yy)	Gender (circle one)	Coverage Type* (circle one)
11		M F	E S C F
12		M F	E S C F
13		M F	E S C F
14		M F	E S C F
15		M F	E S C F
16		M F	E S C F
17		M F	E S C F
18		M F	E S C F
19		M F	E S C F
20		M F	E S C F

*Coverage Code = E – Employee only / S – Employee and Spouse / C – Employee and Child / F – Employee and 2 or more Dependents

Hawaii Medical Assurance Association

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