



Apex Management Group Suite of Affordable Healthcare Solutions Benefits Enrollment / Change of Status Form

1) Employer Name:

Employee Name (First, MI, Last)	Date of Birth:	Date of Hire:	Gender:	Social Security Number:
Mailing Address:	City		State:	Zip Code:
Email Address:	Home Phone:		Cell Phone:	

- 2) Reason for Application**
- Open Enrollment
- New Hire
- Qualifying Event
- COBRA

- 3) Change of Status/Coverage**
- Change of Address Divorce
- Marriage Drop Dependent
- Birth of Child Termination
- Termination Date: _____

4) Effective Date: _____

5) Marital Status: Single / Married / Divorced

6) Enroll/Waive: Basic Plan / Plus Plan / Advantage Plan / Premier Plan / Waive

7) Elect coverage for:

Employee Only: Employee/Child(ren): Employee/Spouse: Employee/Family

Spouse's Name: (First, MI, Last)	Date of Birth:	Gender: M / F	Social Security Number:	Waive:
Child 1: (First, MI, Last)	Date of Birth:	Gender: M / F	Social Security Number:	
Child 2: (First, MI, Last)	Date of Birth:	Gender: M / F	Social Security Number:	
Child 3: (First, MI, Last)	Date of Birth:	Gender: M / F	Social Security Number:	
Child 4: (First, MI, Last)	Date of Birth:	Gender: M / F	Social Security Number:	

The Apex Management Group Suite of Plans are administrated by Hawaii Mainland Administratores,LLC (HMA)
Please email completed document to: Enrollment@hmatpa.com

Please Sign here for enrolling or waiving coverage for yourself or dependents.
I acknowledge I have been given the right to apply for this coverage; however, I and/or my dependent(s), am/are electing to enroll or waive coverage. I acknowledge that I, and/or my dependent(s), may have to wait until the plans next anniversary date to be enrolled for medical coverage if waiving coverage.

Signature of Employee: _____ Date: _____