220 S King Street, Suite 1200
Honolulu, HI 96813
Phone (808) 591-0088

Enrollment Application

HMAA USE ONLY				
Policy #		Div #	Eff Date	
Med	Den	Vis	Rx	Life

Last updated January 2023

This application must be dated within 30 days of the coverage effective date and emailed to BBIBenefits@BloominBrands.com

Policy Information

Employer/Group Name	Policy #	Div #	Employer Phone #
OSI Restaurant Partners, LLC	3305		

Enrollment and Qualifying Event Information

Members must enroll within 31 days of Qualifying Event. We reserve the right to request supporting documentation for the Qualifying Event.

I am enrolling because (please check the appropriate statement):

- ○ This is my company's annual open enrollment with HMAA
- ○ I am a new employee
- ○ I just began working 20+ hours a week - on _________
- ○ I have involuntarily lost my health coverage

Carrier name_______________Coverage termination date __________

My company is now enrolling with HMAA and:

- ○ I am actively working
- ○ I am on COBRA. Coverage began _________ and will end on _________

I am adding my:

- ○ Newborn child
- ○ Newly adopted child - Adoption date _________
- ○ New spouse or civil union partner – Marriage/Union date _________
- ○ Dependent who involuntarily lost his/her health coverage

Carrier name_______________Coverage termination date __________

- ○ OTHER *(specify)*: ____________________

Last Name	First Name	M.I.	SSN

Mailing Address	City	State	Zip Code

Phone #	Email Address	Gender			Status	Birthdate (mm/dd/yy)
		○ M ○ F			○ Single ○ Married ○ Civil Union	

Job Title/Description	Date of Hire (mm/dd/yy)	Hours Worked (per week)	Other Coverage?	If Yes, Other Carrier and Policy #
			○ Yes ○ No	

Plan Selection (check only one)	Medical/Rx Only _____	Medical/Rx/Vision _____	Medical/Rx + Dental _____	Medical/Rx/Vision + Dental _____

Dependent Enrollment Information *(Child coverage available up to age 26)*

Dependent First and Last Name	Relationship to Enrollee	SSN	Birthdate (mm/dd/yy)	Gender			(X) if Disabled	Other Coverage?	If Yes, Other Carrier & Policy #
	○ Spouse ○ Child ○ Civil Union Partner			○ M ○ F				○ Yes ○ No	
	○ Spouse ○ Child ○ Civil Union Partner			○ M ○ F				○ Yes ○ No	
	○ Spouse ○ Child ○ Civil Union Partner			○ M ○ F				○ Yes ○ No	

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Applicant's Signature and Date