## IMPORTANT NOTICE

Payments of Benefits listed in this brochure are calculated on a USUAL, CUSTOMARY, AND REASONABLE basis. (See Benefit Payment Guidelines on the back of this brochure for details). HMSA participating doctors agree to adjust their charges should they exceed these guidelines. Such adjustments do not apply to charges of non-participating doctors; therefore, you will be responsible for charges in excess of those outlined in the guidelines.

We suggest you ask your doctor if he is an HMSA participant and, if not, discuss his charges before services are rendered.

ILLEGIBLE.

SMALL BUSINESSMEN PROGRAM
ACTIVITY REPORTING FORM 12-B

9942110

TO: HAWAII MEDICAL SERVICE ASSOCIATION
P. O. BOX 860
HONOLULU, HAWAII 96808

DATE: 3/5/76

FROM: POLYNESIAN VOYAGING SOCIETY GROUP NO: 4
Name of Company and DBA (Print)

BUSINESS ADDRESS: P.O. Box 6037 Bishop Museum, Honolulu, HI 96818
Number and Street City State Zip Code

TYPE OF BUSINESS: non profit organization GROSS INCOME LIC. NO: 1063872
SCHEDULE II

REPORT NEW EMPLOYEE ENROLLMENTS
REPORT TERMINATED EMPLOYEES

| SECTION A | | | SECTION B | SECTION C | | SECTION D |
|---|---|---|---|---|---|---|
| PROVIDE INFORMATION FROM MEMBERSHIP CARD OR APPLICATION CARD. | | | Show monthly rate or am't being remitted | USE THIS SECTION TO ADD OR DELETE DEPENDENTS | | MEMBERSHIP AND CANCELLATION DATA |
| NAME OF EMPLOYEE | HMSA NUMBER | EMPLOYMENT DATE | New Members Ref. Members New Rate | NAME OF NEW DEPENDENT OR WIFE'S MAIDEN NAME | Birthdate and or Marriage Date | REMARKS |
| Michele' Brown Akao | 11856374 | 3/3/76 | $ | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | TOTAL | $ | | | |

Signed.....
(Employer)
(Signature must accompany report)

- An application card for each new member must accompany this report.
- Submit this form with dues payment to HMSA.
- Enrollment date will be established by HMSA.

12B - Sml. Bus. (2/1/73
Service Department

ILLEGIBLE

SMALL BUSINESSMEN PROGRAM
ACTIVITY REPORTING FORM 12-B

TO: HAWAII MEDICAL SERVICE ASSOCIATION
P. O. BOX 860
HONOLULU, HAWAII 96808

DATE: May 21, 1975

FROM: POLYNESIAN VOYAGING SOCIETY GROUP NO:
Name of Company and DBA (Print)

BUSINESS ADDRESS: c/O Bishop Museum P.O. Box 6037 Hono HI 96818
Number and Street City State Zip Code

TYPE OF BUSINESS: Non profit organization GROSS INCOME LIC. NO: 1063872
SCHEDULE II

REPORT NEW EMPLOYEE ENROLLMENTS
REPORT TERMINATED EMPLOYEES

| SECTION A | | | SECTION B | SECTION C | | SECTION D |
|---|---|---|---|---|---|---|
| PROVIDE INFORMATION FROM MEMBERSHIP CARD OR APPLICATION CARD. | | | Show monthly rate or am't being remitted | USE THIS SECTION TO ADD OR DELETE DEPENDENTS | | MEMBERSHIP AND CANCELLATION DATA |
| NAME OF EMPLOYEE | HMSA NUMBER | EMPLOYMENT DATE | New Members Tef. Members New Rate | NAME OF NEW DEPENDENT OR WIFE'S MAIDEN NAME | Birthdate and or Marriage Date | REMARKS |
| Sandra Maile | 11856374 | 5/1/74 | $ | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | TOTAL | $ | | | |

Signed.....
(Employer)
(Signature must accompany report)

- An application card for each new member must accompany this report.
- Submit this form with dues payment to HMSA.
- Enrollment date will be established by HMSA.

12B - Sml. Bus. (2/1/73
Service Department

The Blue Shield Plan for Hawaii

# HAWAII MEDICAL SERVICE ASSOCIATION

1504 KAPIOLANI BOULEVARD

HONOLULU, HAWAII 96808

TELEPHONE 944-2110 • P. O. BOX 860

BRANCHES:
LIHUE, KAUAI
HILO, HAWAII
WAILUKU, MAUI
KAILUA, KONA

June 9, 1975

Polynesian Voyaging Society
c/o Bishop Museum
P O Box 6037
Honolulu, HI 96818

Gentlemen:

We appreciate this opportunity to serve your organization through your membership in HMSA, the Blue Shield Plan for Hawaii. Your application for enrollment in our Small Business Group Plan has been accepted and benefit allowances will be effective on June 1, 1975 at 12:01 a.m. The enclosed executed copy of the Form No. 27-B and Certificate contain the terms and conditions of membership and benefits under this Plan. These documents should be made easily accessible to those HMSA members enrolled under your group program who may wish to refer to them from time to time.

Your organization is subject to annual re-certification for continued eligibility under the Group Medical Program. This will be accomplished at the appropriate time by mail.

If you need any forms, application cards, brochures, or additional information regarding your Medical Plan, please feel free to call your nearest HMSA office.

Sincerely yours,

Kenneth Kamada
Director
Membership Service

Enclosure

SB-4 (5/73)

The Blue Shield Plan for Hawaii

# HAWAII MEDICAL SERVICE ASSOCIATION

1504 KAPIOLANI BOULEVARD

TELEPHONE 944-2110 • P. O. BOX 860

HONOLULU, HAWAII 96808

BRANCHES:
LIHUE, KAUAI
HILO, HAWAII
WAILUKU, MAUI
KAILUA, KONA

## AGREEMENT FOR ENROLLMENT IN SMALL BUSINESS GROUP PLAN

This Agreement between **POLYNESIAN VOYAGING SOCIETY** (name)

dba: **POLYNESIAN VOYAGING SOCIETY** (group)

and the Hawaii Medical Service Association (HMSA) sets forth the terms of the HMSA Plan with the Group and its employees eligible for membership in HMSA.

The Group agrees to administer the Plan for its employees, their dependents, and thereby act as their agent to accept notice upon their behalf and to remit dues according to established billing procedures and report all enrollments and membership changes to HMSA in accordance with HMSA enrollment regulations.

The Group also agrees that a Certification of Eligibility on an annual basis will be required by the submission to HMSA of the current and valid State of Hawaii General Excise Tax License Number and the Department of Labor Unemployment Insurance Account Number.

The executed copy of this Agreement with the Certificate(s) and related documents containing the terms and conditions of membership and benefits under this Plan constitutes the Agreement between your organization and the Hawaii Medical Service Association with respect to your employees enrolled as HMSA members under your group program.

This Agreement will take effect at 12:01 a.m. on the effective date established by HMSA subject to prepayment of the first month's dues for the members. Payment to HMSA shall thereafter be on a prepaid basis from month to month.

Hawaii State Department of Labor Unemployment Insurance Acct. No. **XXXXX 89494**

Hawaii State General Excise Tax License No. **1063872**

Type of Business: **non-profit organization** Phone No.: **841-3966**

Business Address: **c/o Bishop Museum P.O. Box 6037 Hono HI 96818**

Name of Executive: **Ben R. Finney** Title: **President**

HMSA Group Plan (4 or CHP) **Group 4**

Authorized Signature: *B Finney* Title: **TREASURER**

Dated this **May** day of **21**, 19 **75**

Hawaii Medical Service Association's Use Only:

Accepted by: *Carmen Cosmo* Effective Date: 6-1-75

HMSA Group Number 13045

MAY 30 1975

SERVICE 27-B (4/75)