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MEDICAL ENROLLMENT FORM

8100 34TH AVENUE SOUTH, PO BOX 1309
MINNEAPOLIS, MN 55440-1309

NAME OF EMPLOYER	GROUP NUMBER	SITE

MEDICAL PLAN	☐ NEW HIRE ☐ LATE ENROLLMENT Continuous Coverage ☐ YES ☐ NO If YES, No. of Months ____ Previous Coverage End Date ____	☐ RETIREE ☐ COBRA ☐ OPEN ENROLLMENT ☐ LIFE EVENT ☐ EARLY RETIREMENT	Date of Full Time Employment M/D/Y	Coverage Effective Date M/D/Y

APPLICANT'S LAST NAME (LEGAL NAME)	FIRST NAME	M.I.	DATE OF BIRTH (M/D/Y)	SOCIAL SECURITY NUMBER

STREET ADDRESS/APT NUMBER	CITY	STATE

ZIP CODE	COUNTY	APPLICANT'S TELEPHONE (including Area Code) HOME BUSINESS	☐ MALE ☐ FEMALE	☐ SINGLE ☐ MARRIED

MEDICAL PLAN SELECTED: (If choices are available) ____

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR EACH DEPENDENT: (ATTACH AN ADDITIONAL SHEET IF NECESSARY)

NAME: LAST, FIRST, M	SOCIAL SECURITY NUMBER	DATE OF BIRTH (MO/DAY/YR)	RELATIONSHIP	SEX (M /F)
NAME				
NAME				
NAME				
NAME				
NAME				

Do all of the dependent(s) listed above reside at the same address as the applicant? ☐ YES ☐ NO If NO, list dependent(s) name and address:

____

If last name is different for dependents, please explain why ____

Are any of the above listed dependent(s) age 19 or older, full-time students? ☐ YES ☐ NO If YES, indicate below the name, school attending and if full-time:

NAME	SCHOOL	STATUS
		☐ Part-time ☐ Full-time
		☐ Part-time ☐ Full-time

DOES ANY APPLICANT HAVE CURRENT HEALTH INSURANCE? Check which type: ☐None ☐ Group ☐ Individual

HOW LONG HAS THAT APPLICANT BEEN WITH THAT INSURER? PLEASE LIST ALL:

APPLICANT	NAME OF INSURER	COVERAGE DATES
		TO
		TO
		TO
		TO

At the time of the effective date of coverage being applied for, will you, your spouse and/or dependent(s) be insured by any other health insurance company? ☐ YES ☐ NO

If YES, please complete the **Coordination of Benefits Form.**

CONDITIONS OF COVERAGE:

I HEREBY APPLY FOR COVERAGE ON THE BASIS OF THE STATEMENTS AND ANSWERS TO THE QUESTIONS HEREIN. I hereby declare all answers to be true and complies with the best of my knowledge.

Subject to revocation by me by written notice to my employer, I authorize the required deduction (if any) from my wages. I have read and agree with the terms as stated on this application. By acceptance of coverage and upon signing this Enrollment Form, I authorize HealthPartners and its associated organizations, and others it designates, to share information about me with any medical provider, sponsoring employer, or other entity, where such information is reasonably necessary for plan administration. I understand that HealthPartners and its associated organizations may release information regarding services provided under my health benefits contract when requested by the employer organization sponsoring my benefits plan.

I UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMISSION OF RELEVANT INFORMATION IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIM(S) OR CANCELLATION OF COVERAGE.

X ____

SIGNATURE OF APPLICANT DATE SIGNED

FOR PLAN USE ONLY

ME	DE	SUBGROUP	COB	EFFECTIVE DATE

SIGNATURE OF EMPLOYER (OPTIONAL) DATE