HealthPartners®

MEDICAL ENROLLMENT FORM

8170 33RD AVENUE SOUTH, PO BOX 297
MINNEAPOLIS, MN 55440-0297

NAME OF EMPLOYER			GROUP NUMBER	SITE
EMPLOYEE STATUS ☐ Active/New Hire ☐ Retired ☐ COBRA	EVENT STATUS ☐ OPEN ENROLLMENT ☐ LIFE EVENT Reason:_____ _____	☐ LATE ENROLLMENT Continuous medical coverage If YES, number of months _____ Coverage End Date: _____	Hire Date M/D/YY	Coverage Effective Date M/D/YY

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

STREET ADDRESS / APT NUMBER	CITY	STATE

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

MEDICALPLAN SELECTED: (If choices are available) _____

APPLICANT – COMPLETE ALL UNSHADED AREAS

EMPLOYEE	DISABILITY* (Y/N)	SOCIAL SECURITY NUMBER	DATE OF BIRTH (M/D/YYYY)	RELATIONSHIP TO EMPLOYEE	SEX (M,F)	ENROLLING IN MEDICAL	DENTAL
NAME				SELF		☐	☐
PLEASE COMPLETE THE FOLLOWING INFORMATION FOR EACH DEPENDENT:							
NAME						☐	☐
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:

Are any of the above listed dependent(s) under the age of 25 married? ☐ YES ☐ NO **NAME** _____

Are any of the above listed dependent(s) disabled (eligible for guaranteed coverage)? ☐ YES ☐ NO **NAME** _____

At the time of your effective date with HealthPartners, 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

Check which type: ☐ Group ☐ Individual

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

APPLICANT	NAME OF INSURER	COVERAGE DATES
		TO
		TO
		TO
		TO

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 others it designates, to share information about me with any medical provider, plan sponsor, or other entity, where such information is reasonably necessary for treatment, payment or health care operations. I understand that HealthPartners may release information regarding services provided under my health benefits contract when requested by the 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 CLAIMS, CANCELLATION OR RECISSION OF COVERAGE.

X _____ **X** _____

SIGNATURE OF APPLICANT DATE SIGNED SIGNATURE OF EMPLOYER (OPTIONAL) DATE SIGNED

*Federal Medicare legislation now requires this information. If you have questions about this, please contact Member Services.

The HealthPartners family of health plans are underwritten and/or administered by HealthPartners, Inc., Group Health, Inc., HealthPartners Insurance Company or HealthPartners Administrators, Inc. Fully insured Wisconsin plans are underwritten by HealthPartners Insurance Company. 490018_d25 (5/09) © 2009 HealthPartners