

NAME OF EMPLOYER				GROUP NUMBER	SITE	
DENTAL PLAN	<input type="checkbox"/> NEW HIRE <input type="checkbox"/> LATE ENROLLMENT Continuous Coverage If YES, No. of Months End Date _____	<input type="checkbox"/> RETIREE <input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> EARLY RETIREMENT	<input type="checkbox"/> COBRA <input type="checkbox"/> LIFE EVENT	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/YY)	SOCIAL SECURITY NUMBER	
STREET ADDRESS / APT NUMBER				CITY	STATE	
ZIP CODE	COUNTY	APPLICANT'S TELEPHONE (including area code)			<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED

**WAIVING COVERAGE FOR:**

- 
- SELF
- 
- 
- SPOUSE
- 
- 
- DEPENDENT CHILDREN

**REASON WAIVING:**

- 
- COVERAGE THROUGH ANOTHER EMPLOYER
- 
- 
- OTHER
- 
- please sign below*

**You need only complete this boxed section if you or your employer has selected one of the dental plans listed below. Ask your employer if you do not know which dental plan is being offered.**

**CUSTOMIZED OPTIONS®** (select one):

- 
- HealthPartners Classic Network (select a clinic)
- 
- 
- HealthPartners Dental Network (select a clinic)
- 
- 
- No Network (use any dentist)

 EXCEED OR EXCEED CHOICE

- Each family member selects Tier I or Tier II
- 
- For Tier I providers, identify the clinic number below
- 
- For all Tier II providers indicate Clinic #1000

**APPLICANT - COMPLETE ALL UNSHADED AREAS**

EMPLOYEE	SOCIAL SECURITY NUMBER	DATE OF BIRTH (M/D/YYYY)	RELATIONSHIP TO EMPLOYEE	SEX (M,F)	CLINIC # (If required)
NAME			SELF		

**PLEASE COMPLETE THE FOLLOWING INFORMATION FOR EACH DEPENDENT BEING ENROLLED:**

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 or 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 dental insurance company?**

- 
- YES
- 
- NO If YES, please complete the
- Coordination of Benefits Form**

 Check which type:  Group  Individual

**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 or dental provider, plan sponsor, or other entity, where such information is reasonably necessary for treatment, payment or dental care operations. I understand that HealthPartners may release information regarding services provided under my dental 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** \_\_\_\_\_  
 SIGNATURE OF APPLICANT DATE

**X** \_\_\_\_\_  
 SIGNATURE OF EMPLOYER (OPTIONAL) DATE