

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/YY	Coverage Effective Date
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"/> SINGLE
		HOME	BUSINESS	<input type="checkbox"/> FEMALE	<input type="checkbox"/> MARRIED

DENTAL PLAN SELECTED: (If choices are available) _____

WAIVING COVERAGE (CHECK ONE)

- COVERAGE THROUGH ANOTHER EMPLOYER**
 OTHER
 please sign _____

WITHIN THE PAST THREE MONTHS-

- I HAVE NOT HAD DENTAL COVERAGE (w)**
 I HAVE HAD COMPARABLE DENTAL COVERAGE (e)
NAME OF INSURANCE COMPANY: _____

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

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR EACH DEPENDENT:

NAME				
NAME				
NAME				
NAME				
NAME				
NAME				

APPLICANT - COMPLETE ALL UNSHADED AREAS

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 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 signed

X _____
 signature of employer (optional) date signed

Plans are underwritten and administered by HealthPartners family of health plans, which includes HealthPartners, Inc., HealthPartners Insurance Company and HealthPartners Administrators, Inc. Fully insured Wisconsin plans are underwritten by HealthPartners Insurance Company.