



COMBINED MEDICAL/DENTAL ENROLLMENT FORM
VOLUNTARY DENTAL

NAME OF EMPLOYER, GROUP NUMBER, SITE, EMPLOYEE STATUS, EVENT STATUS, Hire Date, 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), HOME, WORK, SEX (MALE, FEMALE), SINGLE, MARRIED

PLAN SELECTED: MEDICAL, DENTAL, Waiving Coverage, Coverage through other employer, Other, Please sign, WITHIN THE PAST THREE MONTHS-

Table with columns: EMPLOYEE, DISABILITY* (Y/N), SOCIAL SECURITY NUMBER, DATE OF BIRTH (M/D/YYYY), RELATIONSHIP TO EMPLOYEE, SEX (M,F), ENROLLING IN MEDICAL, DENTAL

Table for dependent information with columns: NAME, DISABILITY* (Y/N), SOCIAL SECURITY NUMBER, DATE OF BIRTH (M/D/YYYY), RELATIONSHIP TO EMPLOYEE, SEX (M,F), ENROLLING IN MEDICAL, DENTAL

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? MEDICAL YES NO DENTAL YES NO

CONDITIONS OF COVERAGE: I HEREBY APPLY FOR COVERAGE ON THE BASIS OF THE STATEMENTS AND ANSWERS TO THE QUESTIONS HEREIN. 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.

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

APPLICANT - COMPLETE ALL UNSHADED AREAS