

NAME OF EMPLOYER			GROUP NUMBER	SITE
EMPLOYEE STATUS <input type="checkbox"/> Active/New Hire <input type="checkbox"/> Retired <input type="checkbox"/> COBRA	EVENT STATUS <input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> LIFE EVENT Reason: _____ _____	<input type="checkbox"/> 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 SINGLE
 FEMALE MARRIED

PLAN SELECTED: **MEDICAL:** _____
 DENTAL: _____
Waiving Dental Coverage: Coverage through other employer
 Other Please sign: _____

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		<input type="checkbox"/> <input type="checkbox"/>

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR EACH DEPENDENT:

NAME	DISABILITY* (Y/N)	SOCIAL SECURITY NUMBER	DATE OF BIRTH (M/D/YYYY)	RELATIONSHIP TO EMPLOYEE	SEX (M,F)	ENROLLING IN MEDICAL DENTAL
NAME						<input type="checkbox"/> <input type="checkbox"/>
NAME						<input type="checkbox"/> <input type="checkbox"/>
NAME						<input type="checkbox"/> <input type="checkbox"/>
NAME						<input type="checkbox"/> <input type="checkbox"/>
NAME						<input type="checkbox"/> <input type="checkbox"/>
NAME						<input type="checkbox"/> <input type="checkbox"/>

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) age 19 or older, full-time students? YES NO If YES, indicate below the name, school attending and if full-time:

NAME	SCHOOL	STATUS	
_____	_____	<input type="checkbox"/> Part-time	<input type="checkbox"/> Full-time
_____	_____	<input type="checkbox"/> Part-time	<input type="checkbox"/> Full-time
_____	_____	<input type="checkbox"/> Part-time	<input type="checkbox"/> Full-time

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

If YES for either, 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 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

APPLICANT - COMPLETE ALL UNSHADED AREAS