

HealthPartners Personal Dental Plan Enrollment Form

Please carefully review these instructions before completing the enrollment form.

1. Answer **all** questions **completely** and **accurately** in ink.
2. Carefully read, **sign** and date the enrollment form.
3. Make a copy of the enrollment form for your records. Mail this original to HealthPartners in the enclosed envelope.
4. **Send the first month's premium with your form!**

Applicant Information

Applicant's Name (Person responsible for payment)

Last _____ First _____ M.I. _____

Gender Male Female **Age** ____ **Date of Birth** _____ **Social Security** _____

Applicant Address Street _____ City _____ State ____ Zip _____

Applicant's Phone Numbers & Email Address

Home () _____ Work () _____ Email _____

Choose Your HealthPartners Personal Dental Plan

Personal Dental **Maintenance** Plan Personal Dental **Major** Plan Personal Dental **Comprehensive** Plan

Choose Your Dental Network

- HealthPartners **Dental Group** network (includes 15 Twin Cities locations)
 HealthPartners **Open Access** network (includes 1,750 dentists in Minnesota)

Previous HealthPartners Membership Information

Have you ever been a member of HealthPartners? If yes, please list name and member number:

Name _____ Member Number: _____

Current and/or Previous Dental Information (Please attach a separate sheet if needed.)

- Within the past three months, I have not had dental coverage.
 Within the past three months, I have had comparable dental coverage. (Please list dental information below and include a copy of your dental membership card or proof of coverage with your application.)

Name	Name of Insurer	City, State, Zip	Termination Date

Current Medical Information Including Medicare Coverage (Please attach a separate sheet if needed.)

(If you receive Medical Assistance, you are not eligible for Personal Dental Plans.)

- I have the following medical insurance.

Applicant Name(s)	Name of Insurer	Address of Insurer (City, State, Zip)	Coverage Dates

(over)

Conditions of Acceptance

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 complete to the best of my knowledge. I understand that these statements, answers and subsequent information I provide are the basis for my coverage and rate and are made a part of my HealthPartners Personal Dental plan contract.

I authorize HealthPartners to obtain membership verification from the Minnesota Senior Federation.

I authorize HealthPartners to release information relative to dental plan enrollment (your name and membership number) to the Minnesota Senior Federation. I understand that no health related information will be released.

I understand that providing false information or omission of relevant information in this enrollment form may result in the denial of claims or rescission of coverage back to the effective date of coverage, and recovery of any paid dental claims.

I authorize HealthPartners to obtain from providers of service information relating to me and all other applicants that are necessary for: claims processing, including claims we make for reimbursement or subrogation; quality of care assessment and improvement; accreditation, credentialing, care coordination and utilization management, premium rating, the evaluation of potential or actual claims against us, auditing and legal services, and other access and use without further authorization if permitted or required by another law. I also authorize HealthPartners to release information related to my HealthPartners enrollment to my insurance broker (if identified below). A photocopy of this authorization shall be as valid as the original and remains in effect unless it is revoked.

I understand that I must have medical coverage. If my medical coverage is terminated, dental coverage may be terminated by HealthPartners.

Please keep a copy of this completed enrollment form and any attachments you submitted for your records. It will become a part of your contract if the enrollment is accepted.

SIGNATURE

X _____ Date _____
(Applicant's signature)

Select payment option: monthly quarterly

*** To be completed only if you have selected the monthly payment option.**

I understand that if I choose the monthly payment option, the payment must be automatically withdrawn from my bank account. (For more information about this option, you can request a copy of our Direct Payment Plan brochure.) If you do not select a payment option, you will be defaulted to quarterly billing. **Also, you must include the first month's premium with this enrollment application, regardless of which payment option you choose.**

Name on Checking Account _____ Bank Name _____

Routing Number _____ Checking Account Number _____

If you selected the monthly payment option, please attach voided check to this application.

Questions?

Call 952-883-5599, 1-877-838-4949
or visit healthpartners.com

Send enrollment application to:

HealthPartners Individual Dental Sales
PO Box 1309, MS21106D
Minneapolis, MN 55440-1309

MN Senior Fed #: _____

Expiration Date: _____

For Office Use Only

Package Code: _____

Effective Date: _____

Broker's name if applicable (please print): _____

Broker #: _____ Date: _____

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.