HealthPartners®

HealthPartners Worksite Health – Influenza Vaccine Registration

Please print as shown below. Stay within the boxes. Use CAPITAL letters only.

S	A	M	P	L	E	1	2	3

IF YOU ARE AN ACTIVE HEALTHPARTNERS MEDICAL INSURANCE MEMBER, PLEASE COMPLETE THE FOLLOWING:

Todays Date: | | | / | | | / | | | | |

If you do not have your insurance card, please call HealthPartners Member Services at (952) 883-5000

Your HealthPartners Group Number: | | | | | |

Your HealthPartners Member Number*: | | | | | | | | |

Birthdate: | | | / | | | / | | | | |

SSN**: | | | | - | | | - | | | | |

Required **ONLY if you cannot provide your HealthPartners member number**

Last Name:

First Name:

Employer: