



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. All adults, including dependent children age 18 and over, must sign.
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

Lead Applicant's Name (Person responsible for payment)

Last _____ First _____ M.I. _____

Gender Male Female **Date of Birth** _____ **Lead Applicant Address**

Street _____ City _____ State ____ Zip _____

Lead 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)

Personal Information (Complete for each person to be covered including yourself, spouse and dependents, and attach a separate sheet if needed.)

First, Middle I., Last Name	Relationship to Subscriber	Address (if different from above)	Date of Birth	Social Security #

Previous HealthPartners Membership Information (Please attach a separate sheet if needed.)

The following individual(s) has/have been a member(s) of HealthPartners in the past:

Name _____ Member Number: _____

Current and/or Previous Dental Information (Please choose one option.)

- 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 (Please attach a separate sheet if needed.)

(You **must** have current medical insurance to qualify for Personal Dental. 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 and to accurately represent those persons applying for coverage. 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 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 applicable. A photocopy of this authorization shall be as valid as the original and remains in effect unless it is revoked.

This authorization is intended to cover the release of information described above related to me, as well as to my dependent children for whom I have applied for HealthPartners Personal Dental coverage.

I understand that I must have medical coverage. If my medical coverage is terminated, dental coverage may be terminated by HealthPartners. I understand that my coverage becomes effective the month following the date this enrollment application is received.

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.

All adult enrollees and the parent/legal guardian of all minor enrollees must sign here. Dependent children age 18 and older must sign. An adult can only authorize the release of records for him or herself and minor children, not for a dependent spouse. HealthPartners must receive your enrollment form within 30 days of signature date or it will be returned to you. Enrollment form is valid for 60 days from the date you sign it. If declined, we'll notify you of the reason.

SIGNATURES

X _____ Date _____
(Applicant's signature)

X _____ Date _____
(Spouse's signature, if applying for coverage)

X _____ Date _____
(Dependent's signature, if age 18 or older)

X _____ Date _____
(Guarantor/legal guardian signature (if any applicants are minors))

Select payment option: monthly quarterly

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.**

If you submit payment in the form of a paper check, it will be converted to an e-check. An e-check is a one-time electronic withdrawal from your checking account. Your paper check will be securely destroyed after it has been processed. If you would like to opt out of an e-check payment, please contact HealthPartners Sales for more information about other payment options and questions.

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.

Don't forget to:

- Select a dental plan
- Select a dental network
- Include first month's premium with application
- If you have chosen the monthly payment option, please send a voided check.

Send enrollment application to:

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

Questions?

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

For Office Use Only

Package Code: _____
Effective Date: _____

HealthPartners Sales Rep. _____ App Code _____ Area _____

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.