HealthPartners Personal Dental Plans

Payment Voucher

To activate your HealthPartners Personal Dental Plan coverage, you will need to pay for your first month of coverage. Please fill out both sections of this form to select one payment method for initial payment and a separate option for your ongoing payments.

Applicant information

Lead/self applicant name ______________________ Application number ______________________

I. Choose your method of first payment

❒ Check – 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.

Charge my credit card for the first month's premium. Note: credit card payments are accepted for first month's premium only.
❒ American Express ❒ Visa ❒ MasterCard ❒ Discover

Name on card ______________________ Amount to charge to credit card $_________

Card number ______________________ Exp. date _________ / _________

Signature ______________________ Phone number ______________________

Billing name (please print) ______________________

Billing address ______________________

City ______________________ State_________ Zip _________

II. Choose your method of ongoing payments

Select payment option:
❒ Monthly withdrawal from bank account (please mail or fax form including a voided check) ❒ Quarterly billing

Name on account ______________________ Name of financial institution ______________________

Routing number ______________________ Account number ______________________
❒ Checking ❒ Savings

I am enrolling in the monthly automatic withdrawal billing option. I authorize HealthPartners and the bank I name to automatically withdraw funds for my monthly premium from the specified checking or savings account. This authorization will remain in effect until I notify HealthPartners of cancellation in writing at least 14 days before my next payment is due. I agree to pay all bank charges with any stop payments initiated by me or my bank and any insufficient fund charges.

____
Accountholder Name (please print)

______________________ ______________
Accountholder Signature Signature Date

Where to send this form

Mail or fax this form to:
952-853-8718 (fax)
HealthPartners Individual
Dental Sales
PO Box 1309, MS21106D
Minneapolis, MN 55440-1309

Questions?

Call 952-883-5599 or
1-877-838-4949

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.

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