



2010 Freedom Plan (Cost) Comprehensive Dental Benefit Enrollment Form

Please Type or Print

Please return this application to HealthPartners in the enclosed envelope or to:

HealthPartners
Riverview Membership Accounting
P. O. Box 9463 - MS21103R
Minneapolis, MN 55440
Or you can fax it to 952-853-8746.

Application Information

Last Name	First Name	Middle Initial	
Address	City	State	ZIP code
Date of Birth	Phone Number	Member ID Number	

I understand that I will be billed \$36.70 per month for this plan in addition to my HealthPartners® Freedom Plan (Cost) medical and/or prescription drug premium and in addition to my monthly Medicare Part B premium. I will be billed through the method I selected on my Medical Plan application, unless I selected Social Security Withhold. In that case, I will receive a separate invoice for my dental premium. I understand that enrollment is limited to my Initial Enrollment Period and the Annual Enrollment Period from November 15 through December 31.

I understand if I was previously enrolled in this Freedom dental plan, I may receive a benefit waiting period.

Do you plan to keep additional dental coverage? ___ Yes ___ No

If yes, please list that policy's insurance company and policy number:

Signature _____ Date _____

For HealthPartners use only

Effective Date	Group Number	Contract Number	Entered By	Date
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Original - HealthPartners

Copy - Applicant