



**Send applications to:**  
 HealthPartners  
 Riverview Membership Accounting  
 P. O. Box 9463 - MS21103R  
 Minneapolis, MN 55440

## Classic & Senior Health Advantage Dental Plan Enrollment Form

Please Type or Print

### Application Information

Last Name		First Name		Middle Initial	
Address		City	State	ZIP code	
Social Security Number (optional)	Date of Birth	Phone Number	Member ID Number (If current medical member)		

### Dental Coverage and Clinic Selection

I wish to enroll in the optional dental plan. I understand that I will be billed for the premium listed on my HealthPartners® Classic/Senior Health Advantage Dental Plan Benefit Grid. I understand that if I leave this dental plan, I must wait two (2) years before re-enrolling.

I will be billed through the method I select on my medical plan application.

Dental Clinic Selected: \_\_\_\_\_

Clinic Number: (see Network Directory) \_\_\_\_\_

I would like my coverage to begin: Month \_\_\_\_\_ Year \_\_\_\_\_  
 (Please note that this cannot be retroactive.)

### Applicant's Signature

Signature \_\_\_\_\_ Date \_\_\_\_\_

Return your application to HealthPartners in the enclosed self-addressed stamped envelope. You can also fax this and your other forms to 952-853-8746.

### For HealthPartners use only

Effective Date	Group Number	Contract Number	Entered By	Date
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700429 (10/09)

Original - HealthPartners

Copy - Applicant