HealthPartners®

HealthPartners Individual Sales
P.O. Box 1309, MS21102A
Minneapolis, MN 55425
Phone: 952-883-5599 or
1-877-838-4949
Fax: 952-853-8718

# HealthPartners Compass Individual Plan

Underwritten by HealthPartners Insurance Company, a related company of HealthPartners, Inc.

## Enrollment Form Instructions

This is an enrollment form for a HealthPartners Compass plan. Please carefully review the instructions below before completing the form. Lead applicant must be a permanent resident of Minnesota.

- ✓ Please use ink when completing this form.
- ✓ Answer all questions completely and accurately. This enrollment form provides the evidence of insurability and will be the basis for coverage and premium rates if you are accepted into the plan. Providing false information in this enrollment form may result in the denial of claims or rescission of coverage. Please note there is no coverage provided for maternity care under this policy.
- ✓ Complete all sections in full. The enrollment form will be returned to you if all items are not completed.
- ✓ Lead applicant must be age 19 and no older than 65 to obtain coverage as a policyholder on this plan.
- ✓ Carefully read, sign and date the last page of the enrollment form. All adults, including dependent children over age 18, must sign the form. HealthPartners must receive your enrollment form within 30 days of the signature date or it will be returned to you. If any applicant is under age 18, the parent or legal guardian must sign. Your enrollment form is valid for a period of 60 days from the date you sign it. After 60 days, a new form must be completed in full and re-submitted.
- ✓ Make a copy of the completed and signed enrollment form for your records. Mail the original enrollment form, along with payment for the first month's premium and a completed premium worksheet, to HealthPartners. You may also fax the information. See the top of this page for the mailing address and fax number. Please note that we cannot accept your enrollment form without payment and we cannot accept cash. Payment for multiple applications on one check may be returned.
- ✓ Please review the Summary of Benefits if you need additional details about this plan.

## About the Enrollment Process

Upon receipt of your enrollment form, we will review it for completeness. We may need to contact you for further details or we may need to request health history information from other health care providers. We will notify you of any such request. Please note that you may be billed by your health care provider for the necessary records.

We will notify you of a decision after your enrollment form and any additional information have been reviewed. Normal processing time varies, and depends on if information from other health care providers is necessary to complete your enrollment.

If you are approved for the HealthPartners Compass plan you selected, or an alternate with a lesser monthly premium, you will be automatically enrolled in that plan on the date you choose or the next available effective date. Available effective dates are: the 1st or 16th of each month.

On the day your application is approved, the first month's premium payment you submit with your application will be processed. 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 dispute resolution. Any payment amount over or under your actual premium will be applied to your member account unless you are offered an alternate plan. HealthPartners will only process your payment once you have been approved.

You will be given choices for ongoing payment when you are approved for coverage. Options include quarterly statements or monthly automatic withdrawals. We will default you to quarterly statement billing if we do not receive your selection.

If you are not approved for the HealthPartners Compass plan you selected on your enrollment form, we will notify you of the reason(s) for the decision and provide you with information on other options.

HealthPartners®

Send completed enrollment form, or direct questions to:
HealthPartners Individual Sales
P.O. Box 1309, MS21102A
Minneapolis, MN 55425
Phone: 952-883-5599 or
1-877-838-4949
Fax: 952-853-8718

**HealthPartners Compass Plan**

**Enrollment Form / Evidence Of Insurability**

Please write all answers in ink. Answer all questions completely to avoid a delay in enrollment processing.

## Section 1. Applicant Information

**Lead Applicant's Name**

Last _____ First _____ M.I. _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married

**Lead Applicant's Address**

Street _____ City _____ State _____ ZIP _____ County _____

**Lead Applicant's Telephone/Email**

Preferred Phone (_____) _____ Alternate Phone (_____) _____

E-mail Address _____

☐ You may communicate with me via encrypted e-mail, when possible, for myself and any family member listed on this application.

**Dependent's Address** (if different from above) Add additional page(s) for dependents if needed.

Street _____ City _____ State _____ ZIP _____

## Section 2. Application Details

1. **Choose an effective date and only one of the following deductible plans:**

Requested Effective Date: ❒ First available ❒ __/__/____ (mm/dd/yyyy)

Available effective dates are the 1st or 16th of any month. You will be automatically enrolled for the next available effective date after approval unless a different date is requested. Coverage cannot be retroactive. The effective date you choose must be no more than 60 days beyond the signature date of this enrollment form.

Single Deductible – Drug Option 1 (Generic)

| | | | | | |
|---|---|---|---|---|---|
| ❒ $2,000 – 80% | ❒ $3,000 – 80% | ❒ $5,000 – 80% | ❒ $7,000 – 80% | ❒ $10,000 – 80% | ❒ $15,000 – 80% |
| ❒ $2,000 – 100% | ❒ $3,000 – 100% | ❒ $5,000 – 100% | ❒ $7,000 – 100% | ❒ $10,000 – 100% | ❒ $15,000 – 100% |

Single Deductible – Drug Option 2 (Generic / Brand)

| | | | | | |
|---|---|---|---|---|---|
| ❒ $2,000 – 80% | ❒ $3,000 – 80% | ❒ $5,000 – 80% | ❒ $7,000 – 80% | ❒ $10,000 – 80% | ❒ $15,000 – 80% |
| ❒ $2,000 – 100% | ❒ $3,000 – 100% | ❒ $5,000 – 100% | ❒ $7,000 – 100% | ❒ $10,000 – 100% | ❒ $15,000 – 100% |

Family Deductible – Drug Option 1 (Generic)

| | | | | | |
|---|---|---|---|---|---|
| ❒ $4,000 – 80% | ❒ $6,000 – 80% | ❒ $10,000 – 80% | ❒ $14,000 – 80% | ❒ $20,000 – 80% | ❒ $30,000 – 80% |
| ❒ $4,000 – 100% | ❒ $6,000 – 100% | ❒ $10,000 – 100% | ❒ $14,000 – 100% | ❒ $20,000 – 100% | ❒ $30,000 – 100% |

Family Deductible – Drug Option 2 (Generic / Brand)

| | | | | | |
|---|---|---|---|---|---|
| ❒ $4,000 – 80% | ❒ $6,000 – 80% | ❒ $10,000 – 80% | ❒ $14,000 – 80% | ❒ $20,000 – 80% | ❒ $30,000 – 80% |
| ❒ $4,000 – 100% | ❒ $6,000 – 100% | ❒ $10,000 – 100% | ❒ $14,000 – 100% | ❒ $20,000 – 100% | ❒ $30,000 – 100% |

Other deductible options are available — contact HealthPartners for more information.

HealthPartners Sales Rep. _____ App Code _____ Area _____

**2. Mental Health and Chemical Dependency Coverage:**

This plan includes coverage for mental health and chemical dependency. The decision to keep or opt out of this coverage applies to all individuals applying for coverage under this contract. You may choose to exclude this coverage. (Base rates are lower when excluding coverage.)

Do you wish to include or exclude mental health and chemical dependency coverage? ☐ Include ☐ Exclude

**3. Personal Information:** Complete the following information for each person in your family including yourself, spouse, children, non-custodial children and children under your legal guardianship.

| Applying for coverage (Yes or No) | If no, reason: (examples: employer coverage, military, MCHA, MN Care) | Full Name (First, MI, Last) (start with lead applicant) | Relationship | Age | Date of Birth | Height | Weight | Gender | Social Security #* |
|---|---|---|---|---|---|---|---|---|---|
| Yes | | | Self | | | | | | |
| | | | | | | | | | |
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*Providing your Social Security Number is not required. However, it will help speed underwriting and help HealthPartners work with your physicians to resolve any questions.

Has any person listed in Question 3 ever been a HealthPartners member? ☐ YES ☐ NO
If YES, please list full name, including any former names used and HealthPartners member number.

| Full Name | Member Number |
|---|---|
| | |
| | |
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**4. HealthPartners Membership:** Please check the box that best describes your reason for application:

☐ I am a new applicant and am not currently a HealthPartners individual or conversion plan member.

☐ I am adding a dependent(s) to my current HealthPartners individual plan contract.

☐ I am a current HealthPartners individual plan member and am seeking a different plan or a lower rate.

☐ I am a current HealthPartners member through my employer. Employer Name:_____

☐ Other. Please explain: _____

If applying via FAX: Lead Applicant Signature _____ Date _____

## Section 3. Health Information

In answering health history questions, you should not include any genetic information. That is, please do not include any family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic diseases for which you believe you may be at risk.

**5. Current and Previous Health Plan Information: Name, city and state of the current health plan companies for each person applying for coverage in Question 3**

Please attach a separate sheet if additional space is needed. If you do not have health insurance coverage right now, check this box. ❒

| Applicant Name(s) | Name(s) of Insurance Company (City, State, Zip) | Date Coverage Started (mm/dd/yyyy) | Date Coverage ended (If still active, state active) (mm/dd/yyyy) |
|---|---|---|---|
| | | | |
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**6. Current Medical Clinic(s):** Name, city, state and phone number of all family physician(s) for each person applying for coverage. If there is no regular physician, please give the name, city and state where each applicant last received care. Use additional sheets if necessary.

| Applicant Name(s) | Approximate Date of Last Complete Physical Exam | Physician Name(s) | Clinic Name, City and State |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**7. Physical Exam:** Please list the results of the last physical exam for each person applying for coverage. Include test results such as mammogram, pap smear, prostate-specific antigen (PSA), sigmoidoscopy or colonoscopy.

| Applicant Name(s) | What Test was Completed | Date Completed | Results (Normal or Abnormal) | Clinic/Physician |
|---|---|---|---|---|
| | | | | |
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**8. Tobacco Use/Cessation:** Has any person applying for coverage: **Yes** **No**

Used any tobacco or tobacco cessation product in the last 12 months? . . . . . ☐ ☐

If YES, list all individuals: _____

**9. Foreign Travel:** Does any person applying for coverage have plans for foreign travel within the next six months? . . . . . ☐ ☐

If YES, who? _____ Where? _____ When? _____ For how long? _____

**10. Pregnancy:** Is any person applying for coverage:

a. Currently pregnant; or is your spouse, significant other, or other dependent currently pregnant or do you plan to add a dependent as a result of a birth or adoption? . . . . . ☐ ☐

b. Planning to add any other dependent? . . . . . ☐ ☐

**11.** For each female person applying for coverage, please list date of last menstrual cycle.

Name _____ Date _____ Name _____ Date _____

If applying via FAX: Lead Applicant Signature _____ Date _____

***Complete information is required below for each applicant. If you answer YES to any of these questions, please explain in Question 15, indicating which applicant the YES answer involves. (Please attach a separate sheet if additional space is needed.)***

| | Yes | No |
|---|---|---|
| **12. DWI or DUI**: Been convicted of or had his/her driver's license suspended or revoked for driving while under the influence | ☐ | ☐ |
| **13. Has any person applying for coverage EVER sought medical care, advice or been diagnosed or treated for:** | | |
| a. Heart murmur, angina, coronary artery disease or other heart or circulatory condition | ☐ | ☐ |
| b. Stroke, epilepsy, alzheimer's, traumatic brain injury, brain tumor, multiple sclerosis | ☐ | ☐ |
| c. Hemophilia, polycythemia, thalessemia, blood clots, platelet condition or other blood condition | ☐ | ☐ |
| d. Tuberculosis, emphysema or pulmonary fibrosis | ☐ | ☐ |
| e. Colitis, crohns disease, hepatitis, cirrhosis of the liver, pancreatitis, kidney cysts or chronic kidney disease | ☐ | ☐ |
| f. Scoliosis, spondylolithesis, ankylosing spondylitis or spina bifida | ☐ | ☐ |
| g. Cancer | ☐ | ☐ |
| h. Diabetes — Type I ___ or Type II ___ | ☐ | ☐ |
| i. An immune system condition, including but not limited to lupus, rheumatoid arthritis, scleroderma, connective tissue condition and sjogrens syndrome | ☐ | ☐ |
| **14. Within the past 5 years has any person applying for coverage sought medical care, advice or been diagnosed with or treated for any condition not already mentioned above concerning the following:** | **Yes** | **No** |
| a. Anemia, varicose veins, varicose ulcer, phlebitis or other blood condition | ☐ | ☐ |
| b. Elevated blood glucose, elevated cholesterol or other lipids or had any other abnormal blood test | ☐ | ☐ |
| c. Chest pain or high blood pressure | ☐ | ☐ |
| d. Condition of the muscles, bones or joints including but not limited to osteoarthritis, fibromyalgia, knee, hip, leg, shoulder, back or neck | ☐ | ☐ |
| e. Fainting, dizziness, convulsions, headaches, migraines or any other brain or nervous condition | ☐ | ☐ |
| f. Allergies, asthma, COPD, lung or other respiratory condition | ☐ | ☐ |
| g. Any type of ulcer; condition of the gallbladder, stomach, intestine, rectum or liver | ☐ | ☐ |
| h. Mental, emotional or personality condition, including counseling or hospitalization | ☐ | ☐ |
| i. Any disease or condition of the eyes, ears, nose, throat, tonsils, sinuses or thyroid | ☐ | ☐ |
| j. Any kidney, bladder, prostate or urinary condition | ☐ | ☐ |
| k. Any disease or condition of the breast, reproductive organs; abnormal menstrual periods, infertility or any sexually transmitted disease, PCOS or abnormal pap smear | ☐ | ☐ |
| l. Eating condition, unexplained weight loss, fatigue, fever, enlarged lymph nodes, skin lesions or any other related condition | ☐ | ☐ |
| m. Received inpatient or outpatient treatment for the abuse of drugs, alcohol or prescription drugs | ☐ | ☐ |

If applying via FAX: Lead Applicant Signature _____ Date _____

| | Yes | No |
|---|---|---|
| n. Been told by a medical practitioner or health care professional to modify or restrict eating, drinking or living habits for health purposes | ☐ | ☐ |
| o. Received any holistic, alternative, or complementary treatment including herbal remedies, massage for pain, acupuncture/acupressure, or other therapies | ☐ | ☐ |
| p. Had a physical examination, electrocardiogram, laboratory or diagnostic test, x-ray (other than dental) | ☐ | ☐ |
| q. Been diagnosed or treated for any medical condition not listed above | ☐ | ☐ |
| r. Had any life or health insurance declined, postponed or modified, or had a waiver, rider or extra premium added | ☐ | ☐ |
| s. Received payment for medical disability, illness or injury | ☐ | ☐ |
| t. Been hospitalized or had surgery | ☐ | ☐ |
| u. Has future surgery been discussed or medically advised? | ☐ | ☐ |
| v. Received care outside the United States due to foreign residency or travel | ☐ | ☐ |

**15. Explanations:** You must complete this section for each YES answer given in Questions 12-14. You may also include copies of medical records. **It is your responsibility to pay any fees that may be charged for obtaining medical records.** Please attach a separate sheet if additional space is needed.

| Question # and Letter | Name of Person as Listed in Question 3 | Explanations of Yes Answers in Questions 12 – 14 (Include Name of Condition, Reason Treated and Other Details) | Dates of past or future treatment | Indicate if resolved or ongoing | Complete Name, city and state of Physician(s) and/or Hospital(s) Where Treated |
|---|---|---|---|---|---|
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| | Yes | No |
|---|---|---|
| **16. Medications:** In the past 12 months, has any person applying for coverage taken any medications? If YES, complete the section below | ☐ | ☐ |

**Medications used in the past 12 months:** *Please attach a separate sheet if additional space is needed.*

| Applicant Name(s) | Name of Medication | Dosage/Mg Per Use | # of Doses Per Day | # of Refills Per Year | Condition or reason taken | Indicate if ongoing or date discontinued |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
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| | | | | | | |

If applying via FAX: Lead Applicant Signature _____ Date _____

**Important Information About The Minnesota Insurance Fair Information Reporting Act**
HealthPartners complies with the Minnesota Insurance Fair Information Reporting Act. This law gives you specific rights to receive notice that HealthPartners may be collecting personal information from third parties about you during the health underwriting process. It is a HealthPartners policy that we will not release personal information outside of our companies without the express written consent of the applicant or patient. You have the right to see the personal information we collect about you and there is a procedure to correct inaccurate personal information about you in our possession. You may contact the HealthPartners Individual Sales department by calling 952-883-5599 or 1-877-838-4949 for further information on your rights.

## Conditions of Acceptance

I hereby apply for coverage on the basis of the statements and answers to the questions herein. I hereby represent all answers to be true and complete to the best of my knowledge and to accurately represent the health of 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 individual plan contract. **Furthermore, I understand that this enrollment form must be updated by me to include any condition or disease that may occur between the date of this enrollment form and the effective date of coverage.** I understand that this enrollment form may be denied in whole or in part. I understand that any of the applicants may be denied. I may withdraw this enrollment form at any time during processing with written notification. I understand that if my enrollment form for new or additional coverage is accepted, the coverage will not be effective until after the premium is received and accepted by HealthPartners and I am notified of the effective date.

**I understand that there is no coverage provided for maternity care under this policy. Specific benefit information in the Summary of Benefits is provided in the application packet.**

I authorize HealthPartners to obtain from health plans, providers of service and hospitals, brokers, HealthPartners affiliates and business associates the medical and mental and chemical health records relating to me and all other applicants that are necessary for: enrollment, claims processing, including claims HealthPartners makes for reimbursement or subrogation; quality of care assessment and improvement; accreditation, credentialing, case management, care coordination and utilization management, disease management, underwriting; premium rating, the evaluation of potential or actual claims against HealthPartners, auditing and legal services, and other health care operations. If another provider, hospital or health plan does not accept a copy of this document as authorization to release my information to HealthPartners, then I agree that I will sign a separate authorization, both for the initial underwriting of this application as well as post-enrollment reviews if I am offered coverage. This authorization is valid as long as I am continually insured with HealthPartners or until revoked. A photocopy of this authorization shall be as valid as the original. HealthPartners may access and use information without further authorization if permitted or required by another law.

I also authorize HealthPartners to release information related to my HealthPartners enrollment (including information from my medical records) to my insurance broker, should I choose to name one.

I authorize HealthPartners to collect personal motor vehicle driving records for me and my dependents. I authorize disclosure of such information solely for the purpose of assisting with the underwriting of the enrollment form.

**I authorize HealthPartners to release information related to my HealthPartners enrollment (including information from my medical records) to the lead applicant. This authorization is intended to cover the release of information described above related to each adult signing below, as well as their respective dependent children on whose behalf I have applied for HealthPartners individual coverage. An adult can only authorize the release of records for him or herself and minor children, not for a dependent spouse.**

I understand that payment for the first month's premium and payment information for subsequent premiums must be submitted with this enrollment form or the application may not be considered. If I am accepted for coverage under my selected or an alternate plan, I understand my submitted payment will be processed and I will be automatically enrolled in that plan. I understand that I will be defaulted to quarterly statement billing unless I register for monthly automatic withdrawals from my bank account.

**I understand that rates for this plan may change at my birthday, upon annual renewal or at other times as approved by state regulators.**

**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.**

**Please keep a copy of the completed enrollment form for your records. It will become a part of your contract if the enrollment is accepted.**

**All adult applicants, including dependent children age 18 and older, must sign below.**

Enrollee signature(s)

X_____ Date signed_____

Lead applicant's signature, if age 18 or older

X_____ Date signed_____

Spouse's signature, if applying for coverage

X_____ Date signed_____

Dependent's signature, if age 18 or older

X_____ Date signed_____

Dependent's signature, if age 18 or older

Broker's name, if applicable. (Please print.)_____ Broker #_____ Date_____

HealthPartners Individual Sales
952-883-5599
1-877-838-4949
healthpartners.com/individual

040112 PC

440473 (4/12) 4/12 Benefits

HealthPartners®

# *Initial Payment Form*

***(Payment Voucher)***

Thank you for your application for a HealthPartners individual plan.

To complete the application process, please provide payment for the first month's premium. This payment must be submitted before we can review your application. We will not process the payment until you have been approved for the plan you selected. If you are submitting more than one application, please include a separate payment for each application.

If you have questions, or would prefer to pay over the phone, call HealthPartners Individual Sales at 952-883-5599 or 877-838-4949 between 8 a.m. and 6 p.m. Monday-Friday. You can also email questions to **individualsales@healthpartners.com**.

## Applicant information

Applicant Name _____

Application Number
(online applications only) _____

## Calculate your premium

Payment amount being submitted $_____ (this must be filled in)

## Choose your method of payment

☐ **Check** (Please submit original signed paper check)

Your paper check will be converted to an e-check once you're approved for coverage and accepted. 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.

☐ **Credit Card**

Account Type: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Cardholder Name _____

Card Number _____ Expiration Date ____/____

Billing Address _____ Phone Number _____

City, State, ZIP _____ Email Address _____

**SIGNATURE** _____ Date _____

## Return this payment form by mail or fax with your application form

HealthPartners Individual Sales
P.O. Box 1309
MS21102A
Minneapolis, MN 55440-1309

Fax: 952-853-8718

HealthPartners®

**Individual Health Plans**

**Optional. You can submit this form with your enrollment form to speed processing time.**

## *Authorization for release of prescription drug history report*

### What is this?

You have the option of letting HealthPartners obtain and review a report of your prescription drug history from a consumer reporting agency.

The attached form gives you more details about this option. If you choose this option, you will need to sign the attached form and return it with your enrollment form and first month's premium payment.

### Why should I consider this option?

The information from your prescription drug history report can result in a faster decision on your HealthPartners Individual plan application, because it helps reduce the number of follow-up questions we may ask of you or your doctor. You do not have to pay for this report.

### What should I do next?

Please take a moment to review the attached information, and if you choose, sign the authorization form. Please submit the signed authorization form along with your enrollment form and first month's premium payment.

We need permission and a signature from each applicant to be able to obtain the prescription drug history for that person.

### What if I have questions?

Please call HealthPartners Individual Sales at 952-883-5599 or 1-877-838-4949, Monday through Friday, 8 a.m. to 6 p.m. You can also e-mail questions to individualsales@healthpartners.com.

HealthPartners®

Individual Underwriting
P O Box 1309, MS 21105H
Minneapolis, MN 55440-1309

## Authorization for Release of Protected Information for Prescription Drug Records through Milliman IntelliScript

**Please print:**

Lead Applicant Name: _____

Address: _____

Spouse Applicant Name: _____

Address: _____

Dependent Applicant Name: _____

Address: _____

Dependent Applicant Name: _____

Address: _____

*Attach additional dependent names on separate page.*

**I (applicants listed above) authorize the disclosure and use of my health information as described below:**

**Who may disclose (give out) this information:** pharmacy benefit managers, retail pharmacies, clearinghouses, insurance organizations or other organizations that maintain prescription drug records

**Who may receive and use this information**: HealthPartners, Inc., with offices located at 8170 33rd Avenue South, Bloomington, MN 55425 and its related organizations and Milliman IntelliScript with offices located at 15800 Bluemound Road, Suite 400 Brookfield, WI 53005.

**The purpose for which this information may be disclosed**: for use in connection with the insurance underwriting process involving the individual(s) to whom the information relates or as permitted or required by applicable law.

**What information may be disclosed**: any information held by the discloser relating to the applicant's prescription drug history including: prescription name (generic or brand), dates prescription were filled, indications, dosage, prescribing physician name, specialty, address and phone number, pharmacy name, address and phone number.

**This authorization expires (ends) on the following upon:** completion of the underwriting process related to this application for HealthPartners coverage.

**- continued -**

**I understand that:**

- I am not required to sign this authorization. However, if I (and all of my co-applicants) do sign this authorization, it may help reduce the amount of time to complete the underwriting process related to my application.
- I am authorizing HealthPartners to release my name, date of birth and other identifying information to assist in the underwriting process.
- I may revoke this authorization at any time by notifying, in writing, the department listed above.
- If the disclosed information goes to a healthcare provider or a health plan covered by federal privacy laws, it will be protected by federal privacy laws. Information that goes to other persons or entities may not be protected by state or federal privacy laws and may be re-disclosed.
- Revoking this authorization does not apply to information that has already been released under this authorization.
- I have the right to inspect or request a copy of the health information to be disclosed.

| | |
|---|---|
| Lead Applicant's Signature | Date |
| Spouse's Signature, if applying for coverage | Date |
| Dependent's Signature, if age 18 or older | Date |
| Dependent's Signature, if age 18 or older | Date |
| Legal Guardian's Signature, if any applicants are minors | Date |

Important Information About The Minnesota Insurance Fair Information Reporting Act

HealthPartners complies with the Minnesota Insurance Fair Information Reporting Act. This law gives you specific rights to receive notice that HealthPartners may be collecting personal information from third parties about you during the health underwriting process. It is a HealthPartners policy that we will not release personal information outside of our companies without the express written consent of the applicant or patient. For this reason, HealthPartners does not share personal information about individuals with insurance or health underwriting support organizations. You have the right to see the personal information we collect about you and there is a procedure to correct inaccurate personal information about you in our possession. You may contact the HealthPartners Individual Sales department by calling 952-883-5599 or 1-877-838-4949 for further information on your rights.