HealthPartners Dental

MINNESOTA GROUP DENTAL APPLICATION
SMALL GROUP

Submissions received after the 10th of the month cannot be guaranteed an effective date of the first of the following month. HealthPartners will request additional information as deemed necessary.

- Enrollment forms MUST be completed in their entirety.
- All eligible employees must be accounted for with an application or waiver.

EMPLOYER ELIGIBILITY INFORMATION

Today's Date:	Requested Eff. Date:	HealthPartners Sales Executive:
Full Legal Group Name:		DBA (if applicable):
Address:		
City, State, Zip:		County:
Phone:		Fax:
Federal Tax ID#:		Corporate Headquarters (City, State):
Contact Person:		
Contact Title:		Contact Email:

◯YES ◯NO **1.** Is this organization in any way related to other companies (such as a national corporation) as a wholly or partially owned subsidiary, or does this organization own any other companies or have wholly or partially owned subsidiaries? **If YES, please provide the HealthPartners Controlled Group form, found on HealthPartners.com/employer**

◯YES ◯NO Do you have any other locations or sites? If YES, list the State and/or Country: _____

◯YES ◯NO **2.** Number of years in business _____ Industry _____

◯YES ◯NO **3.** Type of Entity: ◯ **S Corporation** ◯ **C Corporation** ◯ **Sole Proprietorship** ◯ **Partnership** ◯ **Non-Profit** ◯ **LLC** *(select one:* ◯ *C Corporation* ◯ *Sole Proprietorship* ◯ *Partnership)*

3a. Are you a government group, public entity or public school? ◯ **YES** ◯ **NO** ☐ **Erisa** or ☐ **Non-Erisa**

3c. Are you a church or religious group? ◯ **YES** ◯ **NO** ☐ **Erisa** or ☐ **Non-Erisa** *(If YES and Erisa, please provide DOL)*

For 4a and 4b exclude seasonal, temporary and union employees covered under a collective bargaining agreement.

_____ **4a.** On average, how many permanent employees did this organization employ (in all locations), working a normal work week of 20 or more hours throughout the preceding calendar year (January through December)?*

_____ **4b.** Currently, how many employees have a normal work week of 20 hours or more?*

_____ **4c.** What is the total number of employees (full/part time for entire family of companies) for your company? *Medicare Secondary Payer rules apply to employer group health plans with 20 or more employees for each working day in at least 20 weeks in either the current or the preceding calendar year. If you have questions on this rule, please contact your broker or sales representative.*

*Some employees who do not work a full twelve months may be covered under their employer's plan. These employees must work a minimum of nine months in a calendar year. If providing coverage for these employees, the employer must complete the Small Employer Contribution Agreement for Seasonal Employees Form on **healthpartners.com/employer.** **If you are going to cover employees working for a minimum of 9 months, how many will you be covering?** _____

_____ **5.** How many employees reside outside of Minnesota? *(Submit Quarterly Wage Report for each state)*

◯YES ◯NO **6.** Does this organization intend to offer domestic partner coverage? ◯ **Same gender** ◯ **Same *and* opposite gender**
Please refer to Domestic Partner Form on healthpartners.com/employer for eligibility.

PARTICIPATION / EMPLOYEE ELIGIBILITY INFORMATION

_____ **Number of hours all eligible employees must work per week**

Classification(s) of Employees Excluded from Coverage:

☐ Union covered by a collective bargaining agreement ☐ Part-time ☐ Hourly
☐ Union not covered by a collective bargaining agreement ☐ Salaried ☐ Owners
☐ Other (explain): _____

◯YES ◯NO Are retirees eligible for coverage? If yes, define policy _____

Waiting Period for New Employees: ◯ Date of Hire **OR**

First of the month following: ◯ 30 days ◯ 60 days ◯ 90 days
◯ Other, explain: _____

_____ Total number of eligible employees and

_____ Total number of eligible employees that are applying for coverage

_____ Total number of employees that are waiving coverage

Employer Contribution: Minimum 50% of single coverage. No miminum contribution for Voluntary Dental Plan.

Contribution amount: _____Single _____Single +1 _____Family

PRODUCT SELECTION

DENTAL PRODUCTS May also be purchased on a stand-alone basis.

Distinctions℠ Dental Plan
- ◯ Distinctions 1
- ◯ Distinctions 2
- ◯ Distinctions 3
- ◯ Distinctions 4
- ◯ Distinctions 5
- ◯ Distinctions 6
- ☐ Optional orthodontics add-on[1]

Voluntary Distinctions℠ Dental Plan[2]
- ◯ Voluntary Distinctions 3
- ◯ Voluntary Distinctions 4
- ☐ Options orthodontics add-on[1]

- ☐ Open Access Preventive-only Dental Plan
- ☐ Open Access Preventive Plus Dental Plan
- ☐ Open Access Preventive Plus Voluntary Dental Plan[2]
- ☐ Other _____

Dental Options® Defined Contribution Plan
- ◯ Dental Options 1000
- ◯ Dental Options 2000
- ☐ Options orthodontics add-on[1]

Open Access Advantage (select one benefit from each category)
- ◯ Employer sponsored
- ◯ Voluntary[2]

Annual maximum
- ◯ $1000
- ◯ $1500

Out-of-Network
- ◯ Option 1
- ◯ Option2

- ☐ Options orthodontics add-on[1] (employer-sponsored plan only)

[1] Must have 10 or more employees enrolled to be eligible for orthodontic products.
[2] Must have 5 or more employees enrolled to be eligible for voluntary plans.
[3] Available to groups with 50–100 eligible employees

Open Access – Employer sponsored (select one benefit from each category)

Annual maximum	Deductible	Coinsurance
◯ $1000	◯ None	◯ 100/50/50
◯ $1250	◯ $25	◯ 100/80/50
◯ $1500	◯ $50	
◯ $2000 (avail. with 100/80/50 coinsurance only)	◯ $75	
◯ $2500 (avail. with 100/80/50 coinsurance only)		

- ☐ Optional orthodontics add-on[1]

Voluntary Open Access Dental Plan[2] (select one benefit from each category)

Annual maximum	Deductible	Coinsurance
◯ $750	◯ $25	◯ 100/50/50
◯ $1000	◯ $50	◯ 100/80/50
◯ $1250	◯ $75	
◯ $1500 (avail. with 100/80/50 coinsurance only)		

Voluntary Open Access Dental Plan w/Ortho[3] (select one benefit from each category)

Annual maximum	Deductible	Coinsurance
◯ $1000	◯ $25	◯ 100/80/50
◯ $1250	◯ $50	
◯ $1500	◯ $75	

CURRENT CARRIER INFORMATION

Current MEDICAL Carrier: _____ Type of coverage ◯ Group ◯ Individual

Current DENTAL carrier: _____ **Renewal Date:** _____

AGENT/BROKER INFORMATION

Agent Name:	Phone:
Address:	Fax:
City, State, Zip:	Broker Number:
Email:	

Agent of Record Signature (if applicable) | Printed Name and Company | Date

EMPLOYER SIGNATURE

I hereby certify that the information provided in this document, and any additional information submitted to support this application, is accurate and complete. I understand that errors or omissions regarding this information may result in premium adjustments and/or termination of the contract as permitted by law.

CEO/Owner/Authorized Company Representative | Printed Name | Date

HealthPartners®

PO Box 1309
Minneapolis, MN 55440-1309
Sales Metro Phone # 952-883-5200
Non-Metro Phone # 800-298-4235

HealthPartners will notify employees covered on HealthPartners plans of the special enrollment periods detailed in 29 CFR Sec. It is the responsibility of the employer to notify those employees who decline HealthPartners coverage of their special enrollment rights.