

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](http://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](http://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 minimum 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 <sup>SM</sup> Dental Plan Distinctions 1                      Distinctions 4 Distinctions 2                      Distinctions 5 Distinctions 3                      Distinctions 6 Optional orthodontics add-on <sup>1</sup>	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                      \$75 coinsurance only) \$2500 (avail. with 100/80/50 coinsurance only) Optional orthodontics add-on <sup>1</sup>
Voluntary Distinctions <sup>SM</sup> Dental Plan <sup>2</sup> Voluntary Distinctions 3                      Voluntary Distinctions 4 Options orthodontics add-on <sup>1</sup>	
Open Access Preventive-only Dental Plan                      Open Access Preventive Plus Voluntary Dental Plan <sup>2</sup> Open Access Preventive Plus Dental Plan                      Other _____	Voluntary Open Access Dental Plan <sup>2</sup> (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)
Dental Options <sup>®</sup> Defined Contribution Plan Dental Options 1000                      Dental Options 2000 Options orthodontics add-on <sup>1</sup>	
Open Access Advantage (select one benefit from each category) Employer sponsored                      Voluntary <sup>2</sup> Annual maximum                      Out-of-Network \$1000                                      Option 1 \$1500                                      Option2 Options orthodontics add-on <sup>1</sup> (employer-sponsored plan only)	Voluntary Open Access Dental Plan w/Ortho <sup>3</sup> (select one benefit from each category) Annual maximum                      Deductible                      Coinsurance \$1000                                      \$25                                      100/80/50 \$1250                                      \$50 \$1500                                      \$75
<sup>1</sup> Must have 10 or more employees enrolled to be eligible for orthodontic products. <sup>2</sup> Must have 5 or more employees enrolled to be eligible for voluntary plans. <sup>3</sup> Available to groups with 50–100 eligible employees	

## 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 \_\_\_\_\_



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 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.