

NAME OF EMPLOYER			GROUP NUMBER	SITE
DENTAL PLAN	NEW HIRE RETIREE OPEN ENROLLMENT	EARLY RETIREMENT COBRA LIFE EVENT	DATE OF FULL-TIME EMPLOYMENT: ____/____/20____	COVERAGE EFFECTIVE DATE: ____/____/20____

**APPLICANT: COMPLETE ALL UNSHADED AREAS**

APPLICANT'S LAST NAME (LEGAL NAME) \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_

FIRST NAME \_\_\_\_\_ M.I. \_\_\_\_\_ SINGLE \_\_\_\_\_ MARRIED \_\_\_\_\_

STREET ADDRESS / APT NUMBER \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_

ZIP CODE \_\_\_\_\_ COUNTY \_\_\_\_\_ APPLICANT'S TELEPHONE Home: \_\_\_\_\_ Business: \_\_\_\_\_

DENTAL PLAN SELECTED: (If choices are available) \_\_\_\_\_

**WAIVING COVERAGE:**

Coverage through other employer

Other

Please sign \_\_\_\_\_

**PLEASE COMPLETE THE FOLLOWING INFORMATION FOR EMPLOYEE AND EACH DEPENDENT BEING COVERED**

NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH (M/D/YYYY)	RELATIONSHIP TO EMPLOYEE	SEX (M/F)
			SELF	

Do any of the dependent(s) listed above reside at a different address from the applicant?

YES NO If YES, list dependent(s) name and address: \_\_\_\_\_

At the time of your effective date with HealthPartners, will you, your spouse, and/or dependent(s) be insured by any other dental insurance company?

YES NO If YES, please complete the **Coordination of Benefits Form**. Check which type: Group Individual

**CONDITIONS OF COVERAGE:**

I HEREBY APPLY FOR COVERAGE ON THE BASIS OF THE STATEMENTS AND ANSWERS TO THE QUESTIONS HEREIN. I hereby declare all answers to be true and complies with the best of my knowledge.

Subject to revocation by me by written notice to my employer, I authorize the required deduction (if any) from my wages. I have read and agree with the terms as stated on this application. By acceptance of coverage and upon signing this Enrollment Form, I authorize HealthPartners, and others it designates, to share information about me with any medical provider, plan sponsor, or other entity, where such information is reasonably necessary for treatment, payment or health care operations. I understand that HealthPartners may release information regarding services provided under my health benefits contract when requested by the organization sponsoring my benefits plan.

I UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMISSION OF RELEVANT INFORMATION IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIMS, CANCELLATION OR RECISSION OF COVERAGE.

SIGNATURE OF EMPLOYEE \_\_\_\_\_ DATE SIGNED \_\_\_\_\_ SIGNATURE OF EMPLOYER \_\_\_\_\_ DATE SIGNED \_\_\_\_\_