HealthPartners | HealthPartners UnityPoint Health | Robin HealthPartners

EMPLOYEE APPLICATION HEALTH HISTORY

For Employer Use EVENT STATUS STATUS CHANGE EMPLOYEE STATUS ACTIVE/NEW HIRE RETIREE COBRA

NAME OF EMPLOYER_____ GROUP NUMBER_____ SITE_____ EFF DATE_____

MEDICAL PLAN SELECTION_____

I: Employee Information

LAST NAME FIRST NAME MI DATE OF BIRTH ____ /____ / _____

HIRE DATE ____ /____ / _____ ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ DOMESTIC PARTNER

STREET ADDRESS / APT NUMBER CITY STATE

ZIP CODE COUNTY PHONE Home: ( ) – Business: ( ) –

II: Applicant Information List all family members to be covered.

EMPLOYEE: NAME: FIRST, M.I., LAST SOCIAL SECURITY NUMBER	DATE OF BIRTH (M/D/YYYY)	RELATIONSHIP	SEX (M/F)	HEIGHT	WEIGHT (LBS.)
NAME		SELF			
SOC. SEC. #*					
DEPENDENTS:					
NAME					
SOC. SEC. #*					
NAME					
SOC. SEC. #*					
NAME					
SOC. SEC. #*					
NAME					
SOC. SEC. #*					

*Your Social Security number is used for IRS tax reporting regarding your health plan. It does not have any impact on your application or enrollment.

Do all of the dependent(s) listed above reside at the same address as the employee? ☐ YES ☐ NO

If NO, list dependent(s) name and address:_____ Please notify HealthPartners if you are or become eligible for Coordination of Benefits with Medicare as a secondary payer as HealthPartners is required to report this information

Are any dependent(s) age 26 or older and a full-time student? (information required if employer is located in IA or SD only) ☐ YES ☐ NO

If YES, list dependent(s) name and school attending:_____

III: Waiver of Coverage This section MUST be completed if you or your dependents DO NOT want coverage.

I understand that I am eligible to apply for health coverage through my employer. I DO NOT want coverage for:

☐ Myself ☐ My spouse ☐ My dependent child(ren) ☐ Domestic partner

Please indicate the reason you are waiving coverage.

I am declining coverage at this time because I or my dependents have coverage provided through:

☐ Spouse's Employer's plan ☐ Parent's Employer's plan ☐ Individual policy ☐ COBRA (Group Coverage Continuation)

☐ State coverage ☐ Medicare A ☐ or A & B ☐ Medical Assistance ☐ General Assistance

☐ I (and/or my family member(s) choose to be without health insurance ☐ Other, explain:_____

I understand that if I desire to apply for coverage at a later date, I may be restricted to a special enrollment period.

_____

PRINT NAME

_____ _____

SIGNATURE OF EMPLOYEE (REQUIRED IF YOU OR FAMILY MEMBERS ARE WAIVING COVERAGE) **DATE SIGNED**

IV: Health Information Please answer questions 1-6.

In answering question 1, 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 disease for which you believe you may be at risk.

1. Have you or any family member applying for coverage EVER been diagnosed with or treated for any of the following conditions by a member of the medical profession? ☐ YES ☐ NO

a. ☐ cancer	e. ☐ immune system disorder	i. ☐ heart or circulatory disorder	m. ☐ non-cancerous tumor	q. ☐ other (provide detail below)
b. ☐ diabetes	f. ☐ blood disorder	j. ☐ eating disorder	n. ☐ stroke	
c. ☐ seizure/ epilepsy	g. ☐ psychological or neurological disorder	k. ☐ digestive or intestinal disorder	o. ☐ liver disorder	
d. ☐ respiratory disorder	h. ☐ muscle, bone or joint disorder, including rheumatoid arthritis	l. ☐ kidney or urinary tract disorder	p. ☐ alcohol/drug abuse	

2. Has anyone been medically advised to have a surgery that has not yet been completed? ☐ YES ☐ NO

If YES, who received or will receive care:_____ Date(s): _____

Reason:_____

3. Has anyone been hospitalized or had surgery for any condition or injury: ☐ YES ☐ NO If YES, explain:_____

If you have checked ANY condition above, please explain with details below:

PERSON'S NAME	DIAGNOSIS AND DETAILS ABOUT CONDITION, TREATMENT DATE OR DIAGNOSIS	DIAGNOSIS DATE	DATE OF RECOVERY OR ONGOING	DAYS IN HOSPITAL

4. Are you, your spouse, significant other, or dependents applying for coverage currently pregnant? ☐ YES ☐ NO

If YES, please provide name, relationship: _____

a) Due Date: _____

b) Is a C-Section anticipated? ☐ YES ☐ NO

c) Are multiple births expected? ☐ YES ☐ NO If YES, how many:_____

5. Is anyone currently taking, or taken during the past twelve months, any prescribed medication: ☐ YES ☐ NO If YES, list below.

PERSON'S NAME	MEDICATION	REASON PRESCRIBED	DOSAGE (MG/GM)	# PER DAY	REFILLS PER YR.	STILL PRESCRIBED?
						☐ YES ☐ NO
						☐ YES ☐ NO
						☐ YES ☐ NO
						☐ YES ☐ NO

6. Have you or a family member applying for coverage used tobacco products in the last 6 months? ☐ YES ☐ NO

If YES, name and quit date:_____

V: EMPLOYEE'S AUTHORIZATION AND REPRESENTATION Read this section carefully, sign and date the application.

I hereby support my employer's application for coverage and apply for coverage for myself and indicated dependents on the basis of the statements and answers to the questions herein. I hereby declare 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 and waiving coverage. I understand that these statements, answers and subsequent information I provide are the basis for coverage. Furthermore, I understand that this application must be updated by me to include any condition or disease regarding myself and dependents which may occur between the date of my application and the Effective Date of Coverage. Medical information provided does not impact coverage or enrollment provided under this policy.

I hereby authorize HealthPartners to obtain from providers of services and hospitals including but not limited to those providers with whom HealthPartners contracts for service all medical records including those which relate to mental health and chemical dependency treatment, for me and my family members to the extent that those records are necessary for underwriting and enrollment. These records may be used for the administration of the HealthPartners contract, including claims payment, case management, fraud investigation and quality of care review. This authorization is valid as long as I am continually insured or until revoked in writing. A photocopy of this application shall be as valid as the original.

SIGNATURE OF EMPLOYEE_____DATE SIGNED_____

Statement of Nondiscrimination for Health Plan Members

Our Responsibilities:
We follow Federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability or sex. We do not exclude people or treat them differently because of their race, color, national origin, age, disability or sex, including gender identity.

- We help people with disabilities to communicate with us. This help is free. It includes:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio and accessible electronic formats
- We provide services for people who do not speak English or who are not comfortable speaking English. These services are free. They include:
  - Qualified interpreters
  - Information written in other languages

For Language or Communication Help:
Call 1-800-883-2177 if you need language or other communication help. (TTY: 711)

If you have questions about our non-discrimination policy:
Contact the Civil Rights Coordinator at 1-844-363-8732 or integrityandcompliance@healthpartners.com.

To File a Grievance:
If you believe that we have not provided these services or have discriminated against you because of your race, color, national origin, age, disability or sex, you can file a grievance by contacting the Civil Rights Coordinator at 1-844-363-8732, integrityandcompliance@healthpartners.com or Civil Rights Coordinator, Office of Integrity and Compliance, MS 21103K, 8170 33rd Ave. S., Bloomington, MN 55425.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
Room 509F, HHH Building
200 Independence Avenue SW, Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD)

Español *(Spanish)* ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-883-2177. (TTY: 711)	ພາສາລາວ *(Laotian)* ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-883-2177. (TTY: 711)
Hmoob *(Hmong)* LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-883-2177. (TTY: 711)	Deutsch *(German)* ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-883-2177. (TTY: 711)
Tiếng Việt *(Vietnamese)* CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-883-2177. (TTY: 711)	العربية *(Arabic)* ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-883-2177 (رقم هاتف الصم والبكم: 711)
繁體中文 *(Chinese)* 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-883-2177. (TTY: 711)	Français *(French)* ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-883-2177. (ATS: 711)
Русский *(Russian)* ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-883-2177. (телетайп: 711)	한국어 *(Korean)* 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-883-2177. (TTY: 711)
Af Soomaali *(Somali)* OGAYSIIS: Haddii aad ku hadasho afka soomaaliga, Waxaa kuu diyaar ah caawimaad xagga luqadda ah oo bilaash ah. Fadlan soo wac 1-800-883-2177. (TTY: 711)	Tagalog *(Tagalog)* PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-883-2177. (TTY: 711)

Additional languages listed on page 2

Oromiffa *(Cushite [Oromo])* XIYYEEFFANNAA: Afaan dubbattu Oromiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-883-2177. (TTY: 711)	Italiano *(Italian)* ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-883-2177. (TTY: 711)
አማርኛ *(Amharic)* ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-883-2177. (መስማት ተሳናቸው : 711)	ภาษาไทย *(Thai)* เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-883-2177. (TTY: 711)
unD *(Karen)* ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အဃိ, နမၤန့်ၢ် ကျိာ်အတၢ်မၤစၢၤလၢ တလၢာ်ဘူဉ်လၢာ်စ့ၢ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 1-800-883-2177. (TTY: 711)	ελληνικά *(Greek)* ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-883-2177. (TTY: 711)
ខ្មែរ *(Mon-Khmer, Cambodian)* ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-883-2177. (TTY: 711)	Diné Bizaad *(Navajo)* Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-883-2177. (TTY: 711)
Deitsch *(Pennsylvanian Dutch)* Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-883-2177. (TTY: 711)	Ikirundi *(Bantu – Kirundi)* ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-883-2177. (TTY: 711)
Polski *(Polish)* UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-883-2177. (TTY: 711)	Kiswahili *(Swahili)* KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-800-883-2177. (TTY: 711)
हिंदी *(Hindi)* ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा हायता `वाएं उपलब्ध हैं। 1-800-883-2177. (TTY: 711)	日本語 *(Japanese)* 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-883-2177 (TTY: 711) まで、お電話にてご連絡ください。
Shqip *(Albanian)* KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-883-2177. (TTY: 711)	नेपाली *(Nepali)* ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता वेाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहो ् 1-800-883-2177 (टिटिवाइ: 711)
Srpsko-hrvatski *(Serbo-Croatian)* OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-883-2177. (TTY: 711)	Norsk *(Norwegian)* MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-800-883-2177. (TTY: 711)
ગુજરાતી *(Gujarati)* સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-883-2177. (TTY: 711)	Adamawa *(Fulfulde, Sudanic)* MAANDO: To a waawi Adamawa, e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-800-883-2177. (TTY: 711)
اُردُو *(Urdu)* خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-800-883-2177 (TTY: 711).	Українська *(Ukranian)* УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-883-2177. (телетайп: 711)