HealthPartners®

NON-ACA WISCONSIN SMALL GROUP EMPLOYEE APPLICATION

For Groups of 2 to 50 Employees

For Employer Use EVENT STATUS ❒ LIFE EVENT ________________________ EMPLOYEE STATUS ❒ ACTIVE/NEW HIRE ❒ RETIREE ❒ COBRA

NAME OF EMPLOYER __________________________________ GROUP NUMBER _______________________ SITE ________________ EFF DATE ________________

I: Employee Information

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

HOURS WORKED PER WEEK HIRE DATE ____ /____ / _______ ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED ❑ DOMESTIC PARTNER

STREET ADDRESS / APT NUMBER CITY STATE

ZIP CODE COUNTY APPLICANT'S TELEPHONE Home: ( ) – Business: ( ) –

II: Plan Selection / Information Your plan selection may only be changed at your employer's renewal

Please select one of the following: ☐ Medical (complete A) ☐ Dental (complete B) ☐ Medical and Dental (complete A and B)

A. IF MEDICAL PLAN, PLEASE INDICATE PLAN NAME: ____

I am applying for coverage for: (check all that apply)

☐ Myself

☐ My spouse Date of birth ___________________

☐ My dependent children Number of children ___________________

☐ Domestic partner *(please consult your employer)*

B. IF DENTAL PLAN, PLEASE SELECT ONE OF THE FOLLOWING: (Ask your employer if dental is offered)

☐ Single Dental

☐ Single+1 Dental

☐ Family Dental

☐ Waiving Dental Coverage because:

- ☐ *Have other coverage*
- ☐ *Do not want coverage*

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 or my dependent child(ren)

☐ 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, and/or my dependent(s), have coverage provided through:

☐ Spouse's Group Plan ☐ Medicare A_____ or A & B_____ ☐ Group Coverage Continuation (COBRA) ☐ Individual Policy

☐ Medical Assistance ☐ General Assistance

☐ I, and/or my family member(s), choose to be without health insurance.

☐ Other, **explain:** ____

____

PRINT NAME

____ _____________________

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

IV. Applicant Information List all family members to be covered.

EMPLOYEE:

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

DEPENDENTS: (Indicate last name ONLY if different than employee)

NAME						
SOC. SEC. #						
NAME						
SOC. SEC. #						
NAME						
SOC. SEC. #						
NAME						
SOC. SEC. #						

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: ______________________________

Do you want the individual's materials to go to this address? ☐ YES ☐ NO

If last name is different from dependents, please explain why: ______________________________

Please note name and type of disability for any dependent child to age 26.

Name and disability ______________________________

V. Other Medical Insurance Information This section must be completed. If not completed, coverage will be limited.

1. Do you or any family members included in this application currently have or had any health coverage in the past 18 months? ☐ YES ☐ NO
If YES, you must provide coverage history for the past 18 months in the spaces below.

PERSON'S NAME	INSURANCE COMPANY NAME, CITY, STATE, TELEPHONE NUMBER & POLICY NUMBER	EFFECTIVE DATE	TERMINATION DATE	REASON FOR TERMINATION

2a. Are you covered by Medicare **Part A**? ☐ YES ☐ NO **Part B**? ☐ YES ☐ NO If YES, please attach copy of Medicare card.

2b. Is your spouse or domestic partner covered by Medicare **Part A**? ☐ YES ☐ NO **Part B**? ☐ YES ☐ NO If YES, please attach copy of Medicare card.

3. Have you ever been covered by HealthPartners? ☐ YES ☐ NO If YES, what name did you use? ______________________________

VII. Employee's authorization and representation Read this section carefully, sign and date the application.

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 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 my coverage. **I understand that if my application for new or additional coverage is accepted, that applicable coverage will not be effective until after I am notified of the Effective Date.**

I hereby authorize HealthPartners, Inc. to obtain from providers of services and hospitals, including those providers with whom HealthPartners contracts for service, the medical records, including those which relate to mental health and chemical dependency treatment, relating to me and my family members to the extent that those records are necessary for underwriting and enrollment as well as for the administration of the HealthPartners contract, including for purposes of claims payment, case management, fraud investigation and quality of care review. 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. **I UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMISSION OF RELEVANT INFORMATION IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIMS OR CANCELLATION OR RESCISSION OF COVERAGE.**

______________________________ ______________________________

SIGNATURE OF EMPLOYEE **DATE SIGNED**

Federal Medicare legislation now requires this information. If you have questions about answering this, please contact HealthPartners Member Services.

IMPORTANT Please read carefully

Information provided on this application is solely for the purpose of underwriting and administering the HealthPartners plan(s) offered through your employer. In order to protect your privacy, all personal information is on the inside pages, with employment information on the backside. Before submitting your application, fold the form in half and staple it at the top.

To enroll in a HealthPartners plan:

- Complete the application by hand in ink. If you have an electronic PDF form, you can fill out the form on your computer with Adobe Reader and save or print the application as needed.
- Answer every question, providing complete information about yourself and family members you want to cover. If information is missing or incomplete, your enrollment may be delayed and/or your coverage may be limited.
- Please provide Social Security numbers to match your enrollment information to your assigned Member ID number for administrative purposes.

To add dependents to your current coverage:

- Complete the application by hand in ink. If you have an electronic PDF form, you can fill out the form on your computer with Adobe Reader and save or print the application as needed.
- Provide information about the dependent only - name, address (if different than yours), social security number and clinic selection (if enrolling in a HealthPartners Primary Clinic plan). Don't forget to complete the "Employee Information" section on the first page.

If you choose not to apply for coverage:

- You only need to complete the "Employee Information" and "Waiver of Coverage" sections on the first page of this application.
- Be sure to indicate why you are not enrolling, and sign and date the "Waiver of Coverage" section.
- You can waive medical coverage and still apply for dental coverage if both are offered.
- If your employer offers a HealthPartners dental plan:
- On the first page, indicate whether you want single (you only), single+1 or family coverage. If you choose not to apply for coverage, please indicate that you are waiving coverage.
- You can waive dental coverage and still apply for medical coverage if both are offered.

To submit your application:

- Please review all information for completeness and accuracy.
- Be sure to sign and date the application.
- Fold the completed form in half with Section I, "Employee Information," on the outside and staple it at the top.
- Submit the application to your employer or as instructed by your employer.

PO BOX 297
Minneapolis, MN 55440-0297

The HealthPartners family of health plans are underwritten and/or administered by HealthPartners, Inc., Group Health, Inc., HealthPartners Insurance Company or HealthPartners Administrators, Inc. Fully insured Wisconsin plans are underwritten by HealthPartners Insurance Company. 8062 No Health (10/15) © 2015 HealthPartners

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)
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)
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)
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)
Русский *(Russian)*	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-883-2177. (телетайп: 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)

Additional languages listed on page 2

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ພາສາລາວ (*Laotian*)	ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 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)
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)
Français (*French*)	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-883-2177. (ATS: 711)
한국어 (*Korean*)	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 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)
Oroomiffa (*Cushite [Oromo]*)	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-883-2177. (TTY: 711)
አማርኛ (*Amharic*)	ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደም ሚከተለው ቁጥር ይደውሉም-800-883-2177. (መስማት ለተሳናቸው: 711)
unD (*Karen*)	ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အယိ, နမၤန့ၢ် ကျိာ်အတၢ်မၤစၢၤလၢ တလၢာ်ဘူဉ်လၢာ်စ့ၢ် နီတမံၤဘဉ်သ့န့ၣ်လီၤ. ကိး 1-800-883-2177. (TTY: 711)
ខ្មែរ (*Mon-Khmer, Cambodian*)	ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 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)
Polski (*Polish*)	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-883-2177. (TTY: 711)
हिंदी (*Hindi*)	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता `वाएं उपलब्ध हैं। 1-800-883-2177. (TTY: 711)
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)
Srpsko-hrvatski (*Serbo-Croatian*)	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 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)
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).
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)
ภาษาไทย (*Thai*)	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 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)
Diné Bizaad (*Navajo*)	Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dę́ę́', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-883-2177. (TTY: 711)

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