



EMPLOYEE MEDICAL ENROLLMENT FORM

8170 33rd Avenue South, PO Box 297 Minneapolis, MN 55440-0297

NAME OF EMPLOYER		GROUP NUMBER		SITE
EMPLOYEE STATUS Active/New Hire Retired COBRA	EVENT STATUS			HIRE DATE:
	OPEN ENROLLMENT	LIFE EVENT Reason:	LATE ENROLLMENT Continuous medical coverage If YES, number of months: _____ Coverage End Date: _____	COVERAGE EFFECTIVE DATE:

APPLICANT: COMPLETE ALL UNSHADED AREAS

APPLICANT'S LAST NAME (Legal name)		DATE OF BIRTH		
FIRST NAME	MI	SINGLE	MARRIED	
STREET ADDRESS / APT NUMBER		CITY	STATE	
ZIP CODE	COUNTY	APPLICANT'S TELEPHONE Home:	Business:	

MEDICAL PLAN SELECTED: (If choices are available) _____

Waiving Medical Coverage: Coverage through other employer Other _____

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

Legal spouse, dependent up to age 26, or disabled dependent

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

**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 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: _____

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: _____

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

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

How long has that applicant been with that insurer? Please list all: _____

