HealthPartners®

SMALL GROUP EMPLOYEE APPLICATION OR MID-YEAR HIRES

For employer use

NAME OF EMPLOYER _____ GROUP NUMBER _____ SITE _____ EFF DATE _____

EVENT STATUS ☐ LIFE EVENT Submit appropriate documents with this application within 31 days of the life event.

Reason _____ Date of life event _____

EMPLOYEE STATUS ☐ ACTIVE/NEW HIRE ☐ RETIREE ☐ COBRA

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 _____ EMPLOYEE'S TELEPHONE Home: _____ Business: _____

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

Please choose one of the following: ○ Medical (fill out A) ○ Comprehensive Dental (fill out B) ○ Medical and Dental (fill out A and B)

A. IF MEDICAL PLAN, PLEASE WRITE PLAN NAME AND NETWORK NAME: _____

I'm applying for coverage for: (check all that apply)

☐ Myself

☐ My spouse Date of birth* _____

☐ My dependent children Number of children _____

Dependents age 19 and under will automatically be enrolled in the HealthPartners pediatric dental plan.

☐ Domestic partner *(please consult your employer)*

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

○ Single Dental

○ Single+1 Dental

○ Family Dental

○ Declining Dental coverage because:

☐ *Have other coverage*

☐ *Do not want coverage*

PLAN AND NETWORK NAME: _____

**Must be completed under applicant information, page 2, as well.*

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

I understand that I'm able 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 choose the reason you are waiving coverage.

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

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

☐ Medical Assistance ☐ General Assistance ☐ MinnesotaCare ☐ MNSure Policy

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

☐ Other, **explain:** _____

I understand that if I decline coverage now, enrollment in this or any other plan will be restricted to an annual open enrollment period or qualifying life event.

_____

PRINT NAME

_____ _____

SIGNATURE OF EMPLOYEE (REQUIRED IF YOU OR FAMILY MEMBERS ARE DECLINING 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)	RELATIONSHIP	SEX (M/F)
NAME		SELF	
SOC. SEC. # *			
DEPENDENTS: (Write last name ONLY if different than employee)			
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 live at the same address as the employee? ☐ YES ☐ NO

If NO, list dependent(s) name and address: _____

Please write name and type of disability for any dependent age 26 and older (HealthPartners will evaluate eligibility for guaranteed coverage).

NAME	DISABILITY

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

I am applying for coverage on the basis of the statements and answers to the questions herein. I represent all answers to be true and complete to the best of my knowledge and to accurately represent the ages of those persons applying for coverage. I understand that these statements, answers and subsequent information I provide are the basis for my coverage and rate. Furthermore, I understand that this enrollment form must be updated by me to include changes in address or other information I have provided on the form that may occur between the date of this enrollment form and the effective date of coverage. I understand that the coverage I am applying for will not be effective until after the premium is received and accepted by HealthPartners. I understand that HealthPartners will notify me of the effective date.

I UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMISSION OF RELEVANT INFORMATION IN THIS ENROLLMENT FORM MAY RESULT IN THE DENIAL OF CLAIMS OR A RETROACTIVE CHANGE IN RATE.

I authorize HealthPartners to obtain from health plans, providers of service and hospitals, brokers, HealthPartners affiliates and business associates the medical and mental and chemical health records relating to me and all other applicants that may be necessary for: claims processing, including claims HealthPartners makes for reimbursement or subrogation; quality of care assessment and improvement; accreditation, credentialing, case management, care coordination and utilization management, disease management, the evaluation of potential or actual claims against HealthPartners, auditing and legal services, and other health care operations. If another provider, hospital or health plan does not accept a copy of this document as authorization to release my information to HealthPartners, then I agree that I will sign a separate authorization. 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. HealthPartners may access and use information without further authorization if permitted or required by another law.

Enrollment in this or any other plan may be restricted to an annual open enrollment period or special enrollment period as allowed by law.

_____ _____

SIGNATURE OF EMPLOYEE DATE SIGNED

IMPORTANT Please read carefully.

Information given on this application is used to manage the HealthPartners plan(s) offered through your employer. To protect your privacy, all personal information is on the inside page, and employment information is on the first page.

To enroll in a HealthPartners plan:

- If you have an electronic PDF form, you can fill out the application on your computer with Adobe Acrobat Reader and then save or print. You can also fill it out by hand in ink.
- Answer every question with 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.
- Make sure to write the Social Security numbers to match your enrollment information to your assigned Member ID. 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.

To add dependents to your coverage:

- If you have an electronic PDF form, you can fill out the application on your computer with Adobe Acrobat Reader and then save or print. You can also fill it out by hand in ink.
- Give information about the dependent – name, address (if different from yours) and Social Security number. Remember to fill out the "Employee information" section on the first page.

If you choose not to apply for coverage:

- You only need to fill out the "Employee information" and "Waiver of coverage" sections on the first page.
- State why you're not enrolling, and sign and date the "Waiver" section.
- You can decline medical coverage and still apply for comprehensive dental coverage if both are offered.
- If your employer offers a HealthPartners dental plan:
  - Choose whether you want single (you only) or family coverage on the first page. If you choose not to apply for coverage, state that you're declining coverage.
  - You can decline comprehensive dental coverage and still apply for medical coverage if both are offered.

To submit your application:

- Make sure that all information is filled out and correct.
- Be sure to sign and date the application.
- Submit the application to your employer.
- For life events, submit supporting documents with this application within 31 days of the life event. Examples of supporting documents include birth certificate, marriage license, etc.

HealthPartners®

PO BOX 297
Minneapolis, MN 55440-0297

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 ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-883-2177. (መስማት ለተሳናቸው: 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 सहायता सेवाएं 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 सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 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)