HealthPartners | HealthPartners UnityPoint Health | Robin HealthPartners

SMALL EMPLOYER EMPLOYEE APPLICATION

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.

EMPLOYEE STATUS ☐ ACTIVE/NEW HIRE ☐ RETIREE ☐ COBRA

Reason Date of life event

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 ○ Declining Dental coverage because:

○ Single+1 Dental ☐ *Have other coverage*

○ Family Dental ☐ *Do not want coverage*

PLAN AND NETWORK NAME: _____

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

III: Waiver of Coverage for Medical

This section MUST be filled out if you or your dependents DO NOT want medical 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 Employer's Plan ☐ Parent's Employer's plan ☐ Individual Policy ☐ COBRA (Group Coverage Continuation)

☐ State coverage ☐ Medicare A or ☐ A and 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 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)	GENDER (M/F/U)	ENROLLING IN: MEDICAL	DENTAL
			SELF			☐	☐
DEPENDENTS: (Write last name ONLY if different than employee)							
						☐	☐
						☐	☐
						☐	☐
						☐	☐

***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:_____

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: _____

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.

If I choose to electronically sign my name, I am agreeing to conduct transactions electronically and intend for my electronic signature to have the same effect as my written signature.

_____ _____

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