HealthPartners®

MEDICAL ENROLLMENT FORM

8170 33rd AVENUE SOUTH, PO BOX 297
MINNEAPOLIS, MN 55440-0297

NAME OF EMPLOYER	GROUP NUMBER	SITE

EMPLOYEE STATUS	EVENT STATUS		Hire Date	Coverage Effective Date
☐ Active/New Hire ☐ Retired ☐ COBRA	☐ OPEN ENROLLMENT ☐ LIFE EVENT Reason:____________ ____________	☐ LATE ENROLLMENT Continuous medical coverage If YES, number of months ____________ Coverage End Date: ____________	M/D/YY	M/D/YY

APPLICANT'S LAST NAME (LEGAL NAME)	FIRST NAME	M.I.	DATE OF BIRTH (M/D/YYYY)	SOCIAL SECURITY NUMBER

STREET ADDRESS / APT NUMBER	CITY	STATE

ZIP CODE	COUNTY	APPLICANT'S TELEPHONE (including Area Code)			
		HOME	BUSINESS	☐ MALE ☐ FEMALE	☐ SINGLE ☐ MARRIED

MEDICAL PLAN SELECTED: (If choices are available) ____________________

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

	DISABILIITY* (Y/N)	SOCIAL SECURITY NUMBER	DATE OF BIRTH (M/D/YYYY)	RELATIONSHIP TO TO EMPLOYEE	SEX (M/F)	MEDICAL CLINIC # (For Primary Clinic Plans only)	DENTAL CLINIC # (For Primary Clinic Plans with preventive dental coverage)
NAME				SELF			
NAME							
NAME							
NAME							
NAME							
NAME							

APPLICANT – COMPLETE ALL UNSHADED AREAS

Do all of the dependent(s) listed above reside at the same address as the applicant? ☐ YES ☐ NO If NO, list dependent(s) name and address

Are any of the above listed dependent(s) under the age of 25 married? ☐ YES ☐ NO NAME ____________________

Are any of the above listed dependent(s) disabled (eligible for guaranteed coverage)? ☐ YES ☐ NO NAME ____________________

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:

APPLICANT	NAME OF INSURER	COVERAGE DATES
		TO
		TO
		TO
		TO

CONDITIONS OF COVERAGE:

I HEREBY APPLY FOR COVERAGE ON THE BASIS OF THE STATEMENTS AND ANSWERS TO THE QUESTIONS HEREIN. I hereby declare all answers to be true and complies with the best of my knowledge.

Subject to revocation by me by written notice to my employer, I authorize the required deduction (if any) from my wages. I have read and agree with the terms as stated on this application. By acceptance of coverage and upon signing this Enrollment Form, I authorize HealthPartners, and others it designates, to share information about me with any medical provider, plan sponsor, or other entity, where such information is reasonably necessary for treatment, payment or health care operations. I understand that HealthPartners may release information regarding services provided under my health benefits contract when requested by the organization sponsoring my benefits plan.

I UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMISSION OF RELEVANT INFORMATION IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIMS, CANCELLATION OR RECISSION OF COVERAGE.

X ____________________

SIGNATURE OF APPLICANT DATE SIGNED

X ____________________

SIGNATURE OF EMPLOYER (OPTIONAL) DATE SIGNED

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.

* Federal Medicare legislation now requires this information. If you have a questions, contact Member Services.

© 2009 HealthPartners