HealthPartners®

MEDICAL ENROLLMENT FORM

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

APPLICANT – COMPLETE ALL UNSHADED AREAS

NAME OF EMPLOYER				GROUP NUMBER	SITE
MEDICAL PLAN	☐ NEW HIRE ☐ LATE ENROLLMENT Continuous Coverage If YES, No. of Months End Date _____	☐ RETIREE ☐ OPEN ENROLLMENT ☐ EARLY RETIREMENT	☐ COBRA ☐ LIFE EVENT	Date of Full Time Employment M/D/YY	Coverage Effective Date M/D/YY

APPLICANT'S LAST NAME (LEGAL NAME)	FIRST NAME	M.I.	DATE OF BIRTH (M/D/YY)	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) _____

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

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR EACH DEPENDENT:

NAME				
NAME				
NAME				
NAME				
NAME				
NAME				

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) age 19 or older, full-time students? ☐ YES ☐ NO If YES, indicate below the name, school attending and if full-time:

NAME	SCHOOL	STATUS
_____	_____	☐ Part-time ☐ Full-time
_____	_____	☐ Part-time ☐ Full-time

DOES ANY APPLICANT HAVE CURRENT HEALTH INSURANCE? Check which type: ☐ None ☐ Group ☐ Individual

HOW LONG HAS THAT APPLICANT BEEN WITH THAT INSURER? PLEASE LIST ALL:

APPLICANT	NAME OF INSURER	COVERAGE DATES
		TO
		TO
		TO
		TO

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.

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

Products are underwritten and administered by the HealthPartners family of health plans which includes HealthPartners, Inc., Group Health, Inc., HealthPartners Insurance Company and HealthPartners Administrators, Inc.

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