HealthPartners®

COMBINED MEDICAL/DENTAL ENROLLMENT FORM
VOLUNTARY DENTAL

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

NAME OF EMPLOYER Baldwin-Woodville Area School District	GROUP NUMBER 25901	SITE

EMPLOYEE STATUS
- ❑ Active / New hire
- ❑ Retired
- ❑ COBRA

EVENT STATUS
- ❑ OPEN ENROLLMENT
- ❑ LIFE EVENT
  Reason: _____
  _____
  _____
- ❑ LATE ENROLLMENT
  Continuous medical coverage
  If YES, number of months: _____
  Coverage End Date: _____

HIRE DATE: ____ / ____ / 20____

COVERAGE EFFECTIVE DATE: ____ / ____ / 20____

APPLICANT: COMPLETE ALL UNSHADED AREAS

APPLICANT'S LAST NAME (LEGAL NAME) DATE OF BIRTH ____ / ____ / _____

FIRST NAME M.I. ❑ SINGLE ❑ MARRIED

STREET ADDRESS / APT NUMBER CITY STATE

ZIP CODE COUNTY APPLICANT'S TELEPHONE Home: ( ) – Business: ( ) –

PLAN SELECTED: ❑ MEDICAL _____

❑ DENTAL _____

Waiving Coverage: ❑ Medical ❑ Dental
❑ Coverage through other employer ❑ Other

Please sign _____

WITHIN THE PAST THREE MONTHS:

❑ I HAVE NOT HAD DENTAL COVERAGE (w)

❑ I HAVE HAD COMPARABLE DENTAL COVERAGE (e)
Name of Insurance Company: _____
_____

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

NAME	DISABILITY (Y/N)*	SOCIAL SECURITY NUMBER	DATE OF BIRTH (M/D/YYYY)	RELATIONSHIP TO EMPLOYEE	SEX (M/F)	ENROLLING IN MEDICAL	ENROLLING IN DENTAL
				SELF		❑	❑
						❑	❑
						❑	❑
						❑	❑
						❑	❑

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

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: _____
_____

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?

MEDICAL: ❑ YES ❑ NO
DENTAL: ❑ YES ❑ NO

If YES for either, please complete the **Coordination of Benefits Form**. Check which type: ❑ Group ❑ Individual

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.

SIGNATURE OF EMPLOYEE (required) **DATE SIGNED** **SIGNATURE OF EMPLOYER (optional)** **DATE SIGNED**