

NAME OF EMPLOYER		GROUP NUMBER	SITE
EMPLOYEE STATUS <input type="checkbox"/> Active / New hire <input type="checkbox"/> Retired <input type="checkbox"/> COBRA	EVENT STATUS <input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> LIFE EVENT Reason: _____ _____ _____		HIRE DATE: ____/____/20____
		<input type="checkbox"/> LATE ENROLLMENT Continuous medical coverage If YES, number of months: _____ Coverage End Date: _____	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	DENTAL
				SELF		<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>

*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.