



COMBINED MEDICAL/DENTAL ENROLLMENT FORM

NAME OF EMPLOYER, GROUP NUMBER, SITE, EMPLOYEE STATUS, EVENT STATUS, Hire Date, Coverage Effective Date

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, WORK, MALE, SINGLE, FEMALE, MARRIED

PLAN SELECTED: MEDICAL, DENTAL, Waiving Dental Coverage: Coverage through other employer, Other Please sign:

Table with columns: EMPLOYEE, DISABILITY\* (Y/N), SOCIAL SECURITY NUMBER, DATE OF BIRTH (M/D/YYYY), RELATIONSHIP TO EMPLOYEE, SEX (M,F), ENROLLING IN MEDICAL, DENTAL

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR EACH DEPENDENT:

Table for dependent information with columns: NAME, DISABILITY\* (Y/N), SOCIAL SECURITY NUMBER, DATE OF BIRTH (M/D/YYYY), RELATIONSHIP TO EMPLOYEE, SEX (M,F), ENROLLING IN MEDICAL, DENTAL

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:

Table for dependent age and student status with columns: NAME, SCHOOL, STATUS (Part-time, Full-time)

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.

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

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

APPLICANT - COMPLETE ALL UNSHADED AREAS