HealthPartners | HealthPartners UnityPoint Health | Robin HealthPartners

EMPLOYEE MEDICAL ENROLLMENT FORM

8170 33rd Avenue South, PO Box 297
Minneapolis, MN 55440-0297

NAME OF EMPLOYER		GROUP NUMBER	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: COVERAGE EFFECTIVE DATE:

APPLICANT: COMPLETE ALL UNSHADED AREAS

APPLICANT'S LAST NAME (Legal name)			DATE OF BIRTH
FIRST NAME			MI ☐ SINGLE ☐ MARRIED
STREET ADDRESS / APT NUMBER		CITY	STATE
ZIP CODE	COUNTY	APPLICANT'S TELEPHONE Home:	Business:

MEDICAL PLAN SELECTED: (If choices are available) _____

Waiving Medical Coverage: ☐ Coverage through other employer ☐ Other_____

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

Legal spouse, dependent up to age 26, or disabled dependent

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

**Your Social Security number is used for IRS tax reporting regarding your health plan. It does not have any impact on your application or enrollment.

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:_____

_____

Are any dependent(s) age 26 or older and a full-time student? (information required if employer is located in IA or SD only)

☐ YES ☐ NO If YES, list dependent(s) name and school attending:_____

_____

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:_____

_____

21-1506120-1511151 (11/21) © 2021 HealthPartners

APPLICANT	NAME OF INSURER	COVERAGE DATES
		TO
		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 RESCISSION OF COVERAGE.

SIGNATURE OF EMPLOYEE | DATE SIGNED | SIGNATURE OF EMPLOYER | DATE SIGNED

HealthPartners®

The HealthPartners family of health plans is 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. Robin with HealthPartners plans are underwritten and/or administered by HealthPartners Insurance Company and HealthPartners Administrators, Inc. HealthPartners UnityPoint Health plans are underwritten and/or administered by HealthPartners UnityPoint Health, Inc. or through its subcontractor HealthPartners Administrators Inc. 21-1506120-1511151 (11/21) © 2021 HealthPartners