HealthPartners®

EMPLOYEE CHANGE FORM

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

NAME OF EMPLOYER	GROUP NUMBER	EFFECTIVE DATE OF CHANGE:
SUBGROUP CHANGE FROM _____ TO _____	EMPLOYEE STATUS ☐ Active ☐ Retired ☐ COBRA	EMPLOYEE DISABILITY* ☐ Yes ☐ No

EMPLOYEE: COMPLETE ALL UNSHADED AREAS If you are requesting to change your clinic, you DO NOT need to complete this form. Simply call Member Services at the phone number on the back of your member ID card.

EMPLOYEE'S LAST NAME (LEGAL NAME)			DATE OF BIRTH
FIRST NAME		M.I.	SOCIAL SECURITY NO.
☐ CHANGE ADDRESS TO: STREET ADDRESS		APT. NO.	WORK TELEPHONE
CITY	STATE	ZIP	HOME TELEPHONE
☐ CHANGE NAME FROM:			TO:

CHECK TYPE OF PLAN(S) AFFECTED BY CHANGE: ☐ MEDICAL ☐ DENTAL ☐ MEDICAL AND DENTAL

☐ CANCELLATION OF COVERAGE

CANCELLATIONS

- ☐ Cancel all coverage
- ☐ Cancel all dependent coverage only
- ☐ Cancel coverage only on the dependent(s) listed below

REASONS FOR CANCELLATION

- ☐ Employee terminated
- ☐ Employee now ineligible
- ☐ Dependent now ineligible
- ☐ Moved outside of area
- ☐ Divorce
- ☐ Other
- ☐ Dissatisfied
- ☐ Death

Last date of eligibility _____

☐ COBRA CONTINUATION Qualifying event: | Event Date

☐ MEDICAL PLAN CHANGE From:
Plan _____
to Plan _____

☐ DENTAL PLAN CHANGE From:
Plan _____
to Plan _____

If you have dependents, see below. This change may only be made upon renewal. Once change is made, plan election will remain in force until next renewal date.

☐ ADDITIONS TO COVERAGE Add coverage on the dependents listed below. Indicate reason for change:

- ☐ Birth
- ☐ Married on _____
- ☐ Life event _____ Date _____

DEPENDENT INFORMATION Complete the following information for each dependent affected by the change. Please be sure to list clinic choice for each dependent.

LAST NAME (IF DIFFERENT)	FIRST NAME	MI	DATE OF BIRTH	SEX (M/F)	SOCIAL SECURITY NUMBER	RETLATIONSHIP TO EMPLOYEE	CLINIC NUMBER

**Primary clinic plans only*

Do any of the dependent(s) listed above reside at a different address from the applicant?
☐ NO ☐ YES 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?
☐ NO ☐ YES If YES, please complete the Coordination of Benefits Form. Check which type: ☐ Group ☐ Individual

I UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMISSION OF RELEVANT INFORMATION IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIMS OR CANCELLATION OF COVERAGE:

SIGNATURE OF EMPLOYEE _____ DATE SIGNED _____ SIGNATURE OF EMPLOYER _____ DATE SIGNED _____

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. HealthPartners UnityPoint Health plans are underwritten and/or administered by HealthPartners UnityPoint Health, Inc. or through its subcontractor HealthPartners Administrators Inc., a subsidiary of HealthPartners, Inc.