



EMPLOYEE COMBINED MEDICAL/DENTAL ENROLLMENT FORM

8170 33rd Avenue South, P.O. Box 297
Minneapolis, MN 55440-0297

NAME OF EMPLOYER		GROUP NUMBER		SITE
EMPLOYEE STATUS Active/New Hire Retired COBRA	EVENT STATUS			HIRE DATE:
	OPEN ENROLLMENT	LIFE EVENT Reason:	LATE ENROLLMENT Continuous medical coverage If YES, number of months: _____ Coverage End 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:	

PLAN SELECTED:

MEDICAL (if choices are available) _____	DENTAL (if choices are available) _____
Waiving Medical coverage: Coverage through other employer _____ Other _____ Please sign _____	Waiving Dental coverage: Coverage through other employer _____ Other _____ Please sign _____

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

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

*Your Social Security number is requested but not required for enrollment. This information is used for IRS tax reporting regarding your health plan.

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

How long has that applicant been with that insurer? Please list all: _____

CONDITIONS OF COVERAGE:

I HEREBY APPLY FOR COVERAGE ON THE BASIS OF THE STATEMENTS AND ANSWERS TO THE QUESTIONS HEREIN. 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 FRAUD OR AN INTENTIONAL MISREPRESENTATION OR OMISSION OF MATERIAL FACT IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIMS, CANCELLATION OR RESCISSION OF COVERAGE.

If I choose to electronically sign my name, I am agreeing to conduct transactions electronically and intend for my electronic signature to have the same effect as my written signature.

SIGNATURE OF EMPLOYEE

DATE SIGNED

SIGNATURE OF EMPLOYER

DATE SIGNED



Statement of Nondiscrimination for Health Plan Members

Our Responsibilities:

We follow Federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability or sex. We do not exclude people or treat them differently because of their race, color, national origin, age, disability or sex, including gender identity.

- We help people with disabilities to communicate with us. This help is free. It includes:
 - Qualified sign language interpreters
 - Written information in other formats, such as large print, audio and accessible electronic formats
- We provide services for people who do not speak English or who are not comfortable speaking English. These services are free. They include:
 - Qualified interpreters
 - Information written in other languages

For Language or Communication Help:

Call 1-800-233-9645 if you need language or other communication help. (TTY: 711)

If you have questions about our non-discrimination policy:

Contact the Civil Rights Coordinator at 1-844-363-8732 or integrityandcompliance@healthpartners.com.

To File a Grievance:

If you believe that we have not provided these services or have discriminated against you because of your race, color, national origin, age, disability or sex, you can file a grievance by contacting the Civil Rights Coordinator at 1-844-363-8732, integrityandcompliance@healthpartners.com or Civil Rights Coordinator, Office of Integrity and Compliance, MS 21103K, 8170 33rd Ave. S., Bloomington, MN 55425.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
Room 509F, HHH Building
200 Independence Avenue SW, Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD)

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-233-9645. (TTY: 711)	ພາສາລາວ (Laotian) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການລ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-233-9645. (TTY: 711)
Hmoob (Hmong) LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-233-9645. (TTY: 711)	Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-883-233-9645. (TTY: 711)
Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-233-9645. (TTY: 711)	العربية (Arabic) ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-233-9645 (رقم هاتف الصم والبكم: 711)
繁體中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-233-9645. (TTY: 711)	Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-233-9645. (ATS: 711)
Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-233-9645. (телетайп: 711)	한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-233-9645. (TTY: 711)
Af Soomaali (Somali) OGAYSIIS: Haddii aad ku hadasho afka soomaaliga, Waxaa kuu diyaar ah caawimaad xagga luqadda ah oo bilaash ah. Fadlan soo wac 1-800-233-9645. (TTY: 711)	Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-233-9645. (TTY: 711)

Oromiffa (<i>Cushite [Oromo]</i>) XIYYEEFFANNA: Afaan dubbattu Oromiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-233-9645. (TTY: 711)	Italiano (<i>Italian</i>) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-233-9645. (TTY: 711)
አማርኛ (<i>Amharic</i>) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-800-233-9645. (መስማት ለተሳናቸው፡ 711)	ภาษาไทย (<i>Thai</i>) เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-233-9645. (TTY: 711)
unD (<i>Karen</i>) ဟ်သုဉ်ဟ်သး- နမ့ၢ်ကတိၤ ကညိၣ် ကျိၣ်အသိၣ်, နမ့ၢ်ကျိၣ်အတၢ်မၤစၢၤလၢ တလၢၢ်ဘျုးလၢၢ်စ့ၤ နိတမံၤဘၣ်သ့န့ၣ်လီၤ. ကိး 1-800-233-9645. (TTY: 711)	ελληνικά (<i>Greek</i>) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-233-9645. (TTY: 711)
ខ្មែរ (<i>Mon-Khmer, Cambodian</i>) ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ សេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 1-800-233-9645. (TTY: 711)	Diné Bizaad (<i>Navajo</i>) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, kójjí' hódíílnih 1-800-233-9645. (TTY: 711)
Deutsch (<i>Pennsylvanian Dutch</i>) Wann du Deutsch schwetzsch, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-233-9645. (TTY: 711)	Ikirundi (<i>Bantu – Kirundi</i>) ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-233-9645. (TTY: 711)
Polski (<i>Polish</i>) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-233-9645. (TTY: 711)	Kiswahili (<i>Swahili</i>) KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-800-233-9645. (TTY: 711)
हिंदी (<i>Hindi</i>) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-233-9645. (TTY: 711)	日本語 (<i>Japanese</i>) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-233-9645 (TTY: 711) まで、お電話にてご連絡ください。
Shqip (<i>Albanian</i>) KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-233-9645. (TTY: 711)	नेपाली (<i>Nepali</i>) ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-233-9645 (टिडिवाइ: 711)
Srpsko-hrvatski (<i>Serbo-Croatian</i>) OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-233-9645. (TTY: 711)	Norsk (<i>Norwegian</i>) MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-800-233-9645. (TTY: 711)
ગુજરાતી (<i>Gujarati</i>) સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-233-9645. (TTY: 711)	Adamawa (<i>Fulfulde, Sudanic</i>) MAANDO: To a waawi Adamawa, e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-800-233-9645. (TTY: 711)
اُردُو (<i>Urdu</i>) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں 1-800-233-9645 (TTY: 711)	Українська (<i>Ukrainian</i>) УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-233-9645. (телетайп: 711)