HealthPartners®

DENTAL ENROLLMENT FORM

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

NAME OF EMPLOYER ISD #200			GROUP NUMBER 22456	SITE
DENTAL PLAN	❑ NEW HIRE ❑ RETIREE ❑ OPEN ENROLLMENT	❑ EARLY RETIREMENT ❑ COBRA ❑ LIFE EVENT	DATE OF FULL-TIME EMPLOYMENT: ____/____/ 20____	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:

DENTAL PLAN SELECTED: ☐ Single ☐ Family

WAIVING 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)
			SELF	

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 dental insurance?

❑ YES ❑ NO If YES, 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.

SIGNATURE OF EMPLOYEE (required) **DATE SIGNED** **SIGNATURE OF EMPLOYER (optional)** **DATE SIGNED**

The HealthPartners family of health plans are 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.

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