

DENTAL ENROLLMENT FORM

	al ciicio					a Avenue South, ЛINNEAPOLIS, MN 5		
NAME OF EMPLOYER			GROUP NUMBER		SITE			
DENTAL PLAN	□ NEW HIRE □ RETIREE □ OPEN ENROLLMENT	☐ EARLY RETIREMENT☐ COBRA☐ LIFE EVENT	DATE OF FULL-TIME EMPLOYMENT:	_//20	COVER <i>A</i> EFFECTI	AGE VE DATE:/	_/20	
APPLICANT: COMPLET	E ALL UNSHADED AREA	S						
APPLICANT'S LAST NAME	(LEGAL NAME)			D	ATE OF E	BIRTH/	/	
FIRST NAME				M.I. □ SINGLE □ MARRIED				
STREET ADDRESS / APT N	UMBER		CITY	STATE				
ZIP CODE	P CODE COUNTY APPLICANT'S TELEPHONE Home:				Business:			
DENTAL PLAN SELECTED: WAIVING COVERAGE: □ Coverage through other □ Other Please sign	C							
PLEASE COMPLETE THE F	FOR EMPLOYEE AND EACH DEPE	NDENT BEING COVERS OCIAL SECURITY	DATE OF BIF	RTH	RELATIONSHIP	SEX		
NAME			UMBER	(M/D/YYY		TO EMPLOYEE	(M/F)	
						SELF		
Do any of the dependent(s) YES NO If YES, list		erent address from the applicant? dress:						
At the time of your effect	ive date with HealthPartn	ers, will you, your spouse, and	l/or dependent(s) be i	nsured by an	y other o	dental insurance	∍ ?	
☐ YES ☐ NO If YES, ple	ase complete the Coordinat i	ion of Benefits Form. Check which t	ype: □ Group □ In	dividual				
of my knowledge.	AGE ON THE BASIS OF THE STA	ATEMENTS AND ANSWERS TO THE QU authorize the required deduction (if any						
By acceptance of coverage and sponsor, or other entity, where	upon signing this Enrollment For such information is reasonably n	authorize the required ueduction (if any rm, I authorize HealthPartners, and other lecessary for treatment, payment or heal when requested by the organization spon	s it designates, to share inf th care operations. I unders	ormation about m	e with any	medical provider, pl	an	
,	DING FALSE INFORMATION OR	OMISSION OF RELEVANT INFORMATI		MAY RESULT IN	I THE DEN	IAL OF CLAIMS,		
	4 1 0							
SIGNATURE OF EMPLOYEE	(required)	DATE SIGNED	SIGNATURE OF EMPLO	OVER (ontional)		DATE SIGN	FD	

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