

IV. Applicant Information - List all family members to be covered.

EMPLOYEE:

NAME: FIRST, M.I., LAST
SOCIAL SECURITY NUMBER

DATE OF BIRTH
(M/D/YYYY)

AGE

RELATIONSHIP

SEX
(M/F)

HEIGHT

WEIGHT

DENTAL CLINIC #
(if available)

NAME			SELF				<input type="checkbox"/> TIER I Clinic # _____
SOC. SEC. #							<input type="checkbox"/> TIER II

DEPENDENTS: (INDICATE LAST NAME ONLY IF DIFFERENT THAN EMPLOYEE)

NAME							<input type="checkbox"/> TIER I CLINIC # _____
SOC. SEC. #							<input type="checkbox"/> TIER II
NAME							<input type="checkbox"/> TIER I CLINIC # _____
SOC. SEC. #							<input type="checkbox"/> TIER II
NAME							<input type="checkbox"/> TIER I CLINIC # _____
SOC. SEC. #							<input type="checkbox"/> TIER II
NAME							<input type="checkbox"/> TIER I CLINIC # _____
SOC. SEC. #							<input type="checkbox"/> TIER II
NAME							<input type="checkbox"/> TIER I CLINIC # _____
SOC. SEC. #							<input type="checkbox"/> TIER II

Do all of the dependent(s) listed above reside at the same address as the employee? YES NO

If NO, list dependent(s) name and address: _____

Do you want the individual's materials to go to this address? YES NO

If last name is different from dependents, please explain why: _____

Are any of the above listed dependent(s) age 19 or older, full-time students? YES NO

If YES, indicate the name, school attending and status:

NAME OF STUDENT	SCHOOL ATTENDING	STATUS
_____	_____	<input type="checkbox"/> Part-time <input type="checkbox"/> Full-time
_____	_____	<input type="checkbox"/> Part-time <input type="checkbox"/> Full-time

V. Other Medical Insurance Information - This section must be completed. If not completed, coverage will be limited.

1. Do you or any family members included in this application currently have or had any health coverage within the past 18 months?

Yes No **If yes, you must provide coverage history for the past 18 months in the spaces below:**

Person's name	Insurance company name, city and state telephone number / policy number	Effective date	Termination date	Reason for termination
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2a. Are you covered by Medicare Part A Yes No Part B? Yes No If yes, please attach copy of Medicare card.

2b. Is your spouse covered by Medicare Part A Yes No Part B? Yes No If yes, please attach copy of Medicare card.

3. Have you ever been covered by HealthPartners? Yes No

If yes, what name did you use? _____

Name: _____

VI. Health Information - Please answer questions 1-5

1. Have you or any family member applying for coverage EVER been treated for, or diagnosed with, any of the following conditions? YES NO
(If yes, check all that apply below)

- a. asthma
 - b. cancer
 - c. diabetes
 - d. arthritis
 - e. seizure/epilepsy
 - f. DWI / DUI - date: _____
 - g. respiratory disorder
 - h. immune system disorder
 - i. allergies
 - j. blood disorder
 - k. thyroid disorder
 - l. muscle, bone or joint disorder
 - m. heart or circulatory disorder
 - n. reproduction system disorder
 - o. eating disorder
 - p. headache/migraine
 - q. psychological or neurological disorder
 - r. digestive or intestinal disorder
 - s. kidney or urinary tract disorder
 - t. high blood pressure
 - u. counseling services
 - v. eye or ear disorder
 - w. non-cancerous tumor
 - x. stroke
 - y. liver disorder
 - z. mental deficiency
 - aa. alcohol abuse
 - bb. drug abuse
 - cc. other (provide detail below)
- dd. currently have a condition that may require surgical or hospital care (explain): _____
- ee. been hospitalized or had surgery for any condition or injury (explain): _____

2. Are any of these conditions related to a workers' compensation injury, motor vehicle accident or third party liability claim? YES NO

3. Have you or a family member applying for coverage used tobacco products in the last 12 months? YES NO Name & quit date: _____
(If this question is not answered, we will assume that there is a tobacco user applying for coverage)

If you have checked ANY condition above, please explain with details below:

PERSON'S NAME	DIAGNOSIS AND DETAILS ABOUT CONDITION, TREATMENT	DATE OF DIAGNOSIS	DATE OF RECOVERY	DAYS IN HOSPITAL

4. Are you, your spouse, significant other, or dependents currently pregnant? YES Due date: _____ NO
If YES, please provide name, relationship: _____

a) Is a C-section anticipated? YES NO b) Has a C-section been performed in the past? YES NO

c) Are multiple births expected? YES NO d) Has the pregnancy induced hypertension? YES NO

e) If ultrasounds have been performed, please list how many: _____ f) Has Gestational Diabetes been diagnosed? YES NO

5. Is anyone currently taking, or taken during the past twelve months, any prescribed medication? YES NO If YES, list below.

PERSON'S NAME	MEDICATION	REASON PRESCRIBED	DOSAGE (mg / gm)	# PER DAY	REFILLS PER YR.	STILL PRESCRIBED?
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No

VII. Employee's authorization and representation - Read this section carefully, sign and date the application.

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 to the best of my knowledge and to accurately represent the health of those persons applying for coverage and waiving coverage. I understand that these statements, answers and subsequent information I provide are the basis for my coverage. Furthermore, I understand that this application must be updated by me to include any condition or disease which may occur between the date of my application and the Effective Date of Coverage. **I understand that if my application for new or additional coverage is accepted, that applicable coverage will not be effective until after I am notified of the Effective Date.**

I hereby authorize HealthPartners, Inc. to obtain from providers of services and hospitals, including those providers with whom HealthPartners contracts for service, the medical records, including those which relate to mental health and chemical dependency treatment, relating to me and my family members to the extent that those records are necessary for underwriting and enrollment as well as for the administration of the HealthPartners contract, including for purposes of claims payment, case management, fraud investigation and quality of care review. A photocopy of this application shall be as valid as the original. **I UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMISSION OF RELEVANT INFORMATION IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIMS OR CANCELLATION OR RESCISSION OF COVERAGE.**

SIGNATURE OF EMPLOYEE

DATE SIGNED

IMPORTANT PLEASE READ CAREFULLY

Information provided on this application is solely for the purpose of underwriting and administering the HealthPartners plan(s) offered through your employer. In order to protect your privacy, all personal information is on the inside pages, with employment information on the backside. Before submitting your application, fold the form in half and staple it at the top.

To enroll in a HealthPartners plan:

- Complete the application in ink.
- Answer *every* question, providing complete information about yourself and family members you want to cover. ***If information is missing or incomplete, your enrollment may be delayed and/or your coverage may be limited.***
- Health information is required, but will not be shared with your employer. If you need additional space, please provide information on a separate sheet of paper and slip it inside the folded form before stapling.
- Social security numbers are required, but are used only to match your enrollment information assigned Member ID number for administrative purposes.

To add dependents to your current coverage:

- Complete the application in ink.
- Provide information about the dependent only - name, address (if different than yours), social security number, clinic selection (if enrolling in a HealthPartners Primary Clinic plan) and health information. And don't forget to complete the "Employee Information" section on the back page.

If you choose *not* to apply for coverage:

- You only need to complete the "Employee Information" and "Waiver of Coverage" sections on the back page of this application.
- Be sure to indicate why you are not enrolling, and sign and date the "Waiver" section.
- You can waive medical coverage and still apply for dental coverage if both are offered.

If your employer offers a HealthPartners dental plan:

- On the back page, indicate whether you want single (you only) or family coverage. If you choose not to apply for coverage, please indicate that you are waiving coverage.
- You can waive dental coverage and still apply for medical coverage if both are offered.

To submit your application:

- Please review all information for completeness and accuracy.
- Be sure to sign and date the application.
- Fold the completed form in half with Section I, Employee Information, on the outside and staple it at the top.
- Submit the application to your employer or as instructed by your employer.

Thank you for choosing HealthPartners! Our mission is to improve the health of our members, our patients and the community. We look forward to serving you and your family.



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