

MEDICAL/DENTAL ENROLLMENT FORM

	1 Inver Grove Heigh	hts Scherol Strict #	199	3288			d AVENUE SOUT 4INNEAPOLIS, MP	155440-029	
NAME OF EMPLOYER	R		GROUP	IUMBER		SITE			LOYEE
EMBLOYEE STATUS	EVENT STATUS					HIRE DATE:			
 Active / New hire Retired 	OPEN ENROLLMENT	LIFE EVENT Reason:		INROLLMENT	arage				
COBRA		Neuson.	If YES,	number of months	•	COVERAGE EFFECTIVE D	ATE		
ABBLICANT: COM	BLETE ALL UNSHABEB		Covera	age End Date:	5011.		Continuous n		0
		AREAS CODRA					If YES, numbe Coverage End		
APPLICANT'S LAST N APPLICANT'S LAST N	IAME (LEGAL NAME)	APPLICANT: CON	PLETE ALL UN	SHADED AREAS		TE OF BIRTH	····· /		
FIRST NAME		APPLICANT'S LAST			M.I. M.I.) ARRIED	C
STREET ADDRESS / A STREET ADDRESS / A	APT NUMBER APT NUMBER		· · · · · · · · · · · · · · · · · · ·	CITY	· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·	STATE STATE		_
ZIP CODE ZIP CODE	COUNTY COUNTY	APPLICANT'S TELE	PHONE Home: (LEPHONE Hom) – e:		usiness: (siness:) -		M.
PLAN SELECTED:	MEDICAL CTED: (If choices are availa	STREET ADDRESS /	APT NUMBER		I	HAVE NOT HA	D DENTAL COV	CITY ERAGE	
MEDICAL PLAN SELE	CTED: (If choices are availa DENTAL	able) ZIP CODE	COUNTY		APPLICAN ⁻	T'S TELEPHON HAVE COMPA	E Home: RABLE DENTAL	COVERAG	– E
Waiving Medical Cove	erage: 🛛 Coverage through	h other MEDRICART PLANSER	ECTED: (If choice	s are availablę)					
PLEASE COMPLETE T	HE PORION NO NO NO	ATION FOR EMPLOYEE	ND EACH DEPENI	DENT BEING COVE	e of Insurance ERED	ce Company:			
Legal spouse, dependen	t up to age 26, or disabled de Coverage throug	h other enjoys bedical Co	🛛 🖓 🖓 🖓 🖓 🖓 🖓	ige through other e	employer 🗖	Other			7
RLEASE COMPLETE T	HE FOLLOWING INFORM	ATION FOR EMPLOYEE AN Legal spouse, depende	THE FOLLOWING ND EACH DEPEND Int up to age 26, or	disabled dependent	GREMPLOY RED (M)	'Ee'AND`Each /d/yyyy)	TO EMPLOYEE	EING COVE (M/F)	RED
			CIAL SECURITY	DATE OF BIRTH	RELATION	BISABILIJEY		ING IN	
NAME		NIA A AT	IMBER	(M/D/YYYY)	TO EMPLO	DYEE ^{Y/N} (M/F)	MEDICAL	DENTAL	
					SELF				_
	w requires this information. If you have used for IRS tax reporting regarding yo		npact on your application	or enrollment					
	pt(s),listed,above,reside.at				contact Member S	ervices.			
Do any of the dependent	v requires this information: If you have At (is) listed abovtes as a list of the state of the st	adifierent address from t	is used for IRS tax reportin	ng regarding your health pl	lan. It does not hav	ve any impact on you	application or enrollm	ient.	
	S, list dependent(s) name a								
At the time of your effe	ective date with HealthPart	tners, WillEyou, Yourspolies	E and total appendix	ht(s)=be=insured by	🕅 any other h	ealth insurance	company?		
	SchleatateomhHealth Paq								
	icant been with that insure								/ any othe Individual
	ርም ኒኒሮ A MT with that insurer	r? Please'list all. NO III How long has that app							=
APPLICANT			APPLICANT	URER		COVERATE DATES			
							7 8		
							7 8		
							ТО		
	COVERAGE: OVERAGE ON THE BASIS OF T	THE STATEMENTS AND ANSV	VERS TO THE QUES	TIONS HEREIN. I her	eby declare all	answers to be tru	ue and complies w	ith the best	
of my knowledge.	me by written notice to my em	plover Lauthorize the required	deduction (if any) f	om my wages. I have	read and agree	e with the terms	as stated on this a	pplication	
By acceptance of coverag	ge and upon signing this Enrolln where such information is reaso	nent Form, I authorize HealthP	artners, and others if	designates, to share	information ab	oout me with any	medical provider,	plan	by declare
regarding services provid	ed under my health benefits co	ontract when requested by the	organization sponso	ring my benefits plan.					ead and ag
CANCELLATION OR RES	ROVIDING FALSE INFORMAT		ANT INFORMATIO	N IN THIS APPLICAT	ION MAY RES	ULT IN THE DEN	IAL OF CLAIMS,		iformatior rstand tha
	CISSION OF COVERAGE.	I UNDERSTAND THAT			OMISSION OF	RELEVANT INFO	RMATION IN THI	S APPLICATI	ON MAY R
SIGNATURE OF EMPLO	DYEE	CANCELLATION OR RE DATE SIGN		RAGE. GNATURE OF EMF	PLOYER		DATE SIG	NED	

	derwritten and/or administe DATE SIGNED thers, Inc., Grosponatur	E. OF EMPLOYER surance Company or Healt	hP DATE SIGNED rators,
Inc. Fully insured Wisconsin plans are underwri	itten by HealthPartners Insurance Company	DATE SIGNED	SIGNATURE OF EMPLOYER
19346 (8/18) © 2018 HealthPartners	SIGNATORE OF EMILEOTEE	DATE SIGNED	