HealthPartners®

EMPLOYEE MEDICAL ENROLLMENT FORM

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

NAME OF EMPLOYER	ISD #51 FOLEY PUBLIC SCHOOLS	GROUP NUMBER 29460	SITE
EMPLOYEE STATUS ❑ Active / New hire ❑ Retired ❑ COBRA	EVENT STATUS ❑ OPEN ENROLLMENT ❑ LIFE EVENT Reason: ❑ LATE ENROLLMENT Continuous medical coverage If YES, number of months:_____ Coverage End Date: _____		HIRE DATE: COVERAGE EFFECTIVE DATE:

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:

MEDICAL PLAN SELECTED: (If choices are available) _____

Waiving Medical Coverage: ❑ Coverage through other employer ❑ Other _____

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR EMPLOYEE AND EACH DEPENDENT BEING COVERED
Legal spouse, dependent up to age 26, or disabled dependent

NAME	DISABILITY* (Y/N)	SOCIAL SECURITY NUMBER **	DATE OF BIRTH (M/D/YYYY)	RELATIONSHIP TO EMPLOYEE	SEX (M/F)
				SELF	

Federal Medicare legislation now requires this information. If you have questions, contact Member Services.

****Your Social Security number is used for IRS tax reporting regarding your health plan. It does not have any impact on your application or enrollment.***

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?

❑ YES ❑ NO If YES, please complete the Coordination of Benefits Form. Check which type: ❑ Group ❑ Individual

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

APPLICANT	NAME OF INSURER	COVERAGE DATES
		TO
		TO
		TO
		TO

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 RESCISSION OF COVERAGE.

_____ _____ _____ _____

SIGNATURE OF EMPLOYEE **DATE SIGNED** **SIGNATURE OF EMPLOYER** **DATE SIGNED**