HealthPartners®

WELCOME!

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1. This site provides an electronic version of your Change Form. It is provided as a convenience to employers and employees.

2. We strive to ensure that the contents of this site are correct and complete, but to verify your benefits, please call HealthPartners Member Services.

3. This information is not an offer of coverage or guarantee of coverage. All products are subject to applicable laws and regulations. Your coverage is contingent on all the applicable terms, conditions, limitations and exclusions of your plan documents.

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HealthPartners®

Simply call Member Services at (952) 883-5000 or 1-800-883-2177.

PO BOX 297
Minneapolis, MN 55440-0297

NAME OF EMPLOYER	SUBGROUP CHANGE FROM / TO	GROUP NUMBER	EFFECTIVE DATE OF CHANGE (M/D/Y)

EMPLOYEE'S LAST NAME (LEGAL NAME)	FIRST NAME	MI	DATE OF BIRTH (M/D/Y)	SOCIAL SECURITY NUMBER

☐ **CHANGE ADDRESS TO:** STREET ADDRESS APT NO. WORK TELEPHONE (include area code)

CITY STATE ZIP COUNTY HOME TELEPHONE (include area code)

☐ **CHANGE NAME** **FROM** _____ **TO** _____

CHECK TYPE OF PLAN(S) AFFECTED BY CHANGE: ☐ MEDICAL ☐ DENTAL ☐ MEDICAL AND DENTAL

☐ **CANCELLATION OF COVERAGE**

CANCELLATIONS
- ☐ Cancel all coverage
- ☐ Cancel all dependent coverage only
- ☐ Cancel coverage only on the dependent(s) listed below

REASONS FOR CANCELLATION
- ☐ Employee terminated
- ☐ Employee now ineligible
- ☐ Dependent now ineligible
  last date of eligibility_____
- ☐ Moved outside of area
- ☐ Dissatisfied
- ☐ Death
- ☐ Divorce
- ☐ Other_____

☐ **CHANGE OF COVERAGE**

☐ Cobra Continuation Qualifying event_____ Event Date MM/DD/YY_____

☐ **MEDICAL PLAN CHANGE - FROM:**

☐ **OPEN ACCESS to PRIMARY CLINIC** Clinic#_____

☐ **PRIMARY CLINIC to OPEN ACCESS**

☐ **PLAN** _____ **to PLAN** _____

If you have dependents, see below. This change may only be made upon renewal. Once change is made, plan election will remain in force until next renewal date.

☐ **ADDITIONS TO COVERAGE** – Add coverage on the dependents listed below. **Indicate reason for change:**

- ☐ Birth
- ☐ Adoption – date of placement / legal guardianship_____ (placement papers must accompany this form)
- ☐ Married on_____
- ☐ Other_____

DEPENDENT INFORMATION – Complete the following information for each dependent affected by the change. **Please be sure to list clinic choice for each dependent.**

LAST NAME (ONLY IF DIFFERENT)	FIRST NAME	MI	DATE OF BIRTH (M/D/Y)	SEX (M/F)	SOCIAL SECURITY NUMBER	RELATIONSHIP	CLINIC NUMBER

Do all dependents reside at the same address as the employee? ☐ YES ☐ NO If NO, list dependent's name and address_____

If last name is different for dependent(s), please explain _____

Are any of the above dependent(s) age 19 or older, full-time students? ☐ YES ☐ NO If YES, please indicate the name of dependent, school attending and status below:

NAME	SCHOOL	STATUS
		☐ PART-TIME ☐ FULL-TIME
		☐ PART-TIME ☐ FULL-TIME

OTHER INSURANCE INFORMATION – Failure to complete this section may result in a pre-existing condition limitation.

Do you or any family member included in this application currently have or have you (they) had any health coverage within the past 63 days? ☐ YES ☐ NO If YES, you must provide the 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

I UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMISSION OF RELEVANT INFORMATION IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIMS OR CANCELLATION OF COVERAGE

SIGNATURE OF EMPLOYEE (REQUIRED) DATE SIGNATURE OF EMPLOYER (OPTIONAL) DATE

FOR PLAN USE ONLY	ME	DE	SUBGROUP	COB	EFFECTIVE DATE