HealthPartners®

DENTAL ENROLLMENT FORM

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

NAME OF EMPLOYER				GROUP NUMBER	SITE
DENTAL PLAN	☐ NEW HIRE ☐ LATE ENROLLMENT Continuous Coverage If YES, No. of Months End Date _____	☐ RETIREE ☐ OPEN ENROLLMENT ☐ EARLY RETIREMENT	☐ COBRA ☐ LIFE EVENT	Date of Full Time Employment M/D/YY	Coverage Effective Date M/D/YY

APPLICANT'S LAST NAME (LEGAL NAME)	FIRST NAME	M.I.	DATE OF BIRTH (M/D/YY)	SOCIAL SECURITY NUMBER

STREET ADDRESS / APT NUMBER	CITY	STATE

ZIP CODE	COUNTY	APPLICANT'S TELEPHONE (including area code)			
		HOME	BUSINESS	☐ MALE ☐ FEMALE	☐ SINGLE ☐ MARRIED

DENTAL PLAN SELECTED: (If choices are available) _____

WAIVING COVERAGE (CHECK ONE)

☐ COVERAGE THROUGH ANOTHER EMPLOYER
☐ OTHER
please sign _____

EMPLOYEE	SOCIAL SECURITY NUMBER	DATE OF BIRTH (M/D/YYYY)	RELATIONSHIP TO EMPLOYEE	SEX (M,F)	DENTAL CLINIC #
NAME			SELF		

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR EACH DEPENDENT:

NAME					
NAME					
NAME					
NAME					
NAME					
NAME					

APPLICANT – COMPLETE ALL UNSHADED AREAS

Do all of the dependent(s) listed above reside at the same address as the applicant? ☐ YES ☐ NO If NO, list dependent(s) name and address:

_____

Are any of the above listed dependent(s) under the age of 25 married ? ☐ YES ☐ NO NAME _____

Are any of the above listed dependent(s) disabled (eligible for guaranteed coverage)? ☐ YES ☐ NO NAME _____

At the time of your effective date with HealthPartners, will you, your spouse and/or dependent(s) be insured by any other dental insurance company?
☐ YES ☐ NO If YES, please complete the Coordination of Benefits Form.
Check which type: ☐ Group ☐ Individual

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 or dental provider, plan sponsor, or other entity, where such information is reasonably necessary for treatment, payment or dental care operations. I understand that HealthPartners may release information regarding services provided under my dental 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 RECISSION OF COVERAGE.

X _____ X _____

SIGNATURE OF APPLICANT DATE SIGNED SIGNATURE OF EMPLOYER (OPTIONAL) DATE SIGNED

Plans are underwritten and administered by HealthPartners family of health plans, which includes HealthPartners, Inc., HealthPartners Insurance Company and HealthPartners Administrators, Inc. Fully insured Wisconsin plans are underwritten by HealthPartners Insurance Company.