HealthPartners®

SMALL GROUP EMPLOYEE APPLICATION FOR NEW GROUPS

For Groups of 2 to 50 Employees

For Employer Use EVENT STATUS ❒ LATE ENROLLMENT ❒ STATUS CHANGE EMPLOYEE STATUS ❒ ACTIVE/NEW HIRE ❒ RETIREE ❒ COBRA

NAME OF EMPLOYER _____ GROUP NUMBER _____ SITE _____ EFF DATE _____

I: Employee Information

LAST NAME FIRST NAME MI DATE OF BIRTH ____/____/ _____

HOURS WORKED PER WEEK HIRE DATE ____/____/ _____ ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED ❑ DOMESTIC PARTNER

STREET ADDRESS / APT NUMBER CITY STATE

ZIP CODE COUNTY APPLICANT'S TELEPHONE Home: ( ) - Business: ( ) -

II: Plan Selection / Information Your plan selection may only be changed at your employer's renewal

Please select one of the following: ☐ Medical (complete A) ☐ Dental (complete B) ☐ Medical and Dental (complete A and B)

A. IF MEDICAL PLAN, PLEASE INDICATE PLAN NAME: _____

I am applying for coverage for: (check all that apply)

☐ Myself

☐ My spouse Date of birth _____

☐ My dependent children Number of children _____

☐ Domestic partner *(please consult your employer)*

B. IF DENTAL PLAN, PLEASE SELECT ONE OF THE FOLLOWING: (Ask your employer if dental is offered)

☐ Single Dental

☐ Single+1 Dental

☐ Family Dental

☐ Waiving Dental Coverage because:

- ☐ *Have other coverage*
- ☐ *Do not want coverage*

III: Waiver of Coverage This section MUST be completed if you or your dependents DO NOT want coverage.

I understand that I am eligible to apply for health coverage through my employer. I **DO NOT** want coverage for:

☐ Myself, my spouse or my dependent child(ren)

☐ My spouse

☐ My dependent child(ren)

☐ Domestic partner

Please indicate the reason you are waiving coverage.

I am declining coverage at this time because I or my dependents have coverage provided through:

☐ Spouse's Group Plan ☐ Medicare A_____ or A & B_____ ☐ Group Coverage Continuation (COBRA) ☐ Individual Policy

☐ Medical Assistance ☐ General Assistance ☐ Minnesota Comprehensive Health Association ☐ MinnesotaCare

☐ I (and/or my family member(s) choose to be without health insurance.

☐ Other, **explain:** _____

I understand that if I decide to apply for coverage at a later date, a pre-existing condition exclusion may apply.

_____

PRINT NAME

_____ _____

SIGNATURE OF EMPLOYEE (REQUIRED IF YOU OR FAMILY MEMBERS ARE WAIVING COVERAGE) **DATE SIGNED**

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
NAME			SELF			
SOC. SEC. #						

DEPENDENTS: (Indicate last name ONLY if different than employee)

NAME						
SOC. SEC. #						
NAME						
SOC. SEC. #						
NAME						
SOC. SEC. #						
NAME						
SOC. SEC. #						

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: _____

Please note name and type of disability for any dependent child to age 26(HealthPartners will evaluate eligibility for guaranteed coverage).

Name and disability _____

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 in 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, STATE, TELEPHONE NUMBER & POLICY NUMBER	EFFECTIVE DATE	TERMINATION DATE	REASON FOR TERMINATION

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? _____

VI. Health Information Please answer questions 1–7

In answering questions 2-4b, you should not include any genetic information. That is, please do not include any family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic diseases for which you believe you may be at risk.

1. Is anyone currently taking, or taken during the past 12 months, any prescribed medication? ☐ YES ☐ NO

PERSON'S NAME	MEDICATION	REASON PRESCRIBED	DOSAGE	# PER DAY	REFILLS PER YEAR	STILL PRESCRIBED?
						☐ YES ☐ NO
						☐ YES ☐ NO
						☐ YES ☐ NO
						☐ YES ☐ NO

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

2. Has any person applying for coverage EVER sought medical care, advice or been diagnosed or treated for: **YES** **NO**

a. Tuberculosis, emphysema, COPD or pulmonary fibrosis ☐ ☐
b. Lupus, rheumatoid arthritis, scleroderma, connective tissue disorder or Sjogrens syndrome ☐ ☐
c. Hemophilia, polycythemia, thalessemia, chronic anemia or blood clot ☐ ☐
d. Scoliosis, spondylolithesis, ankylosing spondylosis, spina bifda ☐ ☐
e. Heart murmur, angina, coronary artery disease, carotid artery disease, peripheral vascular disease or stroke ☐ ☐
f. Epilepsy, Alzheimer's, traumatic brain injury, brain tumor, multiple sclerosis, cerebral palsy ☐ ☐
g. Ulcerative colitis, Crohns disease, hepatitis, cirrhosis of the liver, pancreatitis, kidney cysts or chronic kidney disease ☐ ☐
h. Cancer ☐ ☐
i. Diabetes – Type I_____ or Type II_____ ☐ ☐
j. Organ transplant ☐ ☐

If you have been hospitalized or had surgery for any of the conditions listed above in #2, please provide estimated dates in the details section below.

3. For conditions not already mentioned above, WITHIN THE PAST 5 YEARS has any person apply for coverage sought medical care, advise or been diagnosed or treated for:

	YES	NO		YES	NO
a. Allergies or asthma or other respiratory disorder	☐	☐	j. Non-cancerous tumor	☐	☐
b. Alcohol abuse or Drug abuse	☐	☐	k. Immune system disorder	☐	☐
c. Digestive, liver, intestinal, kidney or urinary tract disorder	☐	☐	l. Muscle, bone or joint disorder	☐	☐
d. Thyroid disorder	☐	☐	m. Mental deficiency	☐	☐
e. Eating disorder	☐	☐	n. Neurological or Neuromuscular disorder	☐	☐
f. Headaches / Migraines	☐	☐	o. Reproductive system disorder	☐	☐
g. Psychological disorder – Counseling _____	☐	☐	p. Seizure	☐	☐
h. High blood pressure	☐	☐	q. Other	☐	☐
i. Eye or ear disorder	☐	☐	r. Elevated cholesterol/triglyceride	☐	☐

4a. Has anyone applying for coverage been hospitalized or had surgery in the last five years? ☐ ☐

4b. In the last five years, has anyone applying been medically advised to have surgery that has not yet been completed? ☐ ☐

If YES, who received or will receive care? _____ Date(s) _____ Reason _____

Past or future date of surgical procedure, if applicable _____

5. Are any of these conditions related to a workers' compensation injury, motor vehicle accident or third party liability claim? ☐ ☐

6. Have you or a family member applying for coverage used tobacco products in the last 12 months? ☐ ☐

(If this question is not answered, we will assume that there is a tobacco user applying for coverage) If YES, name and quit date: _____

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

PERSON'S NAME	QUESTION #	DIAGNOSIS AND DETAILS ABOUT CONDITION, TREATMENT	DATE OF DIAGNOSIS	DATE OF RECOVERY	DAYS IN HOSPITAL
Example: George	2a	Description			

7. Are you, your spouse, domestic partner, or dependents currently pregnant? *(Whether or not they are applying for coverage)* ☐ **YES** Due Date_____ ☐ **NO**

If anyone applying for coverage is pregnant:

	YES	NO		YES	NO
a. Is a C-Section advised?	☐	☐	d. Has the pregnancy induced hypertension?	☐	☐
b. Has a C-section been performed in the past?	☐	☐	e. How many ultrasounds are planned?	☐	☐
c. Are multiple births expected? If YES, how many _____	☐	☐	f. Has gestational diabetes been diagnosed?	☐	☐

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 represent 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. This authorization is valid as long as I am continually insured with HealthPartners or until revoked. A photocopy of this authorization 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 by hand in ink. If you have an electronic PDF form, you can fill out the form on your computer with Adobe Reader and save or print the application as needed.
- 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.
- Please provide Social Security numbers to match your enrollment information to your assigned Member ID number for administrative purposes.

To add dependents to your current coverage:

- Complete the application by hand in ink. If you have an electronic PDF form, you can fill out the form on your computer with Adobe Reader and save or print the application as needed.
- 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 first page.

If you choose not to apply for coverage:

- You only need to complete the "Employee Information" and "Waiver of Coverage" sections on the first 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 first 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.

PO BOX 297
Minneapolis, MN 55440-0297