HealthPartners®

Submit Completed Forms To: Rebecca.E.Kaus@HealthPartners.com

SMALL GROUP EMPLOYEE APPLICATION OR MID-YEAR HIRES

For Groups of 1 to 50 Employees

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

NAME OF EMPLOYER Commercial Contractors GROUP NUMBER 27509 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 choose one of the following: ☐ Medical (complete A)* ☐ Comprehensive Dental (complete B) ☐ Medical and Dental (complete A and B)

A. IF MEDICAL PLAN, PLEASE WRITE 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 COMPREHENSIVE DENTAL PLAN, PLEASE CHOOSE ONE OF THE FOLLOWING: (Ask your employer if dental is offered)

☐ Single Dental ☐ Declining Dental Coverage because:

☐ Single+1 Dental ☐ *Have other coverage*

☐ Family Dental ☐ *Do not want coverage*

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

I understand that I am able 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 choose 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 decline coverage now, enrollment in this or any other plan may be restricted to an annual open enrollment period.

_____

PRINT NAME

_____ _____

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

***You will automatically be enrolled in the HealthPartners pediatric dental plan.**

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)	RELATIONSHIP	SEX (M/F)	TOBACCO USER* (Y/N)	WELL-BEING PROGRAM PARTICIPATION (Y/N)**
NAME		SELF			
SOC. SEC. #					
DEPENDENTS: (Write last name ONLY if different than employee)					
NAME					
SOC. SEC. #					
NAME					
SOC. SEC. #					
NAME					
SOC. SEC. #					
NAME					
SOC. SEC. #					

***Tobacco use instructions: Tobacco use is one factor used to calculate your premium costs. All covered employees and dependents over the age of 18 must verify tobacco use as defined by federal regulations.**

Tobacco use is defined as use of any tobacco product an average of four or more times per week within the past six months. This includes all tobacco products except for religious and ceremonial use.

****By answering yes, you agree to complete the HealthPartners well-being tobacco cessation program which includes a health assessment and Quit for Good virtual coaching within 60 days of your employer's effective date. By completing these programs you'll qualify for a lower premium. If you opt out or don't complete the program, you'll pay a higher premium. Your employer will provide you additional instructions for completing your well-being program.**

Do all of the dependent(s) listed above live at the same address as the employee? ☐ YES ☐ NO

If NO, list dependent(s) name and address: _____

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

NAME	DISABILITY

VII. Employee's authorization and representation Read this section carefully, sign and date the application.

I am applying for coverage on the basis of the statements and answers to the questions herein. I represent all answers to be true and complete to the best of my knowledge and to accurately represent the ages and tobacco use of those persons applying for coverage. I understand that these statements, answers and subsequent information I provide are the basis for my coverage and rate. Furthermore, I understand that this enrollment form must be updated by me to include changes in address, tobacco use, or other information I have provided on the form that may occur between the date of this enrollment form and the effective date of coverage. I understand that the coverage I am applying for will not be effective until after the premium is received and accepted by HealthPartners. I understand that HealthPartners will notify me of the effective date.

I UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMISSION OF RELEVANT INFORMATION IN THIS ENROLLMENT FORM MAY RESULT IN THE DENIAL OF CLAIMS or A RETROACTIVE CHANGE IN RATE.

I authorize HealthPartners to obtain from health plans, providers of service and hospitals, brokers, HealthPartners affiliates and business associates the medical and mental and chemical health records relating to me and all other applicants that may be necessary for: enrollment, claims processing, including claims HealthPartners makes for reimbursement or subrogation; quality of care assessment and improvement; accreditation, credentialing, case management, care coordination and utilization management, disease management, the evaluation of potential or actual claims against HealthPartners, auditing and legal services, and other health care operations. If another provider, hospital or health plan does not accept a copy of this document as authorization to release my information to HealthPartners, then I agree that I will sign a separate authorization. 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. HealthPartners may access and use information without further authorization if permitted or required by another law.

Enrollment in this or any other plan may be restricted to an annual open enrollment period or special enrollment period as allowed by law.

_____ _____

SIGNATURE OF EMPLOYEE **DATE SIGNED**

IMPORTANT Please read carefully

Information given on this application is used to manage 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.

To enroll in a HealthPartners plan:

- 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. You can also complete the application by hand in ink.
- Answer every question with 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.
- Information about your tobacco use and partaking in the Well-being Program is required.
- Please write the Social Security numbers to match your enrollment information to your assigned Member ID number for administrative purposes.

To add dependents to your current coverage:

- 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. You can also complete the application by hand in ink.
- Give information about the dependent only - name, address (if different from yours), social security number, clinic choice (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 state why you are not enrolling, and sign and date the "Waiver" section.
- You can decline medical coverage and still apply for comprehensive dental coverage if both are offered.
- If your employer offers a HealthPartners dental plan:
  - On the first page, choose whether you want single (you only) or family coverage. If you choose not to apply for coverage, please state that you are declining coverage.
  - You can decline comprehensive dental coverage and still apply for medical coverage if both are offered.

To submit your application:

- Please make sure that all information is complete and correct.
- Be sure to sign and date the application.
- Submit the application to your employer, as they have directed you to do.

HealthPartners®

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