
Enrollment Instructions



Return the enrollment forms and a deposit slip or voided check to: Mail Handlers Local 323
1602 Selby Ave., Suite 5
St. Paul, MN 55104
For Questions: (651) 646-2827

Election of Coverage and Authorization

HealthPartners Regional Dental Network	Monthly Cost
Single	\$45.43
Single+1	\$97.35
Family	\$149.27

Bill Me Direct

OR

Authorization for Direct Payment – Automatic Premium Payments

Company Name: HealthPartners Inc., I (we) authorize HealthPartners Inc. to initiate entries to debit my (our) account described below:

Checking Account No. _____ or Savings Account No. _____

Financial Institutions Name: _____

Financial Institutions Address: _____

(Attach a voided check, deposit slip, or savings slip)

This authority is to remain in full force and effect until HealthPartners Inc. has received written notification from me (or either one of us) of its termination.

Full Name _____ Phone Number _____

Signature _____ Date _____

Company Use Only:

Representative _____ Location _____

Address _____

FORMS MUST BE RETURNED NO LATER THAN DECEMBER 16, 2011

NAME OF EMPLOYER			GROUP NUMBER 0016	SITE
DENTAL PLAN	<input type="checkbox"/> NEW HIRE <input type="checkbox"/> RETIREE <input type="checkbox"/> OPEN ENROLLMENT	<input type="checkbox"/> EARLY RETIREMENT <input type="checkbox"/> COBRA <input type="checkbox"/> LIFE EVENT	DATE OF FULL-TIME EMPLOYMENT: ___/___/20___	COVERAGE EFFECTIVE DATE: ___/___/20___

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: _____

 DENTAL PLAN SELECTED: (If choices are available) Mail Handlers Group #0016 HealthPartners Regional Dental Network

WAIVING COVERAGE:

 Coverage through other employer

 Other

Please sign _____

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR EMPLOYEE AND EACH DEPENDENT BEING COVERED

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

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

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 RECISSION OF COVERAGE.

SIGNATURE OF EMPLOYEE (required) _____ DATE SIGNED _____ SIGNATURE OF EMPLOYER (optional) _____ DATE SIGNED _____