If you are requesting to change your clinic, you DO NOT need to complete this form.
Simply call Member Services at (952) 883-5000 or 1-800-883-2177.

CHANGE FORM

PO BOX 297
Minneapolis, MN 55440-0297

EMPLOYEE — Complete ALL unshaded areas.

NAME OF EMPLOYER	SUBGROUP CHANGE FROM TO	GROUP NUMBER	EFFECTIVE DATE OF CHANGE (M/D/Y)
		EMPLOYEE STATUS ☐ Active ☐ Retired ☐ COBRA	

*EMPLOYEE DISABILITY ☐ Yes ☐ No

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
- ☐ Divorce
- ☐ Other_______________
- ☐ Dissatisfied
- ☐ Death

☐ 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	DISABILITY* (Y/N)

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 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 health insurance company?

☐ YES ☐ NO If YES, please complete the Coordination of Benefits Form

Check which type: ☐ Group ☐ Individual

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

401026_d25 (06/09) *Federal Medicare legislation now requires this information. If you have questions about this, please contact Member Services.

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