Small Group Employee Application

For Groups of 2 - 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 ____________

The following information is for your employers' records. Please see instructions on the last page.
Before submitting your application, please review all information to be sure it is complete.
Then fold the application in half so this page is facing out, and staple.

I. Employee Information

FIRST NAME	M.I.	LAST NAME	DATE OF BIRTH	HRS. WORKED PER WK.	HIRE DATE

HOME ADDRESS – STREET	CITY	STATE	ZIP CODE	COUNTY

HOME PHONE (include area code)	WORK PHONE (include area code)	MARITAL STATUS
		☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ DOMESTIC PARTNER

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:

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* ☐ *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	DISABILITY* (Y/N)	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. #							
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:______________________________

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

Please note name and type of disability for any dependent child over the age of 25 (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 within 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 and 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? ______________________________

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

Name: ____

VI. Health Information - *Please answer questions 1-7*

In answering questions 1-3b, 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. Has any person applying for coverage EVER sought medical care, advice or been diagnosed or treated for: ☐ **YES** (check all that apply) ☐ **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 clots
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______

2. For conditions not already mentioned above, WITHIN THE PAST 5 YEARS has any person applying for coverage sought medical care, advice or been diagnosed or treated for: ☐ **YES** (check all that apply) ☐ **NO**

a ☐ Allergies or asthma or other respiratory disorder
b ☐ Alcohol abuse or Drug abuse
c ☐ Digestive, liver, intestinal, kidney or urinary tract disorder
d ☐ Thyroid disorder
e ☐ Eating disorder
f ☐ Headaches/migraines
g ☐ Psychological disorder ☐ counseling
h ☐ High blood pressure
i ☐ Eye or ear disorder
j ☐ Non-cancerous tumor
k ☐ Immune system disorder
l ☐ Muscle, bone or joint disorder
m ☐ Mental deficiency
n ☐ Neurological or Neuromuscular disorder
o ☐ Reproductive system disorder
p ☐ Seizure
q ☐ Other
r ☐ Elevated cholesterol/triglycerides

3a. Has anyone applying for coverage been hospitalized or had surgery? ☐ **YES** ☐ **NO**

3b. Has anyone applying been medically advised to have surgery? ☐ **YES** ☐ **NO**

If yes, who received/or will receive care?______________________________ what date(s)?____________ Reason__________________________

Past or future date of surgical procedure, if applicable____

4. Are any of these conditions related to a workers' compensation injury, motor vehicle accident or third party liability claim? ☐ **YES** ☐ **NO**

5. Have you or a family member applying for coverage used tobacco products in the last 12 months? ☐ **YES** ☐ **NO** Name & quit date: ____________________

(If this question is not answered, we will assume that there is a tobacco user applying for coverage)

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			

6. 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:

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

7. Is anyone currently taking, or taken during the past twelve months, any prescribed medication? ☐ **YES** ☐ **NO** If YES, list below.

PERSON'S NAME	MEDICATION	REASON PRESCRIBED	DOSAGE (mg / gm)	# PER DAY	REFILLS PER YR.	STILL PRESCRIBED?
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

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. A photocopy of this authorization shall be as valid as the original and remains in effect as long as continually insured by HealthPartners or until revoked. **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.

Thank you for choosing HealthPartners! Our mission is to improve the health of our members, our patients and the community. We look forward to serving you and your family.

The HealthPartners family of health plans are underwritten and/or administered by HealthPartners, Inc., Group Health, Inc., HealthPartners Insurance Company or HealthPartners Administrators, Inc. Fully insured Wisconsin plans are underwritten by HealthPartners Insurance Company.

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