

HealthPartners *for individuals & families*

ENROLLMENT FORM INSTRUCTIONS

PLEASE USE INK WHEN COMPLETING THIS FORM

The attached form is your application for a HealthPartners *for individuals & families* plan. Please review the instructions below carefully before completing the enrollment form.

1. **Answer all questions completely and accurately for each person to be covered. Remember, this enrollment form provides the evidence of insurability and, as such, will be the basis for coverage and premium rates if you are accepted into the plan. The enrollment form will be returned to you if all items are not completed.**
2. **Complete all unshaded sections.** Any information that is left out delays processing of your enrollment form. Please note that number 13 requests the explanation of any YES answers to questions in numbers 10 and 11. You have two options to explain these answers. You may:
 - a) provide all the details requested; or
 - b) enclose the appropriate medical records with the enrollment form.
3. **Please be sure to indicate the plan you are applying for.**
4. Please write the **name and clinic number of the desired medical clinic selection** for each applicant in number 3.
5. Carefully read, **sign and date** the enrollment form; all adults, including dependent children age 18 and over, must sign. HealthPartners must receive your enrollment form within 30 days of the signature date or it will be returned to you. If any applicant is under age 18, the parent or legal guardian must sign. **Your enrollment form is valid for a period of 60 days from the date you sign it. After 60 days a new application must be completed in full.**
6. Make a copy of the enrollment form for your records. Fold and mail the original to HealthPartners in the enclosed envelope. **Do not send any premium until requested.**

Upon receipt of your enrollment form, we will review it for completeness. We may need to contact you for further details or we may find it necessary to request health history information from other health care providers. You will be notified of any such request. How quickly we can process your enrollment form depends on the promptness of these providers. **You may be billed from your health care provider for the necessary records.**

7. After your enrollment form has been reviewed, we will notify you in writing whether you are accepted into a HealthPartners *for individuals & families* plan and of your premium amount. Normal processing time is three to four weeks, but it may take longer if information from other health care providers is required to complete your enrollment form.

If accepted, the effective date of coverage will depend on when the underwriting process is completed and the premium is received. You will be offered coverage to begin on either the 1st or 16th of a month. Coverage cannot be retroactive. An acceptance letter will be sent to you, indicating your rate and coverage effective date.

If declined, we will notify you of the declination.

Providing false information in this enrollment form may result in the denial of claims or cancellation of coverage. Please note that no coverage is provided for maternity care if the member became pregnant before her effective date of coverage.

You may fax your application to the Individual Sales Department at (952) 883-5260.

If you have any questions concerning your enrollment form, please contact HealthPartners at (952) 883-5600.

Thank you for requesting coverage from HealthPartners.

HealthPartners' mission is to improve the health of our members, our patients and the community.

Send completed enrollment form, or direct questions to:

HealthPartners Individual Sales Department ■ PO BOX 1309 ■ Minneapolis, MN 55440-1309 ■ (952) 883-5600

Please write all answers in INK. Failure to answer all questions completely will delay the processing of your enrollment form.

Lead Applicant's Name <small>(person responsible for payment)</small>	Last	First	M.I.	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
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Lead Applicant's Address	Street	City	State	Zip
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Lead Applicant's Home Telephone (include area code)	Work Telephone (include area code)
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Dependent's Address <small>(if different from above)</small>	Street	City	State	Zip
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1. PLAN APPLYING FOR (Choose One Only): **\$250 Deductible Option** **\$500 Deductible Option** **\$1,000 Deductible Option**

2. PERSONAL INFORMATION: Complete the following information for each person to be covered.

FULL NAME (start with yourself)	AGE	RELATIONSHIP	HEIGHT	WEIGHT	SEX	DATE OF BIRTH	SOCIAL SECURITY NO.	HEALTHPARTNERS, INC. USE ONLY				
								A	D	Rate	Premium	
		Lead Applicant										

Do all of the dependent(s) listed above reside at the same address as the lead applicant? YES NO

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

Are any of the above listed dependent(s) age 19 or older, full-time students? YES NO If YES, please indicate the name, school attending and if full time:

Name _____ School _____ Status: Part-Time Full-Time

Name _____ School _____ Status: Part-Time Full-Time

Total Premium

- Conversion
- Add Dependent
- Rate Reduction
- Rerate
- Reapply

Underwriter _____

Date _____

Effective Date _____

3. MEDICAL CLINIC SELECTION: For each applicant, indicate desired clinic.

APPLICANT NAME	PREFERRED MEDICAL CLINIC (please use clinic name and clinic number found in the Network Directory)	Underwriter

4. PREVIOUS HEALTHPARTNERS MEMBERSHIP: Has any person listed in #2 ever been a member of, or ever applied for membership in:

Group Health MedCenters HealthPartners YES NO If YES, list Member Number: _____

If YES, whom, when and under what name? _____

5. CURRENT MEDICAL CLINIC: Name, address and phone number of your family physician(s). (If there is no regular physician, please give the name and address where each applicant last received care.) Use additional sheets if necessary.

APPLICANT NAME	CLINIC NAME	PHYSICIAN'S NAME	COMPLETE ADDRESS & TELEPHONE NUMBER OF MEDICAL PROVIDER (City, State, ZIP)

6. List current health plan companies for each person in #2.

APPLICANT NAME	NAME OF INSURER	ADDRESS OF INSURER (CITY, STATE, ZIP)	WHEN WILL COVERAGE TERMINATE?

7. TOBACCO USE/CESSATION: Has any person listed in #2:

Used any tobacco or tobacco cessation product in the last 12 months? YES NO If YES, complete the following questions.

APPLICANT	TYPE OF PRODUCT	AMOUNT PER DAY	HOW LONG HAVE THEY USED TOBACCO?

If someone has quit using tobacco products, who, and how long has it been since they quit?

8. FOREIGN TRAVEL: Does anyone have plans for foreign travel within the next six months? When? _____ For how long? _____

9. PREGNANCY: Are any persons listed in #2 now pregnant or exhibiting symptoms of pregnancy? YES NO
If YES, whom? _____ When is birth expected? _____

Complete information is required below for each applicant. If you answer YES to any of these questions, please explain in section 13, indicating the person whom the YES answer involves. Add additional page(s) if you need more space.

10. HEALTH HISTORY: Has any person listed in #2 **EVER** had or been treated for: **YES NO**

- a. Had a physical examination, electrocardiogram, laboratory or diagnostic test or x-ray (other than dental)?
- b. Mental, emotional or personality disorders, including counseling or hospitalization?
- c. Any disease or disorder of the eyes, ears, nose, throat, tonsils or sinuses?
- d. Diabetes or sugar, albumin or blood in the urine?
If YES, Last Blood Sugar Reading _____ Date _____
- e. Chest pain, heart murmur, angina, high blood pressure or other heart or circulatory disorder?
If YES, Last Cholesterol Reading _____ Date _____ If YES, Last Blood Pressure Reading _____ Date _____
- f. Varicose veins, varicose ulcer, phlebitis, anemia or any other vein or blood disorder?
- g. Stroke, epilepsy, fainting, dizziness, convulsions, headaches, migraines or any disease or disorder of the brain or nervous system?
- h. Tuberculosis, asthma, allergies, hay fever, lung, emphysema or respiratory disorder?
- i. Stomach or duodenal ulcer, other ulcer, colitis, diarrhea, hepatitis, or any disorder of the liver, gall bladder, stomach, intestine or rectum?
- j. Kidney, bladder or prostate disorder, any other urinary disorder, any type of hernia?
- k. Any disease or disorder of the breast or reproductive organs, abnormal menstrual periods or any sexually transmitted disease?
- l. Arthritis, rheumatism or any disorder of the joints, muscles or bones, any knee, neck, back or spinal trouble, neuritis, sciatica or scoliosis?
- m. Eating disorders, unexplained weight loss, fatigue, fever, enlarged lymph nodes, skin lesions, or any disorder of the immune system? ...
- n. Cancer or tumors, cysts or growths of any kind?
- o. Had or been advised to have surgery?
- p. Been evaluated for, treated for, or joined any organization for alcoholism/chemical dependency; been arrested for or had a driver's license suspended for driving while intoxicated; consumed alcohol to excess or used drugs improperly or without physician approval? ...
- q. Been told to modify or restrict eating, drinking or living habits for health purposes?
- r. Had any blood tests, including any screening for the presence of viral antibodies?
- s. Has anyone listed in #2 been hospitalized within the past 5 years?

11. Has any person listed in #2 EVER: **YES NO**

- a. Had any signs or symptoms, including illnesses or injuries, for which a physician has not yet been consulted?
- b. Had any medical treatment, health impairment or congenital anomaly not already noted in this enrollment form?
- c. Had any life or health insurance declined, postponed or modified, or had a waiver, rider or extra premium added?
- d. Received payment for disability, illness or injury?

CONDITIONS OF ACCEPTANCE

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 complete to the best of my knowledge and to accurately represent the health of those persons applying for coverage. I understand that these statements, answers and subsequent information I provide to HealthPartners are the basis for my coverage and rate and are made a part of my HealthPartners *for individuals & families* contract. Furthermore, I understand that this enrollment form must be updated by me to include any condition or disease that may occur between the date of this enrollment form and the effective date of coverage. I understand that this enrollment form may be denied in whole or in part. I understand that any of the applicants, including the applicant designated as guarantor or lead applicant, may be denied. I may withdraw this enrollment form at any time during processing with written notification. I understand that if my enrollment form for new or additional coverage is accepted, the coverage will not be effective until after the premium is received and accepted by HealthPartners.

I understand that no coverage is provided for maternity care if the member became pregnant before her effective date of coverage, regardless of whether she knew she was pregnant at the time of this enrollment form.

I hereby authorize HealthPartners to obtain from providers of service and hospitals, the medical (including mental and chemical health) records relating to me and all other applicants necessary for enrollment and for the administration of contracts with HealthPartners. A photocopy of this authorization shall be as valid as the original and will expire after twelve (12) months.

(Please note: some clinics may require a separate authorization.)

I understand that providing false information or omission of relevant information in this enrollment form may result in the denial of claims or cancellation or rescission of coverage.

**➔ All adult applicants and the parent/legal guardian of minor applicants must sign here.
Dependent children age 18 and older must sign.**

Applicant(s) signature

X _____ Date _____

X _____ Date _____

X _____ Date _____

X _____ Date _____

Guarantor/legal guardian signature (if any applicants are minors) X _____ Date _____

**AUTHORIZATION FOR RELEASE OF INFORMATION TO INSURANCE AGENT
(Optional. Complete this section if you are purchasing this health plan through an insurance agent.)**

I hereby authorize HealthPartners to release information related to my HealthPartners *for individuals & families* enrollment form to my insurance agent.

(Name of Agent)

The information for which I authorize such release is limited to the contents of my enrollment form and medical (including mental and chemical health) records information requested or used by HealthPartners in processing the enrollment form. I authorize disclosure of such information solely for the purpose of assisting with the processing of the enrollment form.

This authorization is intended to cover the release of information described above related to me, as well as to my dependent children for whom I have applied for HealthPartners *for individuals & families* coverage.

This authorization will remain in force until I receive notice that my HealthPartners *for individuals & families* enrollment form has been accepted or declined.

Date

Name (Please Print) X
Signature

Name (Please Print) X
Signature

Name (Please Print) X
Signature

Name (Please Print) X
Signature

Please Note: An adult can only authorize the release of records for him or herself and minor children, not for a dependent spouse.

Steve Volkman 1602
Agent's name (if applicable) (please print) Agent # Date

Did you remember to select a medical clinic for yourself and (if applicable) your dependents?

ENROLLEE INFORMATION AND ENROLLEE BILL OF RIGHTS

The following information is provided in accordance with Minnesota Department of Health regulations.

Enrollee Information

- 1 **COVERED SERVICES:** Services provided by HealthPartners will be covered only if services are provided by participating HealthPartners providers or authorized by HealthPartners. Your contract fully defines what services are covered and describes procedures you must follow to obtain coverage.
- 2 **PROVIDERS:** Enrolling in HealthPartners does not guarantee services by a particular provider on the list of providers. When a provider is no longer part of HealthPartners, you must choose among remaining HealthPartners providers.
- 3 **REFERRALS:** Certain services are covered only upon referral. See your contract for referral requirements. All referrals to non-HealthPartners providers and certain types of health care providers must be authorized by HealthPartners.
- 4 **EMERGENCY SERVICES:** Emergency services from providers who are not affiliated with HealthPartners will be covered only if proper procedures are followed. Your contract explains the procedures and benefits associated with emergency care from HealthPartners and non-HealthPartners providers.
- 5 **EXCLUSIONS:** Certain services or medical supplies are not covered. You should read the contract for a detailed explanation of all exclusions.
- 6 **CONTINUATION:** You may continue coverage under certain circumstances. These continuation rights are explained fully in your contract.
- 7 **CANCELLATION:** Your coverage may be canceled by you or HealthPartners only under certain conditions. Your contract describes all reasons for cancellation of coverage.
- 8 **NEWBORN COVERAGE:** If your health plan provides for dependent coverage, a newborn infant is covered from birth, but only if services are provided by participating HealthPartners providers or authorized by HealthPartners. Certain services are covered only upon referral. HealthPartners will not automatically know of the infant's birth or that you would like coverage under your plan. You should notify HealthPartners of the infant's birth and that you would like coverage. If your contract requires an additional premium for each dependent, HealthPartners is entitled to all premiums due from the time of the infant's birth until the time you notify HealthPartners of the birth. HealthPartners may withhold payment of any health benefits for the newborn infant until any premiums you owe are paid.
- 9 **PRESCRIPTION DRUGS AND MEDICAL EQUIPMENT:** Enrolling in HealthPartners does not guarantee that any particular prescription drug will be available nor that any particular piece of medical equipment will be available, even if the drug or equipment is available at the start of the contract year.

Enrollee Bill of Rights

- 1 Enrollees have the right to available and accessible services including emergency services, as defined in your contract, 24 hours a day and seven days a week;
- 2 Enrollees have the right to be informed of health problems, and to receive information regarding treatment alternatives and risks which is sufficient to assure informed choice;
- 3 Enrollees have the right to refuse treatment, and the right to privacy of medical and financial records maintained by the health maintenance organization and its health care providers, in accordance with existing law;
- 4 Enrollees have the right to file a complaint with the health maintenance organization and the commissioner of health and the right to initiate a legal proceeding when experiencing a problem with the health maintenance organization or its health care providers;
- 5 Enrollees have the right to a grace period of 31 days for the payment of each premium for an individual health maintenance contract falling due after the first premium during which period the contract shall continue in force;
- 6 Medicare enrollees have the right to voluntarily disenroll from the health maintenance organization and the right not to be requested or encouraged to disenroll except in circumstances specified in federal law; and
- 7 Medicare enrollees have the right to a clear description of nursing home and home care benefits covered by the health maintenance organization.

IMPORTANT INFORMATION ABOUT THE MINNESOTA INSURANCE FAIR INFORMATION REPORTING ACT

HealthPartners complies with the Minnesota Insurance Fair Information Reporting Act. This law gives you specific rights to receive notice that HealthPartners may be collecting personal information from third parties about you during the health underwriting process. It is a HealthPartners policy that we will not release personal information outside of our companies without the express written consent of the applicant or patient. For this reason, HealthPartners does not share personal information about individuals with insurance or health underwriting support organizations. You have the right to see the personal information we collect about you and there is a procedure to correct inaccurate personal information about you in our possession. You may contact the HealthPartners Individual Sales Department by calling (952) 883-5600 for further information on your rights.