HealthPartners®

Individual Health Plans

Initial Payment Form

(Payment Voucher)

Thank you for your application for a HealthPartners individual plan.

To complete the application process, please provide payment for the first month's premium. This payment must be submitted before we can review your application. We will not process the payment until you have been approved for the plan you selected.

If you have questions, or would prefer to pay over the phone, call HealthPartners Individual Sales at 952-883-5599 or 1-877-838-4949 between 8 a.m. and 6 p.m. Monday-Friday. You can also e-mail questions to **individualsales@healthpartners.com**.

Applicant information

Lead/Self Applicant Name _____

Application Number
(online applications only) _____

Choose your method of first payment

☐ Visa ☐ MasterCard ☐ American Express ☐ Discover ☐ Check

Card Number _____

Expiration Date ____/____

Payment Amount $_____

Signature _____

Billing Name
(please print) _____

Billing Address _____
Street Address

_____
City State ZIP

Phone Number (____) _____

Return this payment form by fax or mail

Fax: 952-853-8718

HealthPartners Individual Sales
P.O. Box 1309
MS21106D
Minneapolis, MN 55440-1309

HealthPartners®

Individual Health Plans

Ongoing Payment Form

(Individual Payment Plan Selection)

HealthPartners offers multiple payment options for your monthly premiums - choose which method works best for you! If you do not select a billing option, we will bill you quarterly.

If you elect to use automatic withdrawal, the payment will be taken on the 5th day of each month. If your coverage begins on the 16th of a month, your first automatic withdrawal will be for one and a half month's premiums. Notification of withdrawal will not be sent from HealthPartners, but it will be available through your bank. This does not require any change in your current banking relationship.

If you have questions, call HealthPartners Individual Sales at 952-883-5599 or 1-877-838-4949 between 8 a.m. and 6 p.m. Monday-Friday or e-mail **individualsales@healthpartners.com**.

Applicant information

Lead/Self Applicant Name _____

Address _____
Street

_____
City State ZIP

Application Number _____

Choose your method of ongoing payment

☐ **I am enrolling in the monthly automatic withdrawal billing option.** I authorize HealthPartners and the bank named below to automatically withdraw funds for my monthly premium from my checking or savings account. This authorization will remain in effect until I notify HealthPartners of cancellation in writing at least 14 business days before my next payment is due. I agree to pay all bank charges associated with any stop payments initiated by me or my bank and any insufficient fund charges.

My financial institution information is listed below.

Name of Financial Institution (Bank) _____

Account Number _____

☐ Checking ☐ Savings

Name on Account _____

Authorized Signature _____

☐ **I prefer to be billed directly. I select:**

☐ Bi-monthly (6 times/year) ☐ Quarterly (4 times/year) ☐ Semi-annually (2 times/year)

Your Signature _____

Return this form by mail

HealthPartners Membership Accounting
Mailstop 21104A
PO Box 297
Bloomington, MN 55440-0297