HealthPartners®

Send completed enrollment form to:
HealthPartners Membership Accounting
MS 21104A
PO Box 297
Minneapolis, MN 55440
Fax: 952-883-5950

For questions, call:
HealthPartners Individual Sales
Phone: 952-883-5599 or 1-877-838-4949

HealthPartners Peak℠ Plan

Underwritten by HealthPartners Insurance Company, a related company of HealthPartners, Inc.

Enrollment Form Instructions

This enrollment form is for the HealthPartners Peak plan. Please carefully review the instructions below before completing the form. The lead applicant must be a permanent resident of Minnesota.

- ✓ Please use ink when filling out this form.
- ✓ Complete all sections in full. We will return the enrollment form to you if you haven't completed all items.
- ✓ If any applicant is under age 18, the parent or legal guardian must sign. Applicant, and those applying for coverage, must not be entitled to benefits under Medicare Part A or enrolled under Medicare Part B in order to obtain coverage on this plan.
- ✓ Carefully read, sign and date the last page of the enrollment form. All adults, including dependent children over age 18, must sign the form. HealthPartners must receive your enrollment form within 30 days of the signature date or we'll return it to you.
- ✓ Make a copy of the completed and signed enrollment form for your records. Mail the original enrollment form, along with payment for the first month’s premium and a completed premium worksheet, to HealthPartners. You may also fax the information. See the top of this page for the mailing address and fax number. Please note we cannot accept your enrollment form without payment and we cannot accept cash. Payment for multiple applications on one check may be returned.
- ✓ Enrollment in this plan won’t replace or cancel any existing HealthPartners policies in which you’re currently enrolled. If you wish to cancel other plans you may have with us, please submit a written request with this application or to the mailing address listed at the top of this page. You'll need to include your member number and an effective date.
- ✓ Please review the Summary of Benefits if you need additional details about this plan.

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HealthPartners Peak Plan

Enrollment Form

Please write all answers in ink. Answer all questions completely to avoid a delay in enrollment processing.

Section 1. Applicant Information

Please check the box that best describes your reason for application:

- ❒ Open Enrollment - October 1, 2013 - March 31, 2014
- ❒ Special Enrollment Period - You may be eligible to enroll outside of the open enrollment period if you qualify for a special enrollment period. The following are some of the events that qualify for a special enrollment period. **If you checked Special Enrollment Period, you must submit supporting documentation as part of your application.**
  - ❒ Birth of child. Date of birth: _____. (Please include a copy of the birth certificate.)
  - ❒ Adoption or placement for adoption. Date of adoption or placement:_____. (Please include proof of the finalized adoption.)
  - ❒ Marriage. Date of marriage: _____. (Please include a copy of the marriage license.)
  - ❒ Permanent move. Move date: _____. (Please provide information on where you moved from and the date of the move.)
  - ❒ Loss of other coverage (e.g. divorce). Date coverage ended:_____. (Please include supporting documentation.)
  - ❒ Other_____ (Please include supporting documentation.)

Lead Applicant's Name (If you're applying on behalf of your child under age 18, list his/her name here.)

Last _____ First _____ M.I. _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married

Lead Applicant's Address (Permanent MN addresses only. No PO boxes.)

Street_____ City _____ State _____ ZIP _____ County _____

Lead Applicant's Mailing Address (if different from above)

Street_____ City _____ State _____ ZIP _____ County _____

Lead Applicant's Telephone

Preferred Telephone (_____) _____ Alternate Telephone (_____) _____

Email Address _____

☐ You may communicate with me via encrypted email, when possible, for myself and any family member listed on this application.

Parent/Guardian Name and Address (this person is the contact for lead applicants under age 18)

Last_____ First_____ M.I._____

Street_____ City_____ State_____ ZIP_____

Complete the following information for each person applying for coverage.

Full Name (First, MI, Last) (start with lead applicant)	Relationship	Date of Birth (MM/ DD/YYYY)	Tobacco Use* (Y/N)	Gender	Social Security #**

*Tobacco use is defined as use of any tobacco product on average of four or more times per week within no longer than the past six months, excluding religious or ceremonial use. **Providing your Social Security Number is not required.

Has any person applying for coverage ever been a HealthPartners member?

If YES, please list his/her name and HealthPartners member number.

Full Name	Member Number

Do you or any person applying for coverage have current coverage?

If YES, please indicate current health plan information below.

Applicant Name(s)	Name(s) of Insurance Company (City, State, Zip)

Section 2. Plan Selection

Choose one of the following plan options:

Peak Deductible Plans

Single Deductible

❒ Silver $2,300 - 80% ❒ Bronze $6,350 - 100% ❒ Catastrophic*** $6,350 - 100%

Family Deductible

❒ Silver $4,600 - 80% ❒ Bronze $12,700 - 100% ❒ Catastrophic*** $12,700 - 100%

Peak HSA Qualified Plans

Single Deductible

❒ Silver $3,650 - 100% ❒ Bronze $6,300 - 100%

Family Deductible

❒ Silver $7,300 - 100% ❒ Bronze $12,600 - 100%

Other: _____

***To enroll in a Catastrophic Plan you must be 18-29 years of age before the beginning of the plan year, or have an Unaffordability or Hardship Certificate of Exemption from the Exchange. Please include your Hardship Certificate of Exemption from the Exchange as part of this application.

Conditions of Acceptance

I am applying for coverage on the basis of the statements and answers to the questions herein. I represent all answers to be true and complete to the best of my knowledge and to accurately represent the ages and tobacco use of those persons applying for coverage. I understand that these statements, answers and subsequent information I provide are the basis for my coverage and rate and are made a part of my HealthPartners contract. **Furthermore, I understand that this enrollment form must be updated by me to include changes in address, tobacco use, or other information I have provided on the form that may occur between the date of this enrollment form and the effective date of coverage.** I understand that the coverage that I am applying for will not be effective until after the premium is received and accepted by HealthPartners. I understand that HealthPartners will notify me of the effective date. I understand that I, or those persons applying for coverage, are not eligible to apply for individual coverage if entitled to benefits under Medicare Part A or enrolled under Medicare Part B.

I UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMISSION OF RELEVANT INFORMATION IN THIS ENROLLMENT FORM MAY RESULT IN THE DENIAL OF CLAIMS, A RETROACTIVE CHANGE IN RATE, OR RECISSION OF COVERAGE.

I authorize HealthPartners to obtain from health plans, providers of service and hospitals, brokers, HealthPartners affiliates and business associates the medical and mental and chemical health records relating to me and all other applicants that may be necessary for: enrollment, claims processing, including claims HealthPartners makes for reimbursement or subrogation; quality of care assessment and improvement; accreditation, credentialing, case management, care coordination and utilization management, disease management, the evaluation of potential or actual claims against HealthPartners, auditing and legal services, and other health care operations. If another provider, hospital or health plan does not accept a copy of this document as authorization to release my information to HealthPartners, then I agree that I will sign a separate authorization. This authorization is valid as long as I am continually insured with HealthPartners or until revoked. A photocopy of this authorization shall be as valid as the original. HealthPartners may access and use information without further authorization if permitted or required by another law. I also authorize HealthPartners to release information related to my HealthPartners enrollment (including information from my medical records) to my insurance broker, should I choose to name one.

Enrollment in this plan or any other plan may be restricted to an annual open enrollment period or special enrollment period as allowed by law.

I understand that payment for the first month's premium and payment information for subsequent premiums must be submitted with this enrollment form or the application may not be considered. If I am accepted for coverage under my selected or an alternate plan, I understand my submitted payment will be processed and I will be automatically enrolled in that plan. I understand that I will be defaulted to quarterly statement billing unless I register for monthly automatic withdrawals from my bank account.

Please keep a copy of the completed enrollment form for your records. It will become a part of your contract upon enrollment.

All adult applicants, including dependent children age 18 and older, must sign below.

Enrollee signature(s)

X_____Date signed_____

Lead applicant’s signature, if age 18 or older

X_____Date signed_____

Spouse's signature, if applying for coverage

X_____Date signed_____

Dependent's signature, if 18 or older

X_____Date signed_____

Dependent's signature, if 18 or older

X_____Date signed_____

Legal guardian signature, for applicants under 18 (adult “no benefits” policyholder)

Broker’s name, if applicable. (Please print.) _____ Broker #_____ Date_____

HealthPartners®

Initial Payment Form

(Payment Voucher)

Thank you for your application for a HealthPartners individual plan.

Please provide payment for the first month's premium. If you're submitting more than one application, please include a separate payment for each application.

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

Applicant information

Applicant Name _____

Application Number (online applications only) _____

Calculate your premium

Payment amount being submitted $_____ (this must be filled in)

Payment (check)

Please submit an original signed paper check.

Your paper check will be converted to an e-check. An e-check is a one-time electronic withdrawal from your checking account. Your paper check will be securely destroyed after it's been processed. If you'd like to opt out of an e-check payment, please contact HealthPartners Sales for more information about other payment options and questions.

Return this payment form with your application form

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P.O. Box 297
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