

HealthPartners Health Insurance Enrollment Form

Independent School District 196

Group #: 3193

Subgroup: 01 02 Other:

SECTION 1 -- EMPLOYEE INFORMATION (Please complete in full and print clearly.)

Employee Last Name		First	MI	Social Security Number	
Street Address				Marital Status ☐ Single ☐ Married	
City	State		Zip Code	Date of Birth	☐ Male ☐ Female
Home Phone Number () -		Work Phone Number () -		Effective Date	Employee #

SECTION 2 -- MEDICAL ENROLLMENT (Please check desired coverage and plan type)

I select coverage for: ☐ Employee ☐ Employee +1 ☐ Family	I select the following plan: ☐ \$1,000 Deductible Plan	For administrative purposes only for HRA/ded plan Amount per/month Amount Annually _____ / _____	Payroll Code
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Dependent Information:

(Please complete if you are enrolling dependents for coverage)

Last Name (If different from above)	First Name	MI	Relationship to employee	Date of birth (Mo/Day/Yr)	Sex (M,F)	Social Security Number (required)
Spouse:			Spouse			
Dependent(s):						

Are any of the above listed dependents disabled (eligible for guaranteed coverage)? ☐ yes ☐ no

If YES, list name(s) here: _____

Do all of the dependents listed above reside at the same address as the applicant? ☐ yes ☐ no

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

SECTION 3 -- Coordination of Benefits

ADDITIONAL MEDICAL COVERAGE INFORMATION:

On the day your HealthPartners coverage begins will you or any family members included on this enrollment form have other medical coverage in addition to this plan? ☐ yes ☐ no

If YES, complete the Coordination of Benefits Form and attach (call HR for form at 651-423-7769 or print form off the I-196 website)

SECTION 4 -- SIGNATURE (Employee must sign and date.)

CONDITIONS OF COVERAGE:

I hereby apply for coverage on the basis of the statements and answers to the questions herein. **BY SIGNING THIS FORM I CERTIFY THAT ALL OF THE STATEMENTS ABOVE ARE TRUE.**

I authorize the required deduction (if any) from my wages. I understand that medical insurance deductions are pre-tax and I acknowledge that my Social Security Benefits may be slightly reduced as a result of my election. I have read and agree with the terms as stated on this application. By acceptance of coverage and upon signing this Benefits Election Form, I authorize HealthPartners to share information about me with any medical provider, sponsoring employer, or other entity, where such information is reasonably necessary for administration. **I understand that my election is irrevocable for the plan year, unless I experience a qualifying event & notify the plan in writing within 30 days of the date of the qualifying event.**

I UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMISSION OF RELEVANT INFORMATION IN THIS APPLICATION MAY RESULT IN DENIAL OF CLAIM(S), CANCELLATION OF OR RECISSION OF COVERAGE.

EMPLOYEE SIGNATURE

DATE SIGNED

PLAN ADMINISTRATOR SIGNATURE

DATE SIGNED