

HealthPartners Empower Individual Plan

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

Enrollment Form Instructions

This is an enrollment form for a HealthPartners Empower Individual plan. Please carefully review the instructions below before completing the form.

- ✓ Please use ink when completing this form.
- ✓ Answer all questions completely and accurately. This enrollment form provides the evidence of insurability and will be the basis for coverage and premium rates if you are accepted into the plan. Providing false information in this enrollment form may result in the denial of claims or rescission of coverage. Please note there is no coverage provided for maternity care for the first 18 months of plan coverage.
- ✓ Complete all sections in full. The enrollment form will be returned to you if all items are not completed.
- ✓ 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 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 form must be completed in full and re-submitted.
- ✓ 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 initial payment form, to HealthPartners in the enclosed self-addressed envelope. You may also fax the information. See the top of this page for the mailing address and fax number. Please note that we cannot accept your enrollment form without payment and we cannot accept cash.
- ✓ Please review the Summary of Benefits if you need additional details about this plan.

About the Enrollment Process

Upon receipt of your enrollment form, we will review it for completeness. We may need to contact you for further details or we may need to request health history information from other health care providers. We will notify you of any such request. Please note that you may be billed by your health care provider for the necessary records.

We will notify you of a decision after your enrollment form and any additional information have been reviewed. Normal processing time varies, and may depend on if information from other health care providers is necessary to complete your enrollment.

If you are approved for the HealthPartners Empower Individual plan you selected, you will be automatically enrolled in that plan for the next available effective date (either the 1st or 16th of a month) and the first month's premium payment you submitted with your enrollment form will be processed. HealthPartners will process your payment only when you are approved. Coverage cannot be retroactive.

Ongoing billing will occur with the method you selected on the payment form. Options include: bi-monthly, quarterly or semi-annual statements or monthly automatic withdrawals.

If you are not approved for the HealthPartners Empower Individual plan you selected on your enrollment form, we will notify you of the reason(s) for the decision and provide you with information on other options.

Questions? Call 952-883-5599 or 1-877-838-4949
Monday - Friday 8 a.m. to 6 p.m. TTY users call
952-883-5127 or 1-800-443-0156.



HealthPartners Empower Individual Plan

Enrollment Form / Evidence Of Insurability

Send completed enrollment form, or direct questions to:

HealthPartners Individual Sales Department -
PO BOX 1309 - MS21106D - Minneapolis, MN 55425.
952-883-5599 or 1-877-838-4949. Fax 952-853-8718.

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

Section 1. Applicant Information

Lead Applicant's Name

Last _____ First _____ M.I. _____

Gender: Male Female Marital Status: Single Married

Lead Applicant's Address

Street _____ City _____ State _____ Zip _____

Lead Applicant's Telephone/Email

Home Telephone (_____) _____ Work Telephone (_____) _____

Cell Phone (_____) _____ Email Address _____

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

Dependent's Address (if different from above) Add additional page(s) for dependents if needed.

Street _____ City _____ State _____ Zip _____

Section 2. Application Details

1. Choose only one of the following deductible plans:

Single Deductible \$1,200 – 80% \$1,400 – 80% \$1,600 – 80% \$2,000 – 80% \$2,300 – 80%
 \$2,600 – 100% \$3,100 – 100% \$5,000 – 100% \$5,600 – 100%

Family Deductible \$2,400 – 80% \$2,800 – 80% \$3,200 – 80% \$4,000 – 80% \$4,600 – 80%
 \$5,200 – 100% \$6,200 – 100% \$10,000 – 100% \$11,200 – 100%

2. Chemical Dependency Coverage: Coverage for chemical dependency is included with the contract. You may choose to opt out of chemical dependency coverage. The decision to keep or opt out of this coverage applies to all individuals applying for coverage under this contract.

Do you wish to opt out of (remove) chemical dependency coverage from your contract? Yes No

(Base rates are lower than coverage with chemical dependency.)

3. Personal Information: Complete the following information for each person to be covered.

HealthPartners, Inc. use ONLY

Full Name (start with yourself)	Age	Relationship	Height	Weight	Sex	Date of Birth	Social Security #	A	D	Rate	Premium

Has any person listed in Question 3 ever been a HealthPartners member? YES NO
 If YES, please list his/her name and HealthPartners member number.

Full Name	Member Number

Total Premium

Conversion

Add Dependent # _____

Rate Reduction # _____

Rerate # _____

Deductible Change # _____

Effective Date _____

Underwriter _____

Date _____

4. HealthPartners Membership: Please check the box that best describes your reason for application:

- I am a new applicant and am not currently a HealthPartners member.
- I am adding a dependent(s) to my current HealthPartners individual plan contract.
- I am a current HealthPartners individual plan member and am seeking a different plan or a lower rate.
- Other. Please explain: _____

Section 3. Health Information

5. Current Medical Clinic(s): 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 paper if necessary.

Applicant Name	Clinic Name(s)	Physician Name(s)	Complete Clinic Address(es) & Phone Number(s)	Date of Last Complete Physical Exam

Please sign if applying via FAX: Lead Applicant Signature _____ Date _____

6. Current Health Plan: Name and address of the current health plan companies for each person listed in Question 3.

Please attach a separate sheet if additional space is needed.

Applicant Name(s)	Name(s) of Insurer(s)	Address(es) of Insurer(s) (City, State, Zip)	Termination Date

Yes No

7. Tobacco Use/Cessation: Has any person listed in Question 3:

Used any tobacco or tobacco cessation product in the last 12 months?

If YES, list all individuals: _____

8. Foreign Travel: Does any person listed in Question 3 have plans for foreign travel within the next six months?

If YES, who? _____ When? _____ For how long? _____

9. Pregnancy: Is any person listed in Question 3 now pregnant?

If YES, who? _____ When is birth expected? _____

10. For each female person listed in Question 3, please list date of last menstrual cycle.

Name _____ Date _____ Name _____ Date _____

Complete information is required below for each applicant. If you answer YES to any of these questions, please explain in Question 14, indicating which applicant the YES answer involves. (Please attach additional paper if more space is needed.)

Yes No

11. Has any person applying for coverage EVER sought medical care, advice or been diagnosed or treated for:

a. Heart murmur, angina, coronary artery disease or other heart or circulatory disorder

b. Stroke, epilepsy, alzheimer's, traumatic brain injury, brain tumor, multiple sclerosis

c. Hemophilia, polycythemia, thalessemia, or blood clots

d. Tuberculosis, emphysema or pulmonary fibrosis.

e. Colitis, crohns disease, hepatitis, cirrhosis of the liver, pancreatitis, kidney cysts or chronic kidney disease.

f. Scoliosis, spondylolithesis, ankylosing spondylosis or spina bifida

g. Cancer

h. Diabetes — Type I ___ or Type II ___ If yes, provide last hemoglobin A1C _____

i. An immune system disorder, including but not limited to lupus, rheumatoid arthritis, scleroderma, connective tissue disorder and sjogrens syndrome

j. Been convicted of a DWI or DUI; had his/her driver's license suspended or revoked for driving while under the influence . .

Please sign if applying via FAX: Lead Applicant Signature _____ Date _____

12. Within the past 5 years has any person applying for coverage sought medical care, advice or been diagnosed with or treated for any condition not already mentioned above concerning the following:

- a. Anemia, varicose veins, varicose ulcer, phlebitis or other blood disorder
b. Elevated blood glucose, elevated cholesterol or other lipids or had any other abnormal blood test
c. Chest pain or high blood pressure.
d. Disorder of the muscles or bones including but not limited to osteoarthritis, fibromyalgias, knee, hip, shoulder or spine
e. Fainting, dizziness, convulsions, headaches, migraines or any other brain or nervous disorder
f. Allergies, asthma, lung or breathing problem or any other respiratory disorder
g. Any type of ulcer; disorder of the gall bladder, stomach, intestine, rectum or liver
h. Mental, emotional or personality disorders, including counseling or hospitalization
i. Any disease or disorder of the eyes, ears, nose, throat, tonsils or sinuses or thyroid
j. Any kidney, bladder, prostate or urinary disorder.
k. Any disease or disorder of the breast, reproductive organs; abnormal menstrual periods, infertility or any sexually transmitted disease
l. Eating disorder, unexplained weight loss, fatigue, fever, enlarged lymph nodes, skin lesions or any other related disorder
m. Received inpatient or outpatient treatment for alcohol or drug use.

If yes, who received care _____ What date(s) _____

- n. Been told by a medical practitioner or health care professional to modify or restrict eating, drinking or living habits for health purposes
o. Received any holistic, alternative, or complementary treatment including herbal remedies, massage for pain, acupuncture/acupressure, or other therapies
p. Had a physical examination, electro cardiogram, laboratory or diagnostic test, x-ray (other than dental)
q. Been diagnosed or treated for any medical condition not listed above
r. Had any life or health insurance declined, postponed or modified, or had a waiver, rider or extra premium added.
s. Received payment for medical disability, illness or injury
t. Been hospitalized, had surgery or been medically advised to have surgery.

If yes, who received care _____ What date(s) _____

Date(s) of hospitalization or surgery (past or future) _____

Please sign if applying via FAX: Lead Applicant Signature _____ Date _____

13. Medications: In the past 12 months, has any person listed in Question 3 taken any medications?

If YES, complete the section below

Medications used in the past 12 months: *Please attach additional paper if more space is needed.*

Applicant Name(s)	Name of Medication	Dosage/Mg Per Use	Doses Per Day	Refills Per Year	Reason For Medication	Date Last Taken

14. Explanations: Provide the following information for each YES answer given in Questions 11 and 12. You may also include copies of medical records. **It is your responsibility to pay any fees that may be charged for obtaining these records.** Please attach additional paper if more space is needed.

Question # and Letter	Name of Person (as Listed in Question 3)	Explanations of Yes Answers in Questions 11 and 12 (Include Name of Condition, Reason Treated and Other Details)	Date(s) Occurred or When Treated	Remaining Effects	Complete Name and Address Physician(s) and/or Hospital(s) Where Treated

Please sign if applying via FAX: Lead Applicant Signature _____ Date _____

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 or 1-800-247-7015 for further information on your rights.

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 are the basis for my coverage and rate and are made a part of my HealthPartners individual plan 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 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 and I am notified of the effective date.

I understand that there is no coverage provided for maternity care within the first 18 months of coverage. Specific benefit information in the Summary of Benefits is provided in the application packet.

I authorize HealthPartners to obtain from health plans, providers of service and hospitals, the medical records (including mental and chemical health) relating to me and all other applicants that are 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, underwriting; premium rating, the evaluation of potential or actual claims against HealthPartners, auditing and legal services, and other health care operations. The information for which I authorize such release also may be collected from brokers or HealthPartners affiliates and business associates. I agree to execute a separate authorization, if required by a provider of service or hospital. A photocopy of this authorization shall be as valid as the original and remains in effect for 26 months from the signature date. 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 chose to name one.

I authorize HealthPartners to collect personal motor vehicle driving records for me and my dependents. I authorize disclosure of such information solely for the purpose of assisting with the underwriting of the enrollment form.

I authorize HealthPartners to release information related to my HealthPartners enrollment (including information from my medical records) to the lead applicant. This authorization is intended to cover the release of information described above related to each adult signing below, as well as their respective dependent children on whose behalf I have applied for HealthPartners individual coverage. An adult can only authorize the release of records for him or herself and minor children, not for a dependent spouse.

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 will not be considered. If I am accepted for coverage under my selected plan, I understand my submitted payment will be processed and I will be automatically enrolled in that plan. I understand that if I elect the monthly billing option I must consent to the payment being automatically withdrawn from my bank account. If I enroll for an effective date on the 16th of the month, I understand that my first automatic withdrawal will be the equivalent of one and a half month's premiums. I also have the options of bi-monthly, quarterly and semi-annual billing.

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

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

All adult enrollees and the parent/legal guardian of all minor enrollees must sign here including dependent children age 18 and older. Please note that an adult can only authorize the release of records for him or herself and minor children and not for a dependent spouse.

Enrollee signature(s)

X _____ Date _____
Lead applicant's signature

X _____ Date _____
Spouse's signature, if applying for coverage

X _____ Date _____
Dependent's signature, if age 18 or older

X _____ Date _____
Dependent's signature, if age 18 or older

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

Broker's name, if applicable. (Please print.) _____ Broker # _____ Date _____



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



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