HealthPartners®

Send completed enrollment form, or direct questions to:
HealthPartners Individual Sales
P.O. Box 1309, MS21102A
Minneapolis, MN 55425
Phone: 952-883-5599 or
1-877-838-4949
Fax: 952-853-8718

HealthPartners Short Term Health Care Coverage

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

Enrollment Form / Evidence Of Insurability

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

Lead Applicant Information (person seeking to be primary insured or contract holder)

Last Name _____ First Name _____ M.I. _____

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

Lead Applicant's Address

Street _____ City _____ State _____ ZIP _____ County _____

Lead Applicant's Telephone/Email

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.

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

Street _____ City _____ State _____ ZIP _____

Reason for application: (check one)

- ☐ I am a new applicant.
- ☐ I am reapplying for HealthPartners Short Term Health Plan coverage after having been denied for it.
- ☐ I am currently covered by a HealthPartners Short Term Health Plan.
- ☐ I am currently covered by a different HealthPartners Plan.

Have you or any family member(s) included in this enrollment form been covered by short term coverage by any health carrier within the past 555 days? . . . . . ☐ YES ☐ NO

If YES, how many days were you or your family member(s) covered by short term coverage? _____ days

I*f YES, your new policy must have a deductible equal to or greater than and a plan period equal to or less than your current/former policy. State law prohibits you from having short term coverage from any health carrier for more than 365 of the past 555 days.*

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

Full Name (Start with yourself)	Age	Relationship	Sex	Date of Birth	Social Security#* (optional)	HealthPartners Member Number (if ever been a member)
		SELF				

*Providing your Social Security Number is not required. However, it will speed underwriting and help HealthPartners work with your physicians to resolve any questions.

Plan Information

Choose only one of the following deductible plans: ☐ $300 - 80% ☐ $1,000 - 80%
☐ $500 - 80% ☐ $2,000 - 100%

Requested Effective Date (mm/dd/yy) ____/____/____

HealthPartners will notify you as to the actual effective date. The effective date is the day we receive the enrollment form and full payment in our office, or the requested effective date, whichever is later provided the effective date is no more than 60 days beyond the signature date of your enrollment form.

Number of Days Coverage Requested ☐ 30 ☐ 60 ☐ 90

Eligibility Information

	Yes	No
Will the Lead Applicant (applicant seeking to be primary insured or contract holder) be less than 90 days of age or 65 years of age or older, for any portion of intended coverage?	☐	☐
Is any person applying for coverage NOT a legal resident or citizen of the United States?	☐	☐
Does any person applying for coverage:		
Have other health care insurance coverage in force during the period for which coverage is requested, including Medicare?	☐	☐
(Health care insurance coverage does not include any applications currently pending.)		
Have a history of being declined insurance by any health carrier?	☐	☐
Is any person applying for coverage:		
Currently pregnant; or is your spouse, significant other, or other dependent currently pregnant or do you plan to add a dependent as a result of a birth or adoption?	☐	☐
Planning to add any other dependent?	☐	☐
Currently confined to or in any health care facility?	☐	☐
Consulting a medical professional for weight or related concerns?	☐	☐
Within the past five years, has any person applying for coverage had a diagnosis of, received treatment for, or consulted with a provider concerning:		
Heart disorder, stroke or other circulatory condition?	☐	☐
Cancer?	☐	☐
Diabetes?	☐	☐
Multiple Sclerosis, Lupus, rheumatoid arthritis or any other auto-immune condition?	☐	☐
Crohn's Disease or ulcerative colitis?	☐	☐
Kidney condition or liver condition?	☐	☐
Alcohol/chemical dependency or abuse?	☐	☐
Chronic lung condition (except asthma)?	☐	☐
Chronic blood condition?	☐	☐

STOP!

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS THE POLICY CANNOT BE ISSUED.

Conditions not specifically listed in the questions above may still not be covered if they are pre-existing conditions. Please see the Signature & Acknowledgement section for a definition of pre-existing conditions.

If you have any questions about this application, please contact HealthPartners Individual Sales department at 952-883-5599 or 1-877-838-4949. Or log onto **healthpartners.com/individual**.

Signature & Acknowledgment

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 will be made a part of my HealthPartners Short Term Health Plan contract. I understand that I must update this enrollment form to include any change in condition or disease affecting applicants for this coverage, that occur between the date I complete and sign this enrollment form and the date HealthPartners receives this enrollment form or the requested effective date for coverage, whichever is later. I understand that providing false information or omitting relevant information on this enrollment form may result in the denial of claims or rescission of coverage back to the effective date of coverage.

I understand that I and the other applicants listed on this enrollment form may be ineligible for coverage. If I have been a HealthPartners short term individual plan member in the past with claims investigated for fraud, I understand that I may not be eligible for enrollment at HealthPartners discretion. I understand that I am applying for an instant issue policy and may not withdraw my enrollment form once submitted. I understand that full payment must be submitted with this enrollment form or the policy will not be issued. I understand that if my dependent applicants and I are eligible for coverage and a policy is approved and issued, HealthPartners will notify me of the effective date of such policy. The effective date of coverage is the day HealthPartners receives this enrollment form or the effective date requested, whichever is later, provided that the effective date is no more than 60 days beyond the signature date on this enrollment form. Furthermore, I understand that the only dependents that can be added under this policy are children who are newly born or adopted per state law.

I understand that pre-existing conditions are not covered by this plan. A pre-existing condition is, with respect to coverage, any injury, illness, or condition for which the insured(s) has received medical treatment, care, advice or diagnosis, symptoms, or a manifestation before the effective date of the coverage. I also understand that any condition discovered and or treated during the term of this short term policy will be deemed a pre-existing condition in any subsequent short term policy to continue coverage and will not be covered by the subsequent policy.

I understand that if I terminate this short term coverage, that no cash refund will be issued. Application fee is non-refundable. However, if HealthPartners approves my concurrent application for conventional individual coverage and such coverage is offered and accepted, HealthPartners may apply, with my consent, any pre-paid premium from this short term plan to my HealthPartners conventional individual plan.

I authorize HealthPartners to obtain from providers of service and hospitals, the medical records (including mental and chemical health) relating to me and all other applicants that are necessary for: claims processing, including claims we make 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 us, fraud and abuse investigations, auditing and legal services, and other access and use 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. A photocopy of this authorization shall be as valid as the original and remains in effect unless it is revoked I understand that some clinics may require a separate authorization for the release of information for the purposes listed above. I agree to sign such releases for such purposes.

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 me, my spouse, and my minor dependent children for whom I have applied for HealthPartners Short Term Health Plan 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 and dependent applicants age 18 and older must sign.

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 age 18 or older

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

Any person who submits an enrollment form or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Broker's name, if applicable. (Please print.)__Murray Herstein_____ Broker #_1511_____ Date_____

Choose your method of payment

☐ **Charge my credit card for the Total Premium and Application Fee**

☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Card number _____

Expiration Date _____/_____

Premium _____

Application Fee _____$20.00_____

Total Payment Amount $ _____ (this must be filled in)

Signature _____

☐ **I have enclosed a check for the Total Payment Amount (Premium plus Application Fee)**

If you submit payment in the form of a paper check, it 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 has been processed. If you would like to opt out of an e-check payment, please contact HealthPartners Sales for more information about other payment options and questions.