



Local 323 Dental Program Enrollment Instructions

Return the enrollment forms and, if applicable,
a voided deposit slip or check to:

Mail Handlers Local 323
1602 Selby Ave., Suite 5
St. Paul, MN 55104

Election of Coverage and Authorization

HealthPartners Regional Dental Network

2023 Monthly Premiums

Single	\$67.96
Single +1	\$145.66
Family	\$223.33

Bill Me Direct

OR

Authorization for Direct Payment – Automatic Premium Payments

Company Name: HealthPartners Inc., I (we) authorize HealthPartners Inc. to initiate entries to debit my (our) account described below:

Checking or Savings Account No. _____

Financial Institutions Name _____

Financial Institutions Address _____

(Attach a voided check, deposit slip, or savings slip)

This authority is to remain in full force and effect until HealthPartners Inc. has received written notification from me (or either one of us) of its termination.

Full Name _____ Phone Number _____

Signature _____ Date _____

Company Use Only

Representative _____ Location _____

Address _____

FORMS MUST BE RETURNED NO LATER THAN DECEMBER 22, 2022



DENTAL ENROLLMENT FORM

8170 33rd AVENUE SOUTH, PO BOX 297
MINNEAPOLIS, MN 55440-0297

NAME OF EMPLOYER, GROUP NUMBER, SITE, DENTAL PLAN, DATE OF FULL-TIME EMPLOYMENT, COVERAGE EFFECTIVE DATE

APPLICANT: COMPLETE ALL UNSHADED AREAS

APPLICANT'S LAST NAME (LEGAL NAME), DATE OF BIRTH

FIRST NAME, M.I., SINGLE, MARRIED

STREET ADDRESS / APT NUMBER, CITY, STATE

ZIP CODE, COUNTY, APPLICANT'S TELEPHONE Home, Business

DENTAL PLAN SELECTED: (If choices are available)

WAIVING COVERAGE:

Coverage through other employer

Other

Please sign

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR EMPLOYEE AND EACH DEPENDENT BEING COVERED

Table with 5 columns: NAME, SOCIAL SECURITY NUMBER, DATE OF BIRTH (M/D/YYYY), RELATIONSHIP TO EMPLOYEE, SEX (M/F)

Do any of the dependent(s) listed above reside at a different address from the applicant?

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

At the time of your effective date with HealthPartners, will you, your spouse, and/or dependent(s) be insured by any other dental insurance company?

YES NO If YES, please complete the Coordination of Benefits Form. Check which type: Group Individual

CONDITIONS OF COVERAGE:

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 complies with the best of my knowledge.

Subject to revocation by me by written notice to my employer, I authorize the required deduction (if any) from my wages. I have read and agree with the terms as stated on this application.

I UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMISSION OF RELEVANT INFORMATION IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIMS, CANCELLATION OR RECISSION OF COVERAGE.

SIGNATURE OF EMPLOYEE (required), DATE SIGNED, SIGNATURE OF EMPLOYER (optional), DATE SIGNED