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

2022 Monthly Premiums

Single	$57.11
Single +1	$122.40
Family	$187.67

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 17, 2021

DENTAL ENROLLMENT FORM

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

NAME OF EMPLOYER			GROUP NUMBER	SITE
DENTAL PLAN	❑ NEW HIRE ❑ RETIREE ❑ OPEN ENROLLMENT	❑ EARLY RETIREMENT ❑ COBRA ❑ LIFE EVENT	DATE OF FULL-TIME EMPLOYMENT: ____ /____ / 20____	COVERAGE EFFECTIVE DA TE: ____ /____ / 20____

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

NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH (M/D/YYYY)	RELATIONSHIP TO EMPLOYEE	SEX (M/F)
			SELF	

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 dat e 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. By acceptance of coverage and upon signing this Enrollment Form, I authorize HealthPartners, and others it designates, to share information about me with any medical provider, plan sponsor, or other entity, where such information is reasonably necessary for treatment, payment or health care operations. I understand that HealthPartners may release information regarding services provided under my health benefits contract when requested by the organization sponsoring my benefits plan.

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

The HealthPartners family of health plans are underwritten and/or administered by HealthPartners, Inc., Group Health, Inc., HealthPartners Insurance Company or HealthPartners Administrators, Inc. Fully insured Wisconsin plans are underwritten by HealthPartners Insurance Company.

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