

NAME OF EMPLOYER _____	GROUP NUMBER _____	EFFECTIVE DATE OF CHANGE: _____
SUBGROUP CHANGE FROM _____ To _____	EMPLOYEE STATUS Active Retired COBRA	

EMPLOYEE: COMPLETE ALL UNSHADED AREAS If you are requesting to change your clinic, you DO NOT need to complete this form. Simply call Member Services at the phone number on the back of your member ID card.

EMPLOYEE'S LAST NAME (LEGAL NAME) _____ DATE OF BIRTH _____

FIRST NAME _____ M.I. _____ SOCIAL SECURITY _____

CHANGE of ADDRESS STREET ADDRESS _____ APT. NO. _____ WORK TELEPHONE _____

CITY _____ STATE _____ Zip _____ HOME TELEPHONE _____

CHANGE of NAME FROM: _____ To: _____

CHECK TYPE OF PLAN(S) AFFECTED BY CHANGE: MEDICAL DENTAL MEDICAL AND DENTAL

CANCELLATION OF COVERAGE

CANCELLATIONS	REASONS FOR CANCELLATION
Cancel all coverage	Employee terminated Moved outside of area Dissatisfied
Cancel all dependent coverage only	Employee now ineligible Divorce Death
Cancel coverage only on the dependent(s) listed below	Dependent now ineligible Other
	Last date of eligibility _____

COBRA CONTINUATION Qualifying event: _____ Event Date _____

MEDICAL PLAN CHANGE: DENTAL PLAN CHANGE:

from Plan _____ from Plan _____

to Plan _____ to Plan _____

If you have dependents, see below. This change may only be made upon renewal. Once change is made, plan election will remain in force until next renewal date.

ADDITIONS TO COVERAGE Add coverage on the dependents listed below. Indicate reason for change:

Birth _____ Life event _____ Date _____

Married on: _____

DEPENDENT INFORMATION Complete the following information for each dependent affected by the change. Please be sure to list clinic choice for each dependent.

LAST NAME (IF DIFFERENT)	FIRST NAME	MI	DATE OF BIRTH	SEX (M/F)	GENDER (M/F/U)	SOCIAL SECURITY NUMBER	RELATIONSHIP TO EMPLOYEE	CLINIC NUMBER*

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

No Yes 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 health insurance company?

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

I UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMISSION OF RELEVANT INFORMATION IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIMS OR CANCELLATION OF COVERAGE. If I choose to electronically sign my name, I am agreeing to conduct transactions electronically and intend for my electronic signature to have the same effect as my written signature.

SIGNATURE OF EMPLOYEE DATE SIGNED SIGNATURE OF EMPLOYER DATE SIGNED

**Primary clinic plans only*

The HealthPartners family of health plans is 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. HealthPartners UnityPoint Health plans are underwritten and/or administered by HealthPartners UnityPoint Health, Inc. or through its subcontractor HealthPartners Administrators Inc., a subsidiary of HealthPartners, Inc.