HealthPartners®

CHANGE FORM

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

NAME OF EMPLOYER	GROUP NUMBER	EFFECTIVE DATE OF CHANGE: ____ /____ / 20____
SUBGROUP CHANGE FROM _____ TO _____	EMPLOYEE STATUS ❑ Active / New hire ❑ Retired ❑ COBRA	EMPLOYEE DISABILITY* ❑ Yes ❑ No

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 (952) 883-5000 or 1-800-833-2177.

EMPLOYEE'S LAST NAME (LEGAL NAME)			DATE OF BIRTH ____ /____ / _____
FIRST NAME		M.I.	SOCIAL SECURITY NO.
❑ **CHANGE ADDRESS** TO: STREET ADDRESS		APT. NO.	WORK TELEPHONE ( ) -
CITY	STATE	ZIP	HOME TELEPHONE ( ) -
❑ **CHANGE NAME** FROM:		TO:	

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

❑ **CANCELLATION OF COVERAGE**

CANCELLATIONS
- ❑ Cancel all coverage
- ❑ Cancel all dependent coverage only
- ❑ Cancel coverage only on the dependent(s) listed below

REASONS FOR CANCELLATION
- ❑ Employee terminated
- ❑ Employee now ineligible
- ❑ Dependent now ineligible
  Last date of elibility ____ /____ / _____
- ❑ Moved outside of area
- ❑ Divorce
- ❑ Other _____
- ❑ Dissatisfied
- ❑ Death

❑ **CHANGE OF COVERAGE** ❑ Cobra Continuation Qualifying event: Event Date ____ /____ / _____

❑ **MEDICAL PLAN CHANGE** From:
- ❑ **Open Access** to **Primary Clinic** Clinic # _____
- ❑ **Primary Clinic** to **Open Access**
- ❑ **Plan** _____ to **Plan** _____

❑ DENTAL PLAN CHANGE From:
- ❑ **Open Access** to **Select**
- ❑ **Select** to **Open Access**
- ❑ **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
- ❑ Married on ____ /____ / _____
- ❑ Other _____

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)	SOCIAL SECURITY NUMBER	RELATIONSHIP TO EMPLOYEE	CLINIC NUMBER	DISABILITY* (Y/N)
			____ /____ / _____					
			____ /____ / _____					
			____ /____ / _____					
			____ /____ / _____					

Federal Medicare legislation now requires this information. If you have questions, contact Member Services.

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 health insurance company?
❑ YES ❑ NO If YES, please complete the Coordination of Benefits Form. Check which type: ❑ Group ❑ Individual

OTHER INSURANCE INFORMATION Failure to complete this section may result in pre-existing condition limitation.

Do you or any family member included in this application currently have or have you (they) had any health coverage wihin the past 63 days?
❑ YES ❑ NO If YES, you must provide the coverage history for the past 18 months in the spaces below:

PERSON'S NAME	INSURANCE COMPANY NAME, CITY, STATE TELEPHONE NUMBER	EFFECTIVE DATE	TERMINATION DATE
		____ /____ / _____	____ /____ / _____
		____ /____ / _____	____ /____ / _____
		____ /____ / _____	____ /____ / _____

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:

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

FOR PLAN USE ONLY	ME	DE	SUBGROUP	COB	EFFECTIVE DATE

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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