HEALTH TRADITION

Send to:
Health Tradition Health Plan
PO Box 21171
Eagan, MN 55121

Member Enrollment Form

Please complete every section and every field on this form. We cannot process applications that are not fully filled out.

Section 1 – Employee Information

Employee Name (Last, First, Middle Initial) _____

Gender ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

_____

Street Address (or PO Box) **City** **County** **State** **Zip**

_____

Date of Birth (MM/DD/YYYY) **Telephone Number** **Email Address**

_____

Social Security Number **Subscriber Number** (not applicable for first time enrollment)

Are you: ☐ Totally disabled? ☐ On sick leave? ☐ On medical leave? ☐ Retired? ☐ On COBRA?

If yes, provide start date (MM/DD/YYYY): _____ **Full Name of Primary Care Provider**: _____

Section 2 – Employment Information (please contact your employer for assistance if needed)

Employer Name _____

_____

Health Tradition Group Number **First Day Worked** (MM/DD/YYYY) **Average Hours Worked Per Week**

_____

Occupation

Section 3 – Reason for Application

Choose one of the following events:

☐ New employee
☐ Rehire
☐ Return from layoff
☐ Return from leave
☐ Late applicant
☐ Other

☐ Group annual enrollment
☐ Marriage
☐ Divorce
☐ Birth/adoption/placement for adoption
☐ Loss of other group health coverage (please include proof of loss)

☐ Moved into or out of plan service area
☐ Change in work hours
Indicate number of hours per week you *were* working: _____hours
☐ Change of occupation:
Previous Occupation:_____

Date that the event indicated above occurred (MM/DD/YYYY): _____

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Employee Name: _____

Section 4 – Type of Coverage Selected

To determine which plan you are eligible for, please check with your employer.

☐ **Health** If multiple plans are offered, please indicate your selected plan option: _____

Type of coverage: ☐ Single ☐ Employee & Spouse ☐ Employee & Children ☐ Family

Section 5 – Waiver of Coverage

Health Waiver

I understand that I am eligible to apply for group health coverage through my employer. I do NOT want and hereby waive group health coverage for:

☐ Myself ☐ My spouse ☐ My domestic partner (if eligible) ☐ My dependent child or children (all)

☐ Me, my spouse/domestic partner, and my dependent child or children

☐ Only the following dependent child or children: _____

Reason for waiver:

☐ Persons listed above have other insurance ☐ Other

☐ My earnings are such that I would have to pay more than 10% of my annualized gross earnings toward health insurance

I understand that if I do not apply for health coverage when initially eligible and instead apply later, I and my dependents may have to exhaust a 12-month waiting period before coverage is effective.

Signature: _____ Date: _____

Section 6 – Dependent Information

Only list individuals enrolling. You must enter Social Security Numbers. Adult children are eligible for coverage up to the end of the month in which they turn age 26.

1. **Spouse/Domestic Partner Name** (Last, First, Middle Initial) _____

Gender ☐ Male ☐ Female **Type of Coverage** ☐ Health **Relationship** ☐ Spouse ☐ Domestic Partner (if eligible)

_____

Date of Birth (MM/DD/YYYY) **Social Security Number** **Full Name of Primary Care Provider**

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Employee Name: _____

Section 6 – Dependent Information, continued

2. Dependent Name (Last, First, Middle Initial) _____

Gender ☐ Male ☐ Female **Coverage Type** ☐ Health **Relationship** ☐ Child ☐ Stepchild ☐ Grandchild ☐ Legal Ward

_____

Date of Birth (MM/DD/YYYY) **Social Security Number** **Full Name of Primary Care Provider**

3. Dependent Name (Last, First, Middle Initial) _____

Gender ☐ Male ☐ Female **Coverage Type** ☐ Health **Relationship** ☐ Child ☐ Stepchild ☐ Grandchild ☐ Legal Ward

_____

Date of Birth (MM/DD/YYYY) **Social Security Number** **Full Name of Primary Care Provider**

4. Dependent Name (Last, First, Middle Initial) _____

Gender ☐ Male ☐ Female **Coverage Type** ☐ Health **Relationship** ☐ Child ☐ Stepchild ☐ Grandchild ☐ Legal Ward

_____

Date of Birth (MM/DD/YYYY) **Social Security Number** **Full Name of Primary Care Provider**

5. Dependent Name (Last, First, Middle Initial) _____

Gender ☐ Male ☐ Female **Coverage Type** ☐ Health **Relationship** ☐ Child ☐ Stepchild ☐ Grandchild ☐ Legal Ward

_____

Date of Birth (MM/DD/YYYY) **Social Security Number** **Full Name of Primary Care Provider**

6. Dependent Name (Last, First, Middle Initial) _____

Gender ☐ Male ☐ Female **Coverage Type** ☐ Health **Relationship** ☐ Child ☐ Stepchild ☐ Grandchild ☐ Legal Ward

_____

Date of Birth (MM/DD/YYYY) **Social Security Number** **Full Name of Primary Care Provider**

Section 7 – Other Health Insurance Information

Will you or any family member(s) continue or maintain any other health insurance or self-funded group medical plan coverage in addition to the coverage being applied for today? ☐ No ☐ Yes

If yes, please complete the following:

1. Family Member Name _____ **Subscriber Name (of other plan)**_____

_____

Insurance Company/Plan **Group Number** **Effective Date of Coverage** **Cancellation Date (if applicable)**

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Employee Name: _____

Section 7 – Other Health Information, continued

2. Family Member Name _____ **Subscriber Name (of other plan)** _____

_____

Insurance Company/Plan **Group Number** **Effective Date of Coverage** **Cancellation Date (if applicable)**

3. Family Member Name _____ **Subscriber Name (of other plan)** _____

_____

Insurance Company/Plan **Group Number** **Effective Date of Coverage** **Cancellation Date (if applicable)**

Is your spouse or domestic partner, or are any of your dependent children, disabled? ☐ No ☐ Yes

If yes, please list their name(s), nature of disability, and Medicare number (if applicable):

_____

_____

Does a divorce decree affect insurance coverage for any dependent children covered by your policy?
☐ No ☐ Yes *If yes, please send a copy of the portion of the divorce decree that stipulates health coverage.*

Section 8 – Medicare Information

Are you, or any of your family members, eligible for Medicare? ☐ No ☐ Yes

If yes, please complete the following or attach a copy of your Medicare card:

Name of person covered by Medicare: _____

Medicare Number: _____

Reason for Medicare Eligibility ☐ Over age 65 ☐ Disability ☐ End Stage Renal Disease (ESRD)

Effective Dates: Part A:_____ Part B:_____ Part C (Medicare Advantage):_____ Part D:_____

Section 9 – Signature and Authorization

You must sign and date below if enrolling:

To the best of my knowledge, I agree that the information I have provided is true and accurate. I understand that Health Tradition Health Plan reserves the right to accept or decline this application in whole or in part.

I hereby apply for group coverage and authorize my employer to make all necessary salary deductions from my earnings to cover any contribution for group coverage.

_____

Signature **Date** (MM/DD/YYYY)