

Plan Information

Choose only one of the following deductible plans: \$300 - 80% \$500 - 80% \$1,000 - 80% \$2,000 - 100%

Requested Effective Date (mm/dd/yy) ____/____/____

HealthPartners will notify you as to the actual effective date. The effective date is the day we receive the enrollment form and full payment in our office, or the requested effective date, whichever is later provided the effective date is no more than 60 days beyond the signature date of your enrollment form.

Number of Days Coverage Requested 30 60 90

Eligibility Information

	YES	NO
Is the Lead Applicant (applicant seeking to be primary insured or contract holder) less than 90 days of age or older than 64 years?	<input type="checkbox"/>	<input type="checkbox"/>

Is any person applying for coverage NOT a legal resident or citizen of the United States?	<input type="checkbox"/>	<input type="checkbox"/>
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Does any person applying for coverage:

Have other health care insurance coverage in force during the period for which coverage is requested, including Medicare?	<input type="checkbox"/>	<input type="checkbox"/>
<i>(Health care insurance coverage does not include any applications currently pending.)</i>		
Have a history of being declined insurance by any health carrier?	<input type="checkbox"/>	<input type="checkbox"/>

Is any person applying for coverage:

Currently pregnant; or is your spouse, significant other, or other dependent currently pregnant or do you plan to add a dependent as a result of a birth or adoption?	<input type="checkbox"/>	<input type="checkbox"/>
Planning to add any other dependent?	<input type="checkbox"/>	<input type="checkbox"/>
Currently confined to or in any health care facility?	<input type="checkbox"/>	<input type="checkbox"/>
Consulting a medical professional for weight or related concerns?	<input type="checkbox"/>	<input type="checkbox"/>

Within the past five years, has any person applying for coverage had a diagnosis of, received treatment for, or consulted with a provider concerning:

Heart disorder, stroke or other circulatory disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Cancer?	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis, Lupus, rheumatoid arthritis or any other auto-immune disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease or ulcerative colitis?	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disorder or liver disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol/chemical dependency or abuse?	<input type="checkbox"/>	<input type="checkbox"/>
Chronic lung disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Chronic blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>

STOP!	<p>IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS THE POLICY CANNOT BE ISSUED.</p> <p>Conditions not specifically listed in the questions above may still not be covered if they are preexisting conditions. Please see the Signature & Acknowledgement section for a definition of pre-existing conditions.</p>
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If you have any questions about this application, please contact HealthPartners Individual Sales department at 952-883-5600 or 1-800-247-7015. Or log onto healthpartners.com/individual.

Signature & Acknowledgment

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 complete to the best of my knowledge and to accurately represent the health of those persons applying for coverage. I understand that these statements, answers and subsequent information I provide are the basis for my coverage and will be made a part of my HealthPartners Short Term Health Plan contract. I understand that I must update this enrollment form to include any change in condition or disease affecting applicants for this coverage, that occur between the date I complete and sign this enrollment form and the date HealthPartners receives this enrollment form or the requested effective date for coverage, whichever is later. I understand that providing false information or omitting relevant information on this enrollment form may result in the denial of claims or rescission of coverage back to the effective date of coverage.

I understand that I and the other applicants listed on this enrollment form may be ineligible for coverage. If I have been a HealthPartners short term individual plan member in the past with claims investigated for fraud, I understand that I may not be eligible for enrollment at HealthPartners discretion. I understand that I am applying for an instant issue policy and may not withdraw my enrollment form once submitted. I understand that full payment must be submitted with this enrollment form or the policy will not be issued. I understand that if my dependent applicants and I are eligible for coverage and a policy is approved and issued, HealthPartners will notify me of the effective date of such policy. The effective date of coverage is the day HealthPartners receives this enrollment form or the effective date requested, whichever is later, provided that the effective date is no more than 60 days beyond the signature date on this enrollment form. Furthermore, I understand that the only dependents that can be added under this policy are children who are newly born or adopted per state law.

I understand that pre-existing conditions are not covered by this plan. A pre-existing condition is, with respect to coverage, any injury, illness, or condition for which the insured(s) has received medical treatment, care, advice or diagnosis, symptoms, or a manifestation before the effective date of the coverage. I also understand that any condition discovered and or treated during the term of this short term policy will be deemed a pre-existing condition in any subsequent short term policy to continue coverage and will not be covered by the subsequent policy.

I understand that if I terminate this short term coverage, that no cash refund will be issued. However, if HealthPartners approves my concurrent application for conventional individual coverage and such coverage is offered and accepted, HealthPartners may apply, with my consent, any pre-paid premium from this short term plan to my HealthPartners conventional individual plan.

I authorize HealthPartners to obtain from providers of service and hospitals, the medical records (including mental and chemical health) relating to me and all other applicants that are necessary for: claims processing, including claims we make for reimbursement or subrogation; quality of care assessment and improvement; accreditation, credentialing, case management, care coordination and utilization management, disease management, the evaluation of potential or actual claims against us, fraud and abuse investigations, auditing and legal services, and other access and use without further authorization if permitted or required by another law. I also authorize HealthPartners to release information related to my HealthPartners enrollment (including information from my medical records) to my insurance broker. A photocopy of this authorization shall be as valid as the original and remains in effect unless it is revoked I understand that some clinics may require a separate authorization for the release of information for the purposes listed above. I agree to sign such releases for such purposes.

I authorize HealthPartners to release information related to my HealthPartners enrollment (including information from my medical records) to the lead applicant. This authorization is intended to cover the release of information described above related to me, my spouse, and my minor dependent children for whom I have applied for HealthPartners Short Term Health Plan coverage.

Please keep a copy of the completed enrollment form for your records. It will become a part of your contract if the enrollment is accepted.

All adult enrollees and the parent/legal guardian of all minor enrollees must sign here. Dependent children age 18 and older must sign.

X _____ Date _____
Signature of Primary Proposed Insured

X _____ Date _____
Signature of Spouse or Other Insured (if proposed to be insured)

X _____ Date _____
Signature(s) of Other Dependents 18 or Older

X _____ Date _____
Signature(s) of Other Dependents 18 or Older

Any person who submits an enrollment form or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Broker's name, if applicable. (Please print.) _____ Broker # _____ Date _____

HealthPartners Short Term Health Plan

Underwritten by HealthPartners Insurance Company



Premium Worksheet

Use this worksheet to calculate your premium rates and submit your payment for coverage by the HealthPartners Short Term Health Plan. Rate tables for this plan appear on the back of this page.

The premium for this plan is determined by the age of each individual seeking coverage, your plan selection, where you live and the number of days you wish to be covered.

If you are a single adult applicant, simply locate the appropriate rate for your age, location and plan selection from the rate table and add the \$20 application fee.

Covering a spouse or dependents?

To calculate a family premium, find the appropriate rates for your self and adult spouse. Add in amount(s) for any child dependent(s) ages 90 days to 25 years old, plus the \$20 application fee. Premiums are charged for a maximum of three children per family, and only one plan and coverage term is allowed per family. If you are buying the plan on behalf of a child, ages 90 days to 18 years only, use the 90 days to 18 age rate for the oldest child. Any additional children will be charged the dependent child rate.

Important

If you or your spouse have a birthday during the policy term, and it moves you into a different age bracket, you will need to adjust your premium amount accordingly. For help, call HealthPartners Individual Sales at 952-883-5600 or 800-247-7015 between 8 a.m. and 6 p.m. Monday-Friday.

HealthPartners requires payment in full at time of enrollment, including the \$20 application fee. If you do not include full payment, your application will be returned to you. If you are ineligible for coverage, your entire payment will be returned to you.

Calculate your premium

Applicant Rate		\$	_____
Spouse Rate		\$	_____
Dependent Child Rate	Child 1	\$	_____
	Child 2	\$	_____
	Child 3	\$	_____
Application Fee		\$	\$20.00
Total Premium and Application Fee		\$	_____

Choose your method of payment

_____ I have enclosed a check for the Total Premium and Application Fee.

_____ Charge my credit card for the Total Premium and Application Fee.

_____ Visa _____ MasterCard _____ American Express _____ Discover

Card Number _____

Exp. Date _____ / _____

Signature _____

Return this premium worksheet with your Short Term Health Plan enrollment form.