HEALTH TRADITION

Member Enrollment Form

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

Please complete every section and every field on this form. Applications not completed in full cannot be processed.

Section 1–Employee Information

Employee Name (Last, First, Middle Initial)

Gender
☐ Male ☐ Female

Marital Status
☐ Single ☐ Married

Street Address (or P. O. Box) **City** **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/YYY):_____

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/Week**

Occupation **Job Location**

Section 3–Reason for Application

Choose one of the following events:

☐ New employee
☐ Rehire
☐ Return from layoff
☐ Return from leave
☐ Loss of other group health coverage **(please include proof of loss)**
☐ Group annual enrollment
☐ Late applicant
☐ Birth, adoption/placement for adoption
☐ Marriage
☐ Change in work hours. Indicate number of hours per week you *were* working:_____hours
☐ Divorce
☐ Change of Occupation:
Previous Occupation: _____
☐ Other: _____

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 plan option selected: _____

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

Section 5–Waiver of Coverage (Please complete if you are eligible but NOT electing 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(ren)

☐ Me, my spouse/domestic partner, and my dependent child(ren)

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. Social Security Numbers must be entered. Adult children are eligible for coverage up to the end of the month in which they turn age 26)*

Spouse/Domestic Partner Name (Last, First, Middle Initial) **Date of Birth** (MM/DD/YYYY) **Social Security Number**

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

Dependent Name (Last, First, Middle Initial) **Date of Birth** (MM/DD/YYYY) **Social Security Number**

Gender ☐ Male ☐ Female **Type of Coverage** ☐ Health **Relationship** ☐ Child ☐ Stepchild ☐ Legal Ward ☐ Other: _____

Dependent Name (Last, First, Middle Initial) **Date of Birth** (MM/DD/YYYY) **Social Security Number**

Gender ☐ Male ☐ Female **Type of Coverage** ☐ Health **Relationship** ☐ Child ☐ Stepchild ☐ Legal Ward ☐ Other: _____

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Employee Name:____

Section 6–Dependent Information Continued

Dependent Name (Last, First, Middle Initial) **Date of Birth** (MM/DD/YYYY) **Social Security Number**

Gender ☐ Male ☐ Female
Type of Coverage ☐ Health
Relationship ☐ Child ☐ Stepchild ☐ Legal Ward ☐ Other: __________

Dependent Name (Last, First, Middle Initial) **Date of Birth** (MM/DD/YYYY) **Social Security Number**

Gender ☐ Male ☐ Female
Type of Coverage ☐ Health
Relationship ☐ Child ☐ Stepchild ☐ Legal Ward ☐ Other: __________

Dependent Name (Last, First, Middle Initial) **Date of Birth** (MM/DD/YYYY) **Social Security Number**

Gender ☐ Male ☐ Female
Type of Coverage ☐ Health
Relationship ☐ Child ☐ Stepchild ☐ Legal Ward ☐ Other: __________

Section 7–Other Health Insurance Information

Are your spouse/domestic partner or any of your dependent children disabled? ☐ No ☐ Yes

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

____

____

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

If yes, please complete the following:

Family Member Name	Subscriber Name (under Other plan)	Insurance Company/ Plan	Group Number	Type of Coverage	Effective Date Of Coverage	Cancellation Date (if Applicable)
1.______				☐ Single ☐ Family	______	______
2.______				☐ Single ☐ Family	______	______
3.______				☐ Single ☐ Family	______	______

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.

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Employee Name:_____

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 ☐ End-Stage Renal Disease (ESRD) ☐ Total Disability

Effective Dates: Part A_____ Part B_____ Part C (Medicare Advantage)_____ Part D _____

Section 9–Signature and Authorization (Must sign and date 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)