



# HealthPartners Health Plan

## *Empower HSA for Individuals & Families*

### *Application Process:*

#### How To Apply:

- Read the instructions on page 2 of this document.**
- Complete the application, being sure to answer all questions completely.
- Do not send money with your application. You will be notified in writing by HealthPartners if your application has been accepted and where to send your first months premium.**
- Sign and date the application. Applications must be received within 30 days of the signature date.
- Return the application to the address below, or fax directly to 763-390-3129. **Note:**  
If you choose to fax the application fax this checklist so that you may receive application status updates.

**All American Health Insurance 515 Pineview Lane N. Plymouth, MN 55441**

- If coverage is issued, you will receive your ID card(s), membership contract and member handbook.
- To provide you with application status updates complete the following contact information.

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
E-mail Address \_\_\_\_\_  
Daytime Phone \_\_\_\_\_

There is no guarantee the coverage will be offered. **Do not cancel your existing medical policy until you have verification and policy certificate. Should you be declined coverage from any private health insurer, you would in most cases qualify for the Minnesota Comprehensive Health Association (MCHA) health coverage <http://www.mchamn.com>**

**Contact Murray Herstein at 612.991.3546 or email [murrayh@comcast.net](mailto:murrayh@comcast.net) for help with this application or enrollment needs.**

## Empower HSA Midwest Choice<sup>SM</sup> Plan

Underwritten by Midwest Assurance Company, a related company of HealthPartners, Inc.

This plan is intended to qualify as a high deductible health plan that may be paired with a Health Savings Account (HSA), however, you should check with your tax advisor for guidance on your particular situation.

### Enrollment Form Instructions

Please use ink when completing this form

The attached form is your application for an Empower HSA Midwest Choice Plan. Please carefully review the instructions below before completing the enrollment form.

1. Answer all questions completely and accurately for each person to be covered. Remember, this enrollment form provides the evidence of insurability and, as such, will be the basis for coverage and premium rates if you are accepted into the plan. The enrollment form will be returned to you if all items are not completed.
2. Complete all sections in full. Any information that is left out delays processing of your enrollment form. Please note that number 13 requests the explanation of any YES answers to questions in numbers 10 and 11. You have two options to explain these answers. Please provide the details.
3. Indicate the deductible plan you are applying for in Number 1.
4. Indicate if you are opting out of chemical dependency coverage in Number 2. You are only eligible for this option upon initial enrollment.
5. Carefully read, sign and date the enrollment form. All adults, including dependent children age 18 and over, must sign. HealthPartners must receive your enrollment form within 30 days of the signature date or it will be returned to you. If any applicant is under age 18, the parent or legal guardian must sign. Your enrollment form is valid for a period of 60 days from the date you sign it. After 60 days a new form must be completed in full.
6. Make a copy of the enrollment form for your records. Fold and mail the four-page original to HealthPartners in the enclosed envelope. Do not send any premium until requested.  
Upon receipt of your enrollment form, we will review it for completeness. We may need to contact you for further details or we may need to request health history information from other health care providers. You will be notified of any such request. Our speed of processing your enrollment form depends on the promptness of these providers. You may be billed from your health care provider for the necessary records.
7. After your enrollment form has been reviewed, we will notify you of our decision. If you are accepted into an Empower HSA Midwest Choice Plan, an acceptance letter that includes your premium amount will be sent to you. Normal processing time is three to four weeks, but it may take longer if information from other health care providers is required to complete your enrollment form.

The effective date of coverage is determined after the underwriting process is completed and the premium is received. Coverage always begins on the 1st or 16th of a month. Coverage cannot be retroactive. When your premium is received, a letter of confirmation with the effective date of coverage will be sent to you.

If declined, we will notify you of the reason(s) for the declination.

Deductibles and out-of-pocket maximums are based on the Consumer Price Index and may change annually.

**Providing false information in this enrollment form may result in the denial of claims or rescission of coverage. Please note there is no coverage provided for maternity care for the first 18 months of plan coverage. Please review your summary of benefits for additional details.**

You may fax your application to the Individual Sales Department at 952-883-5260. If you have any questions concerning your enrollment form, please contact HealthPartners at 952-883-5600 or 1-800-247-7015. Thank you for requesting coverage from HealthPartners.

*HealthPartners' mission is to improve the health of our members, our patients and the community.*



5. **CURRENT MEDICAL CLINIC:** Name, address and phone number of your family physician(s). (If there is no regular physician, please give the name and address where each applicant last received care.) Use additional sheets if necessary.

APPLICANT NAME	CLINIC NAME	PHYSICIAN'S NAME	COMPLETE CLINIC ADDRESS & PHONE NUMBER	DATE OF LAST PHYSICAL EXAM

6. **List current health plan companies for each person in #3.** (Please attach a separate sheet if additional space is needed.)

APPLICANT NAME(s)	NAME OF INSURER	ADDRESS OF INSURER (CITY, STATE, ZIP)	TERMINATION DATE

7. **TOBACCO USE/CESSATION:** Has any person listed in #3:

Used any tobacco or tobacco cessation product in the last 12 months?  YES  NO  
 If YES, who? \_\_\_\_\_

8. **FOREIGN TRAVEL:** Does anyone have plans for foreign travel within the next six months?  YES  NO  
 If YES, who? \_\_\_\_\_ When? \_\_\_\_\_ For how long? \_\_\_\_\_

9. **PREGNANCY:** Are any persons listed in #2 now pregnant or exhibiting symptoms of pregnancy?  YES  NO  
 If YES, who? \_\_\_\_\_ When is birth expected? \_\_\_\_\_  
 For each female person, list date of last menstrual cycle.  
 Name \_\_\_\_\_ Date \_\_\_\_\_ Name \_\_\_\_\_ Date \_\_\_\_\_

**Complete information is required below for each applicant. If you answer YES to any of these questions, please explain in section 13, indicating the person whom the YES answer involves.** (Please attach a separate sheet if additional space is needed.)

10. **HEALTH HISTORY: Has any person listed in #3 EVER sought medical care or advice or been treated for or been diagnosed with:**  YES  NO
- a. Had a physical examination, electrocardiogram, laboratory or diagnostic test, or x-ray (other than dental)?  YES  NO
  - b. Mental, emotional or personality disorders, including counseling or hospitalization?  YES  NO
  - c. Any disease or disorder of the eyes, ears, nose, throat, tonsils or sinuses?  YES  NO
  - d. Diabetes or sugar, albumin?  YES  NO  
 If YES, Last hemoglobin A1C Reading \_\_\_\_\_ Date \_\_\_\_\_
  - e. Chest pain, heart murmur, angina, high blood pressure or other heart or circulatory disorder?  YES  NO
  - f. Varicose veins, varicose ulcer, phlebitis, anemia, blood clots or other related disorder?  YES  NO
  - g. Stroke, epilepsy, fainting, dizziness, convulsions, headaches, migraines or any disease or disorder of the brain or nervous system?  YES  NO
  - h. Tuberculosis, asthma, allergies, hay fever, lung, emphysema or respiratory disorder?  YES  NO
  - i. Stomach or other ulcer, hernia, colitis, diarrhea, hepatitis, or any disorder of the liver, gall bladder, stomach, intestine or rectum?  YES  NO
  - j. Kidney, bladder, prostate or any urinary disorder?  YES  NO
  - k. Any disease or disorder of the breast or reproductive organs, abnormal menstrual periods, infertility or any sexually transmitted disease?  YES  NO
  - l. Arthritis, rheumatism or any disorder of the joints, muscles or bones, any knee, neck, back or spinal trouble, neuritis, sciatica or scoliosis?  YES  NO
  - m. Eating disorders, unexplained weight loss, fatigue, fever, enlarged lymph nodes, skin lesions, or any other related disorder?  YES  NO
  - n. Cancer or tumors, cysts or growths of any kind?  YES  NO
  - o. An immune system disorder?  YES  NO
  - p. Been convicted of DWI or DUI? Had his/her driver's license suspended or revoked for driving while under the influence of alcohol or a controlled substance?  YES  NO  
 If yes, list who and dates. \_\_\_\_\_
  - q. Received inpatient or outpatient treatment for alcohol or drug use?  YES  NO  
 If yes, who and when? \_\_\_\_\_
  - r. Been told to modify or restrict eating, drinking or living habits for health purposes?  YES  NO
  - s. A blood disorder?  YES  NO
  - t. Has anyone listed in #3 been hospitalized within the past 5 years?  YES  NO
  - u. Had or been advised to have surgery?  YES  NO

Please sign if applying via FAX: X Lead Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

11. Has any person listed in #3 EVER: .....YES NO
- a. Been diagnosed or treated for a medical condition not already listed above? .....
- b. Had any life or health insurance declined, postponed or modified, or had a waiver, rider or extra premium added? .....
- c. Received payment for medical disability, illness or injury? .....

12. **MEDICATIONS:** For each person listed in #3 please complete the following:  
(Please attach a separate sheet if additional space is needed.)

**Current Medications:**

APPLICANT	name of medication	dosage/mg per use	# of doses		reason for medication
			taken per day	# of refills per year	

**Medications used in the last 12 months:**

APPLICANT	name of medication	dosage/mg per use	# of doses		reason for medication	date last taken
			taken per day	# of refills per year		

13. **EXPLANATIONS:** Give the following information regarding all YES answers to questions for each person to be covered. You may also include copies of medical records. **(It will be your responsibility to pay any fees that may be charged for obtaining these records.)** Please attach a separate sheet if additional space is needed.

Question number and letter	Name of person as listed in number 3	Explanations of "YES" answers in sections 10 and 11 (Include name of condition, reason treated or other details)	Date(s) occurred or when treated	Remaining effects	Complete name and address of physician and/or hospital where treated

PLEASE SIGN IF APPLYING VIA FAX: X Lead Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

**IMPORTANT INFORMATION ABOUT THE MINNESOTA INSURANCE FAIR INFORMATION REPORTING ACT**

HealthPartners complies with the Minnesota Insurance Fair Information Reporting Act. This law gives you specific rights to receive notice that HealthPartners may be collecting personal information from third parties about you during the health underwriting process. It is a HealthPartners policy that we will not release personal information outside of our companies without the express written consent of the applicant or patient. For this reason, HealthPartners does not share personal information about individuals with insurance or health underwriting support organizations. You have the right to see the personal information we collect about you and there is a procedure to correct inaccurate personal information about you in our possession. You may contact the HealthPartners Individual Sales Department by calling 952-883-5600 for further information on your rights.

**CONDITIONS OF ACCEPTANCE**

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 rate and are made a part of my HealthPartners Individual plan contract.

**Furthermore, I understand that this enrollment form must be updated by me to include any condition or disease that may occur between the date of this enrollment form and the effective date of coverage.** I understand that this enrollment form may be denied in whole or in part. I understand that any of the applicants may be denied. I may withdraw this enrollment form at any time during processing with written notification. I understand that if my enrollment form for new or additional coverage is accepted, the coverage will not be effective until after the premium is received and accepted by HealthPartners and I am notified of the effective date.

**I understand that there is no coverage provided for maternity care within the first 18 months of coverage. For specific benefit information see the Summary of Benefits included in your packet.**

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: enrollment, 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, underwriting; premium rating, the evaluation of potential or actual claims against us, 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 form to my insurance broker. A photocopy of this authorization shall be as valid as the original and remains in effect unless it is revoked. (Please note: some clinics may require a separate authorization.)

I authorize HealthPartners to collect personal motor vehicle driving records for me and my dependents. The information for which I authorize such release may be collected from brokers or other HealthPartners business associates. I authorize disclosure of such information solely for the purpose of assisting with the underwriting of the enrollment form.

This authorization is intended to cover the release of information described above related to me, as well as to my dependent children for whom I have applied for HealthPartners Individual coverage.

I understand that if I choose to be billed monthly, the payment must be automatically withdrawn from my bank account. If I enroll for an effective date on the 16th of the month, I understand that my first automatic withdrawal will be the equivalent of one and a half month's premiums. I also have the options of quarterly and annual billing.

**I understand that providing false information or omission of relevant information in this enrollment form may result in the denial of claims or rescission of coverage back to the effective date of 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.

Enrollee signature(s)

X \_\_\_\_\_ Date \_\_\_\_\_  
(applicant's signature)

X \_\_\_\_\_ Date \_\_\_\_\_  
(spouse's signature, if applying for coverage)

X \_\_\_\_\_ Date \_\_\_\_\_  
(dependent's signature, if age 18 or older)

X \_\_\_\_\_ Date \_\_\_\_\_  
(dependent's signature, if age 18 or older)

Guarantor/legal guardian signature (if any applicants are minors) X \_\_\_\_\_ Date \_\_\_\_\_

Please Note: An adult can only authorize the release of records for him or herself and minor children, not for a dependent spouse.

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

**Did you remember to select a deductible plan option?**