



## WELCOME!

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EXCEED<sup>SM</sup> AND EXCEEDCHOICE<sup>SM</sup> DENTAL PLANS

DENTAL ENROLLMENT FORM
8100 34TH AVENUE SOUTH, PO BOX 297
MINNEAPOLIS, MN 55440-0297

NAME OF EMPLOYER, GROUP NUMBER, SITE, DENTAL PLAN, APPLICANT'S LAST NAME (LEGAL NAME), FIRST NAME, M.I., DATE OF BIRTH (M/D/YY), SOCIAL SECURITY NUMBER, STREET ADDRESS/APT NUMBER, CITY, STATE, ZIP CODE, COUNTY, APPLICANT'S TELEPHONE, HOME, BUSINESS, MALE, SINGLE, FEMALE, MARRIED

APPLICANT'S PROVIDER/BENEFIT TIER SELECTION:

- TIER I - HEALTHPARTNERS CLASSIC NETWORK
TIER II - EXTENDED NETWORK

- WAIVING COVERAGE (CHECK ONE)
COVERAGE THROUGH ANOTHER EMPLOYER
OTHER

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR EACH DEPENDENT: (ATTACH AN ADDITIONAL SHEET IF NECESSARY)

Table with 5 columns: NAME: LAST, FIRST, M.I. SOCIAL SECURITY NUMBER, DATE OF BIRTH (MO/DAY/YR), RELATIONSHIP, SEX (M,F), DEPENDENT'S PROVIDER/BENEFIT TIER SELECTION: (CLINIC SELECTION REQUIRED FOR TIER I.)

Do all of the dependent(s) listed above reside at the same address as the applicant? YES NO

If last name is different for dependents, please explain why

Are any of the above listed dependent(s) age 19 or older, full-time students? YES NO

Table with 3 columns: NAME, SCHOOL, STATUS (Part-time, Full-time)

At the time of your effective date with HealthPartners, will you, your spouse and/or dependent(s) be insured by any other dental insurance company? YES NO

If YES, please complete the Dental Coordination of Benefits Form.

CONDITIONS OF COVERAGE: 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 complies with the best of my knowledge.

SIGNATURE OF APPLICANT, DATE SIGNED, FOR PLAN USE ONLY: PACKAGE CODE, SUBGROUP, COB, EFFECTIVE DATE, SIGNATURE OF EMPLOYER (OPTIONAL), DATE