McAlpin Agency, Inc.
3990 Central Avenue NE
Columbia Heights, MN 55421
(763) 788-9274
www.mcalpinagency.com

HealthPartners® Three for Free Individual Health Plan

Summary of Benefits

Balanced, affordable coverage
with immediate value

HealthPartners Three for Free individual plan is the coverage you need, including three free office visits each year

If you're looking for a plan that gives you more for your money, look no further:

- Your first three office or urgent care visits each year are free (you're responsible for your deductible on laboratory and radiology services)
- The first $200 of your preventive care each year is paid in full
- Generic prescription medication is available with a $5 copay
- Your first emergency visit per year is covered 100 percent after a $250 copay

How Three for Free works

Example	Cost of Care	Cost to Member
Leslie saw a doctor for sore throat. She was tested for strep.	$100 office visit	$30
	$30 strep test in lab	
Bill broke his arm playing softball and visited the emergency room for an X-ray and cast	$400 emergency room visit	$250
	$40 X-ray	
	$250 arm casting	

Note: These are examples. Your actual plan deductible and coinsurance may vary.

See the doctors you prefer

As a HealthPartners member, you have the freedom and convenience to see the doctors you choose with no need for referrals!

Receive the most benefit from your plan when you see a network provider. Select from more than 565,000 providers and more than 5,000 hospitals nationwide. Finding a network provider is easy. Visit **healthpartners.com/individual** and use the online provider search or contact us for a CD directory.

Access your healthy discounts and resources

Enjoy healthcare savings and resources available exclusively to HealthPartners members:

- Fitness club discounts
- Savings on exercise classes and sporting equipment
- Eyewear discounts
- Online health information library and cost calculators
- After-hours nurse advice phone lines

Manage your healthcare online

Create a personal account at **healthpartners.com** and get secure access to:

- Check your plan benefits
- View claims and Explanation of Benefits (EOB) details
- Get test results
- Track immunization records
- Create a directory of favorite providers
- Schedule appointments

Apply for a HealthPartners plan today

When you're ready to complete an application for a HealthPartners Three for Free plan, visit **healthpartners.com/individual** to apply online or talk to your broker. You can also complete an application and submit via mail or fax.

You must reside in Minnesota to apply for this plan.

Learn about other HealthPartners individual plans

We realize your healthcare needs change over time, and we have other plans to help to meet those needs:

Traditional – comprehensive coverage with a range of deductibles to help you manage your budget

Empower – a high-deductible plan that can be paired with a Health Savings Account (HSA) for financial control

Short Term – affordable, temporary coverage when you need immediate protection

Dental – budget-friendly plans you can customize to meet your needs.

Find help with your questions and decision

We understand that choosing a health plan for you and your family may be confusing. It's important to us that you get the help you need, so we have resources you can use to help make your decision:

Contact our friendly sales consultants Monday – Friday 8 a.m. to 6 p.m. Call at 952-883-5599 or 1-877-838-4949 or e-mail **individualsales@healthpartners.com**.

Visit **healthpartners.com/individual** and try our interactive plan selection tool. We'll ask you a few simple questions and, based on your responses, provide a quick recommendation for a plan we think best meets your needs.

Summary of Benefits

The following is a brief summary of the HealthPartners Three for Free individual coverage. For a detailed description of terms and conditions, refer to a HealthPartners Insurance Certificate or call 952-883-5599 or 1-877-838-4949.

	80% Plan Options		100% Plan Option	
	Deductible	Out-of-pocket maximum	Deductible	Out-of-pocket maximum
Calendar year deductible and out-of-pocket maximum Per person – for family deductible/maximum information, contact HealthPartners	$4,000	$6,500	$4,000	$4,000
	$5,000	$7,500	$5,000	$5,000
	$7,500	$10,000	$7,500	$7,500
	$10,000	$12,500	$10,000	$10,000
Preventive care - Routine physicals and eye exams	100% up to $200 maximum per year (no deductible), then 80% after deductible is met		100% up to $200 maximum per year (no deductible), then 100% after deductible is met	
Office visits - Illness or injury - Urgent care - Mental healthcare - Chemical healthcare	100% (no deductible) for first three visits, then 80% after deductible is met for additional visits		100% (no deductible) for first three visits, then 100% after deductible is met for additional visits	
Emergency care	One emergency visit per year for $250 copay, then 80% after deductible is met for additional visits		One emergency visit per year for $250 copay, then 100% after deductible is met for additional visits	
Inpatient and outpatient hospital care **Outpatient MRI and CT** **Laboratory services**	80% after deductible is met until out-of-pocket maximum is reached, then 100% coverage		100% after deductible is met	
Prescription medications	Generic: $5 copay (no deductible) Brand: 80% after deductible is met		Generic: $5 copay (no deductible) Brand: 100% after deductible is met	
Physical, occupational and speech therapy	80% after deductible is met, maximum of 20 visits per year		100% after deductible is met, maximum of 20 visits per year	
Behavioral healthcare **Durable medical equipment**	80% after deductible until out-of-pocket maximum is reached, then 100%		100% after deductible	
Home healthcare	80% after deductible is met, maximum of 120 visits per year		100% after deductible is met, maximum of 120 visits per year	
Well child services to age 6; immunizations to age 18 **Prenatal care**	100% (no deductible)		100% (no deductible)	
Maternity - Labor and delivery - Postnatal care	No coverage		No coverage	
	Deductible	Out-of-pocket maximum	Deductible	Out-of-pocket maximum
Out-of-network **Calendar year deductible** **Out-of-pocket maximum**	$8,000 $10,000 $15,000 $20,000	No maximum	$8,000 $10,000 $15,000 $20,000	No maximum
Out-of-network coverage	40% after deductible is met		50% after deductible is met	
Lifetime maximum per person **In and out-of-network**	$5 million			

Three simple steps to apply for a HealthPartners individual health plan

1. Choose a deductible that fits your needs and budget.

A deductible is the amount that each family member will pay upfront each year. Once you have paid that amount in medical expenses each year, HealthPartners pays 80 percent to 100 percent of expenses. Don't forget – with the Three for Free plan, your first three office or urgent visits per year are covered at 100 percent with no deductible!

If you're not sure which deductible is right for you and your family, contact HealthPartners. We're here to help you understand your options.

2. Complete an application online, via mail or fax or talk to your broker.

Visit **healthpartners.com/individual** for details. It's helpful to have the following information handy while you complete your application:

- Current and previous health insurance information
- Doctor's contact information
- Information about your health history and medications
- Payment information (payment for your first month's premium is due with your application)

3. Learn about the review process.

Applications for the HealthPartners Three for Free individual plan are reviewed by our underwriters, and you will be notified of a decision in one to two weeks. A decision on your application may take longer if additional medical information is needed. For full details on the application process, visit **healthpartners.com/individual**.

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healthpartners.com

The HealthPartners family of health plans are underwritten and administered by HealthPartners, Inc., Group Health, Inc., HealthPartners Insurance Company or HealthPartners Administrators, Inc.

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Important Information on HealthPartners Individual Health Plans

Provider Reimbursement

Our goal in reimbursing providers is to provide affordable care for our members while encouraging quality care through best care practices and rewarding providers for meeting the needs of our members. Several different types of reimbursement arrangements are used with providers. All are designed to achieve that goal. Some providers are paid on a “fee-for-service” basis, which means that the health plan pays the provider a certain set amount that corresponds to each type of service furnished by the provider.

Some providers are paid on a “discount” basis, which means that when a provider sends us a bill, we have negotiated a reduced rate on behalf of our members. We pay a predetermined percentage of the total bill for services.

Some providers are paid a “salary” with a possible additional payment made based on performance criteria such as quality of care and patient satisfaction measures.

Sometimes we have “case rate” arrangements with providers, which means that for a selected set of services the provider receives a set fee, or a “case rate,” for services needed up to an agreed upon maximum amount of services for a designated period of time. Alternatively, we may pay a “case rate” to a provider for all of the selected set of services needed during an agreed upon period of time.

Sometimes we have “withhold” arrangements with providers, which means that a portion of the provider's payment is set aside until the end of the year. The year-end reconciliation can happen in one or more of the following ways:

Withhold arrangements are sometimes used to pay primary care, specialty, referral or hospital providers who furnish services to members. The provider usually receives all or a portion of the withheld amount based on performance of agreed upon criteria, which may include patient satisfaction levels, quality of care and/or care management measures along with the financial performance of HealthPartners. Certain factors are measured to determine if the provider has satisfied the withhold criteria, such as patient satisfaction, survey results and compliance with industry standards for preventative services, clinical guidelines and care management.

Sometimes the amount of the withhold that the provider receives is based upon "cost targets" for care expenses. If total care costs are less than the cost target, all or a portion of the withheld amount is returned to the provider after the end of the year. Such cost targets include "stop-loss" protections which reduce the chance that treating patients with costly illnesses will have a direct negative impact on the provider's performance.

A provider may qualify to participate in a bonus program and receive additional payment if the provider meets certain performance criteria. Generally, these performance criteria are similar to the withhold criteria described above.

Some providers-usually hospitals-are paid on the “basis of the diagnosis” that they are treating; in other words, they are paid a set fee to treat certain kinds of conditions. Sometimes we pay hospitals and other institutional providers a set fee, or “per diem,” for each day or according to the number of days the patient spent in the facility.

Occasionally, our reimbursement arrangements with providers include some combination of the methods described above. For example, we may pay a case rate to a provider for a selected set of services needed during an agreed upon period of time, or for services needed up to an agreed upon maximum amount of services, and pay that same provider on a fee-for-service basis for services that are not provided within the time period or that exceed the maximum amount of services. In addition, although we may pay a provider, such as a medical clinic, using one type of reimbursement method, that clinic may pay its employed providers using another reimbursement method. Please check with your individual provider if you wish to know the basis on which he or she is paid.

Please Note: Enrolling in this plan doesn’t guarantee services by a particular provider. If you wish to be certain of receiving care from a specific doctor, you should contact that doctor to ask whether or not the doctor is still a HealthPartners network provider, and whether or not the doctor is accepting additional patients.

Access to health care services doesn’t guarantee access to a particular type of doctor. Please contact Member Services at 952-883-7000 or 1-866-443-9352 for specific information about access to different types of doctors.

Our approach to protecting personal information

HealthPartners complies with federal and state laws regarding the confidentiality of medical records and personal information about our members and former members. Our policies and procedures help ensure that the collection, use and disclosure of information complies with the law. When needed, we get consent or authorization from our members (or an approved member representative when the member is unable to give consent or authorization) for release of personal information. We give members access to their own information consistent with applicable law and standards. Our policies and practices support appropriate and effective use of information, internally and externally, and enable us to serve and improve the health of our members, our patients and the community, while being sensitive to privacy. For a copy of our privacy notice, please visit **healthpartners.com** or call Member Services at 952-883-5000 or 1-800-883-2177. Please contact your provider for a copy of the HealthPartners privacy notice.

Our mission is to improve the health of our members, our patients and the community.

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HealthPartners Three for Free Individual Plan

2009 Rates - rates for April 1, 2009 through March 31, 2010

This rate sheet lists rates for the HealthPartners Three for Free Individual Plan. Use the following pages to find rates for you and your family.

Rates are available for either tobacco-free applicants or applicants who have used tobacco or a tobacco cessation product in the past 12 months. You may also choose to have coverage for chemical dependency.

Please keep this rate sheet for future reference. When a member has a birthday that places he or she in a new age category, that member's rate will be adjusted accordingly. You will not receive additional notification.

Covering Dependents

You may cover dependent children ages 24 or younger using these rates. Premiums are charged for a maximum of three children on a family contract. A family contract covers at least one adult policyholder and one or more dependent children.

If you are applying to cover only dependent children, use the age 0-29 rate for the first child. Additional children will be charged the dependent children rates. Premiums are charged for a maximum of three additional children.

If you have questions or need help estimating your rates, call HealthPartners Individual Sales at 952-883-5599 or 1-877-838-4949. TTY users call 952-883-5127 or 1-800-443-0156.

Worksheet for Estimating Premiums

Your Deductible Level		________
Your Rate		$ ________
Spouse Rate (if applicable)		$ ________
Dependent Child Rate	1 Child	$ ________
	2 Children	$ ________
	3 or More	$ ________
Estimated Monthly Premium		$ ________

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Tobacco-free without Chemical Dependency Coverage

	80% Coinsurance				100% Coinsurance			
Age	**$4,000**	**$5,000**	**$7,500**	**$10,000**	**$4,000**	**$5,000**	**$7,500**	**$10,000**
0-29	$99.12	$89.65	$82.89	$76.59	$110.64	$99.10	$90.00	$82.10
30-34	$107.12	$96.88	$89.57	$82.77	$119.57	$107.09	$97.27	$88.73
35-39	$113.75	$102.88	$95.12	$87.90	$126.97	$113.72	$103.29	$94.22
40-41	$117.17	$105.96	$97.97	$90.53	$130.77	$117.14	$106.38	$97.04
42-43	$121.85	$110.20	$101.90	$94.15	$136.01	$121.82	$110.64	$100.92
44-45	$132.82	$120.12	$111.06	$102.62	$148.25	$132.78	$120.59	$110.00
46-47	$147.42	$133.33	$123.28	$113.91	$164.54	$147.38	$133.85	$122.10
48-49	$163.64	$148.01	$136.85	$126.45	$182.66	$163.61	$148.59	$135.54
50-51	$183.28	$165.76	$153.26	$141.62	$204.57	$183.23	$166.41	$151.80
52-53	$205.27	$185.65	$171.65	$158.61	$229.12	$205.22	$186.38	$170.02
54-55	$225.79	$204.21	$188.81	$174.47	$252.02	$225.74	$205.02	$187.01
56-57	$246.12	$222.59	$205.81	$190.17	$274.71	$246.05	$223.47	$203.85
58-59	$268.27	$242.63	$224.33	$207.29	$299.44	$268.20	$243.59	$222.20
60-64	$290.36	$262.61	$242.81	$224.36	$324.09	$290.29	$263.65	$240.50

Dependent Children Rates

1 child	$87.21	$78.87	$72.92	$67.39	$97.34	$87.19	$79.19	$72.23
2 children	$174.42	$157.74	$145.84	$134.78	$194.68	$174.38	$158.38	$144.46
3 or more	$261.63	$236.61	$218.76	$202.17	$292.02	$261.57	$237.57	$216.69

Tobacco-free with Chemical Dependency Coverage

	80% Coinsurance				100% Coinsurance			
Age	**$4,000**	**$5,000**	**$7,500**	**$10,000**	**$4,000**	**$5,000**	**$7,500**	**$10,000**
0-29	$102.09	$92.34	$85.38	$78.89	$113.96	$102.07	$92.70	$84.57
30-34	$110.34	$99.78	$92.26	$85.25	$123.15	$110.31	$100.19	$91.39
35-39	$117.17	$105.96	$97.98	$90.54	$130.78	$117.13	$106.39	$97.04
40-41	$120.68	$109.14	$100.91	$93.25	$134.69	$120.65	$109.57	$99.95
42-43	$125.50	$113.50	$104.95	$96.97	$140.09	$125.47	$113.96	$103.95
44-45	$136.80	$123.72	$114.39	$105.70	$152.69	$136.76	$124.21	$113.30
46-47	$151.84	$137.33	$126.98	$117.33	$169.48	$151.80	$137.87	$125.76
48-49	$168.55	$152.45	$140.95	$130.24	$188.13	$168.51	$153.05	$139.61
50-51	$188.78	$170.73	$157.86	$145.86	$210.71	$188.73	$171.40	$156.35
52-53	$211.43	$191.22	$176.80	$163.37	$235.99	$211.37	$191.97	$175.12
54-55	$232.56	$210.34	$194.48	$179.70	$259.58	$232.51	$211.17	$192.62
56-57	$253.50	$229.27	$211.98	$195.88	$282.95	$253.43	$230.17	$209.97
58-59	$276.32	$249.90	$231.06	$213.51	$308.42	$276.25	$250.89	$228.87
60-64	$299.07	$270.48	$250.09	$231.09	$333.81	$299.00	$271.56	$247.71

Dependent Children Rates

1 child	$89.83	$81.24	$75.11	$69.41	$100.26	$89.80	$81.56	$74.40
2 children	$179.66	$162.48	$150.22	$138.82	$200.52	$179.60	$163.12	$148.80
3 or more	$269.49	$243.72	$225.33	$208.23	$300.78	$269.40	$244.68	$223.20

Rates are subject to change.

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Tobacco user without Chemical Dependency Coverage

	80% Coinsurance				100% Coinsurance			
Age	**$4,000**	**$5,000**	**$7,500**	**$10,000**	**$4,000**	**$5,000**	**$7,500**	**$10,000**
0-29	$132.16	$119.53	$110.52	$102.12	$147.52	$132.13	$120.00	$109.47
30-34	$142.83	$129.17	$119.43	$110.36	$159.42	$142.79	$129.69	$118.30
35-39	$151.67	$137.17	$126.83	$117.20	$169.29	$151.63	$137.72	$125.62
40-41	$156.22	$141.28	$130.63	$120.71	$174.36	$156.18	$141.84	$129.39
42-43	$162.46	$146.93	$135.86	$125.53	$181.34	$162.42	$147.52	$134.56
44-45	$177.09	$160.16	$148.08	$136.83	$197.66	$177.04	$160.79	$146.67
46-47	$196.56	$177.77	$164.37	$151.88	$219.39	$196.51	$178.47	$162.80
48-49	$218.19	$197.34	$182.46	$168.60	$243.54	$218.14	$198.12	$180.72
50-51	$244.37	$221.01	$204.35	$188.82	$272.76	$244.31	$221.88	$202.40
52-53	$273.69	$247.53	$228.87	$211.48	$305.49	$273.62	$248.51	$226.69
54-55	$301.05	$272.28	$251.75	$232.62	$336.03	$300.98	$273.36	$249.35
56-57	$328.16	$296.79	$274.41	$253.56	$366.28	$328.07	$297.96	$271.80
58-59	$357.69	$323.50	$299.11	$276.39	$399.25	$357.60	$324.78	$296.27
60-64	$387.15	$350.14	$323.74	$299.15	$432.12	$387.05	$351.53	$320.66

Dependent Children Rates

1 child	$116.28	$105.16	$97.23	$89.85	$129.78	$116.25	$105.58	$96.31
2 children	$232.56	$210.32	$194.46	$179.70	$259.56	$232.50	$211.16	$192.62
3 or more	$348.84	$315.48	$291.69	$269.55	$389.34	$348.75	$316.74	$288.93

Tobacco user with Chemical Dependency Coverage

	80% Coinsurance				100% Coinsurance			
Age	**$4,000**	**$5,000**	**$7,500**	**$10,000**	**$4,000**	**$5,000**	**$7,500**	**$10,000**
0-29	$136.12	$123.12	$113.84	$105.18	$151.95	$136.09	$123.60	$112.75
30-34	$147.11	$133.05	$123.01	$113.67	$164.20	$147.07	$133.58	$121.85
35-39	$156.22	$141.29	$130.63	$120.72	$174.37	$156.18	$141.85	$129.39
40-41	$160.91	$145.52	$134.55	$124.33	$179.59	$160.87	$146.10	$133.27
42-43	$167.33	$151.34	$139.94	$129.30	$186.78	$167.29	$151.95	$138.60
44-45	$182.40	$164.96	$152.52	$140.93	$203.59	$182.35	$165.61	$151.07
46-47	$202.46	$183.10	$169.30	$156.44	$225.97	$202.41	$183.82	$167.68
48-49	$224.74	$203.26	$187.93	$173.66	$250.85	$224.68	$204.06	$186.14
50-51	$251.70	$227.64	$210.48	$194.48	$280.94	$251.64	$228.54	$208.47
52-53	$281.90	$254.96	$235.74	$217.82	$314.65	$281.83	$255.97	$233.49
54-55	$310.08	$280.45	$259.30	$239.60	$346.11	$310.01	$281.56	$256.83
56-57	$338.00	$305.69	$282.64	$261.17	$377.27	$337.91	$306.90	$279.95
58-59	$368.42	$333.21	$308.08	$284.68	$411.23	$368.33	$334.52	$305.16
60-64	$398.76	$360.64	$333.45	$308.12	$445.08	$398.66	$362.08	$330.28

Dependent Children Rates

1 child	$119.77	$108.31	$100.15	$92.55	$133.67	$119.74	$108.75	$99.20
2 children	$239.54	$216.62	$200.30	$185.10	$267.34	$239.48	$217.50	$198.40
3 or more	$359.31	$324.93	$300.45	$277.65	$401.01	$359.22	$326.25	$297.60

Rates are subject to change.

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HealthPartners®

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1-877-838-4949
Fax: 952-853-8718

HealthPartners Three for Free Individual Plan

Underwritten by HealthPartners Insurance Company, a related company of HealthPartners, Inc.

Enrollment Form Instructions

This is an enrollment form for a HealthPartners Three for Free Individual plan. Please carefully review the instructions below before completing the form.

- ✓ Please use ink when completing this form.
- ✓ Answer all questions completely and accurately. This enrollment form provides the evidence of insurability and will be the basis for coverage and premium rates if you are accepted into the plan. 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 under this policy.
- ✓ Complete all sections in full. The enrollment form will be returned to you if all items are not completed.
- ✓ Carefully read, sign and date the last page of the enrollment form. All adults, including dependent children over age 18, must sign the form. 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 and re-submitted.
- ✓ Make a copy of the completed and signed enrollment form for your records. Mail the original enrollment form, along with payment for the first month's premium and a completed initial payment form, to HealthPartners in the enclosed self-addressed envelope. You may also fax the information. See the top of this page for the mailing address and fax number. Please note that we cannot accept your enrollment form without payment and we cannot accept cash.
- ✓ Please review the Summary of Benefits if you need additional details about this plan.

About the Enrollment Process

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. We will notify you of any such request. Please note that you may be billed by your health care provider for the necessary records.

We will notify you of a decision after your enrollment form and any additional information have been reviewed. Normal processing time varies, and may depend on if information from other health care providers is necessary to complete your enrollment.

If you are approved for the HealthPartners Three for Free Individual plan you selected, you will be automatically enrolled in that plan for the next available effective date (either the 1st or 16th of a month) and the first month's premium payment you submitted with your enrollment form will be processed. HealthPartners will process your payment only when you are approved. Coverage cannot be retroactive.

Ongoing billing will occur with the method you selected on the ongoing payment form. Options include: bi-monthly, quarterly or semi-annual statements or monthly automatic withdrawals.

If you are not approved for the HealthPartners Three for Free Individual plan you selected on your enrollment form, we will notify you of the reason(s) for the decision and provide you with information on other options.

Questions? Call 952-883-5599 or 1-877-838-4949 Monday - Friday 8 a.m. to 6 p.m. TTY users call 952-883-5127 or 1-800-443-0156.

HealthPartners Three for Free Individual Plan

Enrollment Form / Evidence Of Insurability

Send completed enrollment form, or direct questions to:

HealthPartners Individual Sales Department -
PO BOX 1309 - MS21106D - Minneapolis, MN 55425.
952-883-5599 or 1-877-838-4949. Fax 952-853-8718.

Please write all answers in ink. Answer all questions completely to avoid a delay in enrollment processing.

Section 1. Applicant Information

Lead Applicant's Name

Last ______________________________ First ______________________ M.I. _______

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married

Lead Applicant's Address

Street ____________________________ City ________________ State _______ Zip _______

Lead Applicant's Telephone/Email

Home Telephone (______) ______________ Work Telephone (______) ______________

Cell Phone (______) ______________ Email Address ____________________________

☐ You may communicate with me via encrypted e-mail, when possible, for myself and any family member listed on this application.

Dependent's Address (if different from above) Add additional page(s) for dependents if needed.

Street ____________________________ City ________________ State _______ Zip _______

Section 2. Application Details

1. **Choose only one of the following deductible plans:**

   ☐ $4,000 – 80% ☐ $4,000 – 100% ☐ $5,000 – 80% ☐ $5,000 – 100%
   ☐ $7,500 – 80% ☐ $7,500 – 100% ☐ $10,000 – 80% ☐ $10,000 – 100%

2. **Chemical Dependency Coverage:** Coverage for chemical dependency is included with the contract. You may choose to opt out of chemical dependency coverage. The decision to keep or opt out of this coverage applies to all individuals applying for coverage under this contract.

   Do you wish to opt out of (remove) chemical dependency coverage from your contract? ☐ Yes ☐ No
   (Base rates are lower than coverage with chemical dependency.)

HealthPartners Sales Rep. _______ App Code ______________ Area ______________

3. **Personal Information:** Complete the following information for each person to be covered.

Full Name (start with yourself)	Age	Relationship	Height	Weight	Sex	Date of Birth	Social Security #	A	D	Rate	Premium

HealthPartners, Inc. use ONLY

Total Premium

☐ Conversion
☐ Add Dependent # ________
☐ Rate Reduction # ________
☐ Rerate # ________
☐ Deductible Change # ________
Effective Date ________
Underwriter ________
Date ________

Has any person listed in Question 3 ever been a HealthPartners member? ☐ YES ☐ NO
If YES, please list his/her name and HealthPartners member number.

Full Name	Member Number

4. **HealthPartners Membership:** Please check the box that best describes your reason for application:
   - ☐ I am a new applicant and am not currently a HealthPartners member.
   - ☐ I am adding a dependent(s) to my current HealthPartners individual plan contract.
   - ☐ I am a current HealthPartners individual plan member and am seeking a different plan or a lower rate.
   - ☐ Other. Please explain: ____________________

Section 3. Health Information

5. **Current Medical Clinic(s):** 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 paper if necessary.

Applicant Name	Clinic Name(s)	Physician Name(s)	Complete Clinic Address(es) & Phone Number(s)	Date of Last Complete Physical Exam

Please sign if applying via FAX: Lead Applicant Signature ____________________ Date __________

6. Current Health Plan: Name and address of the current health plan companies for each person listed in Question 3.

Please attach a separate sheet if additional space is needed.

Applicant Name(s)	Name(s) of Insurer(s)	Address(es) of Insurer(s) (City, State, Zip)	Termination Date

Yes No

7. Tobacco Use/Cessation: Has any person listed in Question 3:

Used any tobacco or tobacco cessation product in the last 12 months?. . . . . ☐ ☐

If YES, list all individuals:____

8. Foreign Travel: Does any person listed in Question 3 have plans for foreign travel within the next six months?. . . . . ☐ ☐

If YES, who? ____________________________When? ___________________For how long?_____________

9. Pregnancy: Is any person listed in Question 3 now pregnant? . . . . ☐ ☐

If YES, who?______________________________________When is birth expected?_______________________________

10. For each female person listed in Question 3, please 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 Question 14, indicating which applicant the YES answer involves. (Please attach additional paper if more space is needed.)

Yes No

11. Has any person applying for coverage EVER sought medical care, advice or been diagnosed or treated for:

a. Heart murmur, angina, coronary artery disease or other heart or circulatory disorder . . . . ☐ ☐

b. Stroke, epilepsy, alzheimer's, traumatic brain injury, brain tumor, multiple sclerosis . . . . ☐ ☐

c. Hemophilia, polycythemia, thalessemia, or blood clots . . . . ☐ ☐

d. Tuberculosis, emphysema or pulmonary fibrosis. . . . . ☐ ☐

e. Colitis, crohns disease, hepatitis, cirrhosis of the liver, pancreatitis, kidney cysts or chronic kidney disease . . . . ☐ ☐

f. Scoliosis, spondylolithesis, ankylosing spondylosis or spina bifida . . . . ☐ ☐

g. Cancer . . . . ☐ ☐

h. Diabetes — Type I ___ or Type II ___ If yes, provide last hemoglobin A1C______. . . . . ☐ ☐

i. An immune system disorder, including but not limited to lupus, rheumatoid arthritis, scleroderma, connective tissue disorder and sjogrens syndrome . . . . ☐ ☐

j. Been convicted of a DWI or DUI; had his/her driver's license suspended or revoked for driving while under the influence . . ☐ ☐

Please sign if applying via FAX: Lead Applicant Signature ____ Date _________________

	Yes	No
12. Within the past 5 years has any person applying for coverage sought medical care, advice or been diagnosed with or treated for any condition not already mentioned above concerning the following:		
a. Anemia, varicose veins, varicose ulcer, phlebitis or other blood disorder	☐	☐
b. Elevated blood glucose, elevated cholesterol or other lipids or had any other abnormal blood test	☐	☐
c. Chest pain or high blood pressure	☐	☐
d. Disorder of the muscles or bones including but not limited to osteoarthritis, fibromyalgias, knee, hip, shoulder or spine	☐	☐
e. Fainting, dizziness, convulsions, headaches, migraines or any other brain or nervous disorder	☐	☐
f. Allergies, asthma, lung or breathing problem or any other respiratory disorder	☐	☐
g. Any type of ulcer; disorder of the gall bladder, stomach, intestine, rectum or liver	☐	☐
h. Mental, emotional or personality disorders, including counseling or hospitalization	☐	☐
i. Any disease or disorder of the eyes, ears, nose, throat, tonsils or sinuses or thyroid	☐	☐
j. Any kidney, bladder, prostate or urinary disorder.	☐	☐
k. Any disease or disorder of the breast, reproductive organs; abnormal menstrual periods, infertility or any sexually transmitted disease	☐	☐
l. Eating disorder, unexplained weight loss, fatigue, fever, enlarged lymph nodes, skin lesions or any other related disorder	☐	☐
m. Received inpatient or outpatient treatment for alcohol or drug use	☐	☐
If yes, who received care ______________________ What date(s) ______________		
n. Been told by a medical practitioner or health care professional to modify or restrict eating, drinking or living habits for health purposes	☐	☐
o. Received any holistic, alternative, or complementary treatment including herbal remedies, massage for pain, acupuncture/acupressure, or other therapies	☐	☐
p. Had a physical examination, electro cardiogram, laboratory or diagnostic test, x-ray (other than dental)	☐	☐
q. Been diagnosed or treated for any medical condition not listed above	☐	☐
r. Had any life or health insurance declined, postponed or modified, or had a waiver, rider or extra premium added	☐	☐
s. Received payment for medical disability, illness or injury	☐	☐
t. Been hospitalized, had surgery or been medically advised to have surgery	☐	☐
If yes, who received care ______________________ What date(s) ______________		
Date(s) of hospitalization or surgery (past or future) ______________________		

Please sign if applying via FAX: Lead Applicant Signature ______________________ Date ______________

	Yes	No
13. Medications: In the past 12 months, has any person listed in Question 3 taken any medications? If YES, complete the section below	☐	☐

Medications used in the past 12 months: *Please attach additional paper if more space is needed.*

Applicant Name(s)	Name of Medication	Dosage/Mg Per Use	Doses Per Day	Refills Per Year	Reason For Medication	Date Last Taken

14. Explanations: Provide the following information for each YES answer given in Questions 11 and 12. You may also include copies of medical records. **It is your responsibility to pay any fees that may be charged for obtaining these records.** Please attach additional paper if more space is needed.

Question # and Letter	Name of Person (as Listed in Question 3)	Explanations of Yes Answers in Questions 11 and 12 (Include Name of Condition, Reason Treated and Other Details)	Date(s) Occurred or When Treated	Remaining Effects	Complete Name and Address Physician(s) and/or Hospital(s) Where Treated

Please sign if applying via FAX: 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 or 1-800-247-7015 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 maternaity care under this policy. Specific benefit information in the Summary of Benefits is provided in the application packet.

I authorize HealthPartners to obtain from health plans, 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 HealthPartners makes 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 HealthPartners, auditing and legal services, and other health care operations. The information for which I authorize such release also may be collected from brokers or HealthPartners affiliates and business associates. I agree to execute a separate authorization, if required by a provider of service or hospital. A photocopy of this authorization shall be as valid as the original and remains in effect for 26 months from the signature date. HealthPartners may access and use information 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, should I chose to name one.

I authorize HealthPartners to collect personal motor vehicle driving records for me and my dependents. I authorize disclosure of such information solely for the purpose of assisting with the underwriting of the enrollment form.

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 each adult signing below, as well as their respective dependent children on whose behalf I have applied for HealthPartners individual coverage. An adult can only authorize the release of records for him or herself and minor children, not for a dependent spouse.

I understand that payment for the first month's premium and payment information for subsequent premiums must be submitted with this enrollment form or the application will not be considered. If I am accepted for coverage under my selected plan, I understand my submitted payment will be processed and I will be automatically enrolled in that plan. I understand that if I elect the monthly billing option I must consent to the payment being 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 bi-monthly, quarterly and semi-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.

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 including dependent children age 18 and older. Please note that an adult can only authorize the release of records for him or herself and minor children and not for a dependent spouse.

Enrollee signature(s)

X____ Date__________________
Lead 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

X____ Date__________________
Guarantor/legal guardian signature, if any applicants are minors

Broker's name, if applicable. (Please print.) Steve McAlpin Broker # D 582 Date__________

Individual Health Plans

Initial Payment Form
(Payment Voucher)

Thank you for your application for a HealthPartners individual plan.

To complete the application process, please provide payment for the first month's premium. This payment must be submitted before we can review your application. We will not process the payment until you have been approved for the plan you selected. If you are submitting more than one application, please include a separate payment for each application.

If you have questions, or would prefer to pay over the phone, call HealthPartners Individual Sales at 952-883-5599 or 1-877-838-4949 between 8 a.m. and 6 p.m. Monday-Friday.
You can also e-mail questions to **individualsales@healthpartners.com**.

Applicant information

Lead/Self Applicant Name ______________________

Application Number ______________________
(online applications only)

Choose your method of first payment

☐ Visa ☐ MasterCard ☐ American Express ☐ Discover ☐ Check

Card Number ______________________

Expiration Date ______/______

Payment Amount $__________

Signature ______________________

Billing Name ______________________
(please print)

Billing Address ______________________
Street Address

____
City State ZIP

Phone Number (   ) ______________________

Return this payment form by fax or mail

Fax: 952-853-8718

HealthPartners Individual Sales
P.O. Box 1309
MS21102A
Minneapolis, MN 55440-1309

HealthPartners®

Individual Health Plans

Optional. You can submit this form with your enrollment form to speed processing time.

Authorization for release of prescription drug history report

What is this?

You have the option of letting HealthPartners obtain and review a report of your prescription drug history from a consumer reporting agency.

The attached form gives you more details about this option. If you choose this option, you will need to sign the attached form and return it with your enrollment form and first month's premium payment.

Why should I consider this option?

The information from your prescription drug history report can result in a faster decision on your HealthPartners Individual plan application, because it helps reduce the number of follow-up questions we may ask of you or your doctor. You do not have to pay for this report.

What should I do next?

Please take a moment to review the attached information, and if you choose, sign the authorization form. Please submit the signed authorization form along with your enrollment form and first month's premium payment.

We need permission and a signature from each applicant to be able to obtain the prescription drug history for that person.

What if I have questions?

Please call HealthPartners Individual Sales at 952-883-5599 or 1-877-838-4949, Monday through Friday, 8 a.m. to 6 p.m. You can also e-mail questions to individualsales@healthpartners.com.

Individual Underwriting
P O Box 1309, MS 21105H
Minneapolis, MN 55440-1309

Authorization for Release of Protected Information for Prescription Drug Records through Milliman IntelliScript

Please print:

Lead Applicant Name: ______________________________

Address: ______________________________

Spouse Applicant Name: ______________________________

Address: ______________________________

Dependent Applicant Name: ______________________________

Address: ______________________________

Dependent Applicant Name: ______________________________

Address: ______________________________

Attach additional dependent names on separate page.

I (applicants listed above) authorize the disclosure and use of my health information as described below:

Who may disclose (give out) this information: pharmacy benefit managers, retail pharmacies, clearinghouses, insurance organizations or other organizations that maintain prescription drug records

Who may receive and use this information: HealthPartners, Inc., with offices located at 8170 33rd Avenue South, Bloomington, MN 55425 and its related organizations and Milliman IntelliScript with offices located at 15800 Bluemound Road, Suite 400 Brookfield, WI 53005.

The purpose for which this information may be disclosed: for use in connection with the insurance underwriting process involving the individual(s) to whom the information relates or as permitted or required by applicable law.

What information may be disclosed: any information held by the discloser relating to the applicant's prescription drug history including: prescription name (generic or brand), dates prescription were filled, indications, dosage, prescribing physician name, specialty, address and phone number, pharmacy name, address and phone number.

This authorization expires (ends) on the following upon: completion of the underwriting process related to this application for HealthPartners coverage.

- continued -

I understand that:

- I am not required to sign this authorization. However, if I (and all of my co-applicants) do sign this authorization, it may help reduce the amount of time to complete the underwriting process related to my application.
- I am authorizing HealthPartners to release my name, date of birth and other identifying information to assist in the underwriting process.
- I may revoke this authorization at any time by notifying, in writing, the department listed above.
- If the disclosed information goes to a healthcare provider or a health plan covered by federal privacy laws, it will be protected by federal privacy laws. Information that goes to other persons or entities may not be protected by state or federal privacy laws and may be re-disclosed.
- Revoking this authorization does not apply to information that has already been released under this authorization.
- I have the right to inspect or request a copy of the health information to be disclosed.

Lead Applicant's Signature	Date
Spouse's Signature, if applying for coverage	Date
Dependent's Signature, if age 18 or older	Date
Dependent's Signature, if age 18 or older	Date
Legal Guardian's Signature, if any applicants are minors	Date

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