HealthPartners®

DENTAL COORDINATION OF BENEFITS FORM

DENTAL CLAIMS DEPARTMENT
PO BOX 1172
Minneapolis, MN 55440-1172

Please complete the information below and return this form to HealthPartners. If you have questions regarding this form, please contact Dental Claims Department at 952-883-5165 or 1-800-642-1323.

The HealthPartners and/or HealthPartners Insurance Company Membership Contract contains a "Coordination of Benefits" provision which allows HealthPartners and/or HealthPartners Insurance Company to share responsibility of covering dental care expenses with any other company that covers you or your family for medical or dental benefits. When dental care expenses are shared between two or more companies, payment up to 100 percent of eligible charges may be provided thereby reducing a member's out-of-pocket expenses. In addition to benefitting the individual member, coordination of benefits is beneficial to all members because it avoids duplication of payments which would result in higher premium rates.

HealthPartners and/or HealthPartners Insurance Company Policyholder (Applicant) Name _____ D.O.B. _____

Daytime Phone (including area code) _____ Employer Name _____

Social Security Number _____ HealthPartners and/or HealthPartners Insurance Company Member Number _____

1. Is any family member covered under a dental insurance other than with HealthPartners and/or HealthPartners Insurance Company? ☐ YES ☐ NO
   If YES, complete Section A; if NO, go to question 2.

2. Are you divorced or remarried? ☐ YES ☐ NO
   If YES, complete Section B; if NO, sign and return.

Section A

Please complete Section A with information about other dental insurance only (do not complete this section if other policy terminates when HealthPartners and/or HealthPartners Insurance Company coverage takes effect):

Name of family member of Policyholder (Applicant) _____ Date of Birth _____ Social Security Number _____

Family member's Employer Name and Address _____

Employer's Dental Plan Name _____

Address for Submitting Claims _____

Policy Number _____ Effective Date _____ (must be included) Cancellation Date _____

☐ Single Coverage ☐ Family Coverage

If Family Coverage, list all covered members _____

Section B

If you are divorced or remarried with dependents, please provide complete dental insurance information if different from above for all dependents.

Dependent	Custodial Parent of person responsible for dependent dental care expenses per divorce decree	Date of birth of person responsible	Plan Name	Plan Address	Policy Number	Policyholder Name

Certification and Signature

I certify that the above information is true and correct. I authorize the administrator of the above named plan(s) to release information to HealthPartners and/or HealthPartners Insurance Company regarding dental care benefits to which I may be entitled. I understand that the purpose of this release of information is to assure appropriate coordination of benefits of all plans. I authorize the assignment of benefits to the providers of service.

This authorization shall remain valid for the duration of the coverage of the plan for which a claim is submitted. I understand that a photocopy of this authorization shall be valid as the original.

SIGNATURE OF APPLICANT _____ SPOUSE OR SPOUSAL EQUIVALENT SIGNATURE _____ DATE _____