HealthPartners®

2009 Flu Shot Clinics – Employer Registration Form
HealthPartners Worksite Health

Employer registration must be completed by October 1, 2009, in order to guarantee service from a HealthPartners flu vendor.

Note: Please print as shown below. Stay within the boxes. Use black ink. Use CAPITAL letters only.

S A M P L E 1 2 3

Today's Date: ☐☐/☐☐/☐☐☐☐ ☐ Fully Insured ☐ Self-Insured

Company Name:

HealthPartners Group Number:

Main Phone: ☐☐☐-☐☐☐-☐☐☐☐

Office Location Street Address:

City: **ST:** **Zip:**

Company Contact Person:
First Name: **Last Name:**

Direct Phone: ☐☐☐-☐☐☐-☐☐☐☐ **Fax Number:** ☐☐☐-☐☐☐-☐☐☐☐

E-Mail Address:

Program and Payment Options (*check one*):

☐ 1) Include only HealthPartners covered employees
☐ 2) Include HealthPartners covered employees and covered dependents
☐ 3) Include also non-HealthPartners covered employees

Indicate your preferred HealthPartners flu vendor:

☐ 1) No preference ☐ 2) Preferred vendor

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Number of Location(s): _____ *Please complete requested information for each location.*

LOCATION SPECIFIC INFORMATION

Location #1: _____

Office Location Street Address: _____

City: _____ **ST:** _____ **Zip:** _____

Estimated number of shots: _____ HealthPartners Group #: _____

Location #2: _____

Office Location Street Address: _____

City: _____ **ST:** _____ **Zip:** _____

Estimated number of shots: _____ HealthPartners Group #: _____

Location #3: _____

Office Location Street Address: _____

City: _____ **ST:** _____ **Zip:** _____

Estimated number of shots: _____ HealthPartners Group #: _____

We look forward to working with you. If you have any questions, please call 952-883-7574.

Please fax to (952) 853-8732, or mail to: PO Box 1309, 21106A, Minneapolis, MN 55440-1309