MANAGEMENT AND BUDGET
STATE EMPLOYEE GROUP INSURANCE PROGRAM

Application to Change Insurance Coverage

Instructions: Refer to Your Employee Benefits booklet at https://mn.gov/mmb/segip prior to completing, signing and dating this document. Do not delay sending this form if missing information or documents. There are strict deadlines for requesting these changes and late requests cannot be processed. Use an additional page if necessary for additional dependents. A separate letter requesting proof to verify eligibility will be mailed. Review acceptable documents required to verify dependents on our website. Contact SEGIP at 651-355-0100 or email segip.mmb@state.mn.us with questions. Dependent coverage enrollment is not complete until documentation verifying relationship is received within the stated deadlines and is approved by SEGIP.

Employee Information – All Information is required

Name (Last, First, Middle Initial) _____ Birth date (mm/dd/yy) _____

Employee ID # _____ Phone/Work _____ Home _____

Social Security # _____ Email: _____

Medical Coverage - To find a Clinic ID# go to: http://mn.gov/insdir/provider_directory_openenrollment.aspx

Choose your coverage type:	Choose Medical Carrier:	Primary Care Clinic number **REQUIRED for employee**
◯ Employee –only coverage	◯ Blue Cross	Clinic ID# _____
◯ Family coverage (complete dependent information below)	◯ Health Partners	
	◯ PreferredOne	

Do you have Medicare? ◯ Yes* ◯ No

Do any of your dependent(s) have Medicare? ◯ Yes* ◯ No

***If yes, complete Part C.**

Dental Coverage – Clinic ID# is not required, you can review the Dental Directory at https://mn.gov/mmb/segip.

Choose your coverage type:	Choose Dental Carrier:
◯ Employee –only coverage	◯ State Dental Plan – Delta Dental
◯ Family coverage (complete dependent information below)	◯ Health Partners State of Minnesota Dental Plan

Dependent Information and Relationship to you – All information requested is required for enrollment

Name/*Relationship to you ◯ Add ◯ Drop	Birth date (mm/dd/yy)	Gender M/F	Address	**Social Security	Clinic ID# Required
Name/Relationship to you ◯ Add ◯ Drop					
Name/Relationship to you ◯ Add ◯ Drop					
Name/Relationship to you ◯ Add ◯ Drop					

*If adding a Spouse, complete Part B.

**Do not delay submitting form while waiting to receive a Social Security Number. Write "Applied for" and send the form to SEGIP by the deadline.

Part A. Changes in coverage

SEGIP can allow you to make changes to your insurance coverage outside an annual open enrollment period if you experience a life event. This life event must have occurred within the last **30 days if you are requesting to add** coverage and the last **60 days if you are asking to cancel** coverage. Please check the appropriate box.

☐ Marriage

☐ Birth/adoption/placement for adoption

☐ Divorce

☐ Death of a dependent

☐ Child turned age 26

☐ Change in yours/dependent employment status that affects insurance

☐ Change in enrollment through a government program (Medical Assistance, MN Care) 60 day period to add coverage.

Other (please explain):_____

Date of life event: _____ Change affects: ☐ You ☐ Spouse ☐ Child

SEGIP will request proof to add or cancel coverages for you or your dependents such as a divorce decree or official letter from the employer/group's letterhead verifying the event and date of the event BEFORE allowing a change, including a copy of the employment and/or coverage end notice. You may be required to contact the employer of your spouse or dependent before we make a change. Do not delay sending in this application while waiting for any documentation.

Part B. Spouse eligibility

Please answer the following to help SEGIP staff determine if your spouse may be eligible for coverage on your health insurance.

1. Is your spouse employed full-time by an employer with 100 or more employees? ◯ Yes ◯ No
2. Is your spouse eligible to receive health insurance from his/her employer? ◯ Yes ◯ No
3. Has your spouse chosen to receive from their employer:
   a. Cash instead of health insurance, or ◯ Yes ◯ No
   b. Credit towards the purchase of some other benefit instead of health insurance, or ◯ Yes ◯ No
   c. Cash and a health insurance plan with a deductible of $750 or more. (This includes a high deductible plan) ◯ Yes ◯ No

   If you answered "Yes" to questions, 1, 2 and 3, your spouse is not eligible.

4. Is your spouse eligible for insurance benefits as a State of Minnesota employee or another organization participating in the State Employee Group Insurance Plan (SEGIP)? ◯ Yes ◯ No
5. If yes, has coverage been waived or will coverage be waived? ◯ Yes ◯ No

   If you answered "Yes" to question 4 and "No" to question 5, your spouse is not eligible.

I understand I must notify the SEGIP if my spouse's eligibility for insurance changes.

Important: If your spouse has a high deductible health plan (HDHP) and an HSA, HSA rules prohibit your spouse from certain SEGIP coverage. Please contact your spouse's employer to understand these eligibility rules. If your spouse has a Health Savings Account (HSA), you cannot have a MDEA for general medical expenses and you must request a Limited Purpose MDEA. This Limited MDEA allows your spouse to maintain HSA eligibility.

Part C. *Medicare Information

Name of Medicare-enrolled member(s): _____ Medicare # _____

Type of coverage:	Effective date:	Reason for Medicare coverage: (check one):
☐ Part A (Hospital Insurance)	Part A _____	☐ age
☐ Part B (Medical Insurance)	Part B _____	☐ disability
		☐ end stage renal disease or ALS (Lou Gehrig's Disease

Part D. Important Plan Information and Employee Authorization

Statement of Fraud or Intentional Misrepresentation

Each Member must notify SEGIP immediately of the date the Member knew or should have known that information either is or has become incorrect due to an affirmative statement of information, an omission of information, or a change in circumstances, information as follows:

1. Contained in the enrollment form pertaining to the Member or any individual related to the Member receiving or seeking benefits under the Plan, or
2. Related to a claim for benefits

SEGIP may rescind or cancel the coverage of a Member and/or each individual enrolled in the Plan under the Member upon thirty (30) days prior written notice if it is determined that the Member or individual made an intentional misrepresentation of material fact or was involved in fraud concerning any matter relating to eligibility for coverage or claim for benefits under the Plan.

Coverage for each individual identified in a Notice of Rescission of Coverage will be rescinded as of the date specified in the Notice of Rescission of Coverage, which may be to the effective date of individual's coverage. The Member and any individual involved in the misrepresentation or fraud may be liable for all claims paid by the Plan on behalf of such individuals.

By signing this form, I am attesting that my spouse/dependents are eligible for coverage according to the eligibility rules as defined in the SEGIP Summary Plan Description and/or applicable union contract or compensation plan. I understand that attempting to enroll or enrollment of ineligible dependents may be considered fraud or intentional misrepresentation of a material fact. I further understand, that both myself and any individual involved in fraud or intentional misrepresentation of a material fact, may be liable for all claims paid by the Plan on behalf of such individuals and may be subject to employment discipline, up to and including discharge and may also be subject to criminal penalties.

I am applying for coverage or changes in coverage in the MN State Employee Group Insurance Program, and Health and Dental Premium Account, subject to approval by SEGIP. I authorize my employer to disclose the foregoing information to the insurance carrier(s) indicated, for use in determining my eligibility and in processing my application. This authorization is valid until revoked by operation of law. If paid through the State of Minnesota central payroll system, I authorize payroll deductions for my share of the premiums on a before-tax basis.

To have premiums taken on a post-tax basis, contact SEGIP at 651-355-0100.

If there is a change in my spouse or dependent's eligibility for insurance, I understand that it is my responsibility to notify SEGIP in writing of such a change.

Print Name _____

Your signature _____ Date _____

Fax forms to our office at 651-296-5445, or scan and email to segip.mmb@state.mn.us. If you choose to mail your form send it to:

SEGIP
400 Centennial
658 Cedar Street
Saint Paul, MN 55155

Phone 651-355-0100

Minnesota Management & Budget

NOTICE OF COLLECTION OF PRIVATE DATA

Minnesota Management & Budget (MMB) administers the State Employee Group Insurance Program (SEGIP). This notice explains why we may request information (data) about you, your spouse, and dependents, how we will use it, who will see it, and your obligation to provide that information.

What information will we use?

We will use the information you provide us at this time, as well as information previously provided us, about yourself, your spouse, or dependent(s). If you provide any information about that is not necessary, we will not use it for any purpose.

SEMA4, the information system used to administer employee benefits, contains required information fields that may not be necessary for us to process your request. We do not need the gender or marital status for your beneficiary designation, so you may enter "unknown" in these fields. We only need your dependent's date of death to process a death benefit claim or to discontinue the dependent's coverage due to his or her death. Student status and disability status are needed only to determine eligibility for insurance continuation for your dependent. We need the social security numbers and birth dates of your spouse and dependent to offer insurance continuation, process a death benefit, to ensure we are matching them to the correct insurance benefit transaction and to comply with federal Medicare coordination laws.

Why we ask you for this information?

We ask for this information so that we can successfully administer SEGIP. This information is used to process your request to add or change coverage for yourself, your spouse, dependents or beneficiary. The requested information helps us to determine eligibility, to identify you and your spouse, and dependents, and to contact you or your spouse, and dependents. The information is also used to develop new programs, ensure current programs effectively and efficiently meet member needs, and to comply with federal and state law and rules. We may ask for information about you, your spouse or dependents that we have already collected, including all or part of your social security number, in order to ensure we are matching you to the correct insurance benefit transaction.

Do you have to answer the questions we ask?

You may not be legally required to provide any of the information requested.

What will happen if you do not answer the questions we ask?

If you do not answer these questions, the insurance benefit transaction you requested for you or your spouse, dependent or beneficiary or other insurance benefit transaction may be delayed or denied.

Who else may see this information about you and your spouse and dependents?

We may give data about you and your spouse, and dependents to the insurance carrier you have chosen, SEGIP's other representatives, vendors and actuary; the Legislative Auditor; the Department of Health; the Department of Commerce; and any law enforcement agency or other agency with the legal authority to the information; and anyone authorized by a court order. In addition, the parents of a minor may see information on the minor unless there is a law, court order, or other legally binding instrument that blocks the parent from that information.

How else may this information be used?

We can use or release this information only as stated in this notice unless you give us your written permission to release the information for another purpose or to release it to another individual or entity. The information may also be used for another purpose if Congress or the Minnesota Legislature passes a law allowing or requiring us to release the information or to use it for another purpose.