MANAGEMENT AND BUDGET
STATE EMPLOYEE GROUP INSURANCE PROGRAM

Application to Change Insurance Coverage

Instructions: Refer to the Change my Coverage page https://mn.gov/mmb/segip/change-my-coverage for reasons to change and the Family Eligibility page https://mn.gov/mmb/segip/family-eligibility for documentation requirements on the SEGIP website 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. 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)

Employee ID #

Address

Phone: Work

Home

City, State, Zip code

Email

Medical Coverage - To find a Clinic ID# go to: https://mn.gov/mmb/segip/find-a-clinic. If you are making a mid-year enrollment change you cannot change your carrier at this time.

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

Do you have Medicare? ◯ Yes* ◯ No ***If yes, complete Part C.**

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. If you are making a mid-year enrollment change you cannot change your carrier at this time.

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

Vision Coverage – Fully funded by employee and to be used for hardware only.

Choose your coverage type:	◯ Employee –only coverage	◯ Family coverage (complete dependent information below)

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

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

SEGIP can allow you to make changes to your insurance coverage outside an annual open enrollment period if you experience a qualifying 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

BEFORE allowing a change, SEGIP will request proof to add or cancel coverages for you or your dependents such as a divorce decree or official letter (on letterhead) from the employer/group verifying the event and date of the event. 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 and eligible for health insurance? ◯ Yes ◯ No
2. Is your spouse eligible to receive health insurance from their employer? ◯ Yes ◯ No
3. Has your spouse chosen to receive from their employer:
   - Cash instead of health insurance, **or** ◯ Yes ◯ No
   - Credit towards the purchase of some other benefit instead of health insurance, **or** ◯ Yes ◯ No
   - 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.

You must notify SEGIP if your spouse's eligibility for insurance changes.

NOTE: **Your spouse must submit a** https://mn.gov/mmb-stat/segip/doc/Waiver_of_medical_coverage_form.pdf **if they are eligible for their own full employer contribution toward health coverage through SEGIP.** If the form is not submitted, your spouse will not be enrolled in your coverage and will be automatically enrolled in their own single health coverage. No form is required for dental or vision coverage or if your spouse is not eligible for the full employer contribution.

NOTE: If your spouse or dependent has a high deductible health plan (HDHP) and is contributing to a Health Savings Account (HSA), then you cannot have a MDEA for general medical expenses but may choose a Limited Purpose MDEA. Please contact your spouse's or dependent's employer to understand these HSA eligibility rules.

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

Submit your form to SEGIP: Secure fax 651-296-5445; Mail MMB/SEGIP, 400 Centennial Building, 658 Cedar Street, Saint Paul, MN 55155; Scan and email (secure only when sent from a @state.mn.us account) segip.mmb@state.mn.us.

Questions? Call us at 651-355-0100

Notice of Collection of Private Data

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

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

Why do we ask you for this data? We ask for this data so that we can successfully administer employee benefits, develop new programs, and to determine if existing programs are properly managed and meet member needs, and to comply with federal and state laws and rules. This data is used to process your request to add, waive, drop, or change coverage for yourself and your spouse and dependents. The requested data helps us to determine eligibility, to identify you, and to contact you, your spouse, and dependents.

What will happen if you do not answer the questions we ask? You are not required to provide the data requested. If you do not answer these questions, the insurance benefit transaction you requested for you, your spouse, dependent, or other insurance benefit transaction may be delayed or denied.

Who else may see this data about you and your spouse and dependents? We may give data about you, your spouse and dependents to your insurance carrier, 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 have the data; and anyone authorized by a court order. The parents of a minor may see data on the minor unless there is a law, court order, or other legally binding instrument that blocks the parent from that data.

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