Request for Continuation of Coverage upon Retirement

Retiree: This is available to all employees covered under the Minnesota State Employee Group Insurance Program who are taking regular retirement (including regular early retirement) and who are interested in maintaining their coverage. Be sure to complete all sections below. **Your HR representative will forward the original signed copy to Minnesota Management & Budget (MMB).** Retain a copy for your records.

Instructions are included.

1. Employee Information – All Information is required

Name (Last, First, Middle Initial) | SSN | Employee ID #

Address | Phone: Work | Home:

City, State, Zip code | Date of Birth (mm/dd/yyyy)

Email

Spouse Information – If applicable

Name (Last, First, Middle Initial) | Gender | Male | Female

Date of Birth (mm/dd/yyyy) | SSN

2. Continuation of Health Insurance Coverage

	Self		Spouse/Dependent	
I and/or my spouse are eligible for benefits under Medicare.	Yes	No	Yes	No
I and/or my spouse are currently covered under or have applied for Medicare:				
• Part A Hospitalization? Effective date (mm/dd/yyyy):	Yes	No	Yes	No
• Part B Medical? Effective date (mm/dd/yyyy):	Yes	No	Yes	No

If you or your spouse are 65 or over, you are required to submit Medicare information to your health plan. Enrollment kit(s) from the carrier will be mailed to your home address. Enrollments must be completed and returned to the carrier prior to the first of the month following retirement.

Current Medical Carrier: BlueCross BlueShield HealthPartners PreferredOne

	Self		Spouse/Dependent	
I wish to continue single health insurance coverage.	Yes	No		
My spouse is age 64 or under and I wish to continue family health insurance coverage.			Yes	No
My spouse is age 65 or over and I wish to continue family health insurance coverage.			Yes	No
My spouse is age 65 or over but will remain on the Advantage Health Plan because dependent children will continue to be covered.			Yes	No

3. Continuation of Dental Insurance Coverage You must mark both Yes to continue family coverage.

Current Dental Carrier: State Dental Plan – Delta Dental HealthPartners State of Minnesota Dental Plan

I wish to continue single dental insurance coverage. Yes No

I wish to continue dependent dental insurance in addition to my single coverage. Yes No

4. Continuation of Group Life Insurance Coverage (18 months) *See Enrollment Instructions Section 4 for optional life post-retirement benefits.

I wish to continue my current basic/manager group life insurance for 18 months. Yes No

I wish to continue child life insurance. Yes No

I wish to continue employee optional life insurance.* Yes No

I wish to continue spouse optional life insurance.* Yes No

5. Continuation of Medical/Dental Expense Account (MDEA) This is a pre-tax expense account administered by 121 Benefits.

I wish to continue participation in the MDEA on a post-tax basis. Enrollment in the MDEA continues as long as monthly payments are made timely or until the end of the plan year, whichever occurs first. Yes No

By completing the above, I request that insurance coverage be continued or converted at my own expense. I understand that this request must be submitted within 30 days of my retirement. If I do not continue insurance coverage, I cannot re-enroll at a future date.

Signature of Employee Date (mm/dd/yyyy)

HR Representative Phone Number Signature of HR Representative Date (mm/dd/yyyy)

Department/Employer Last Date on Payroll (mm/dd/yyyy) SEMA4 Retirement Date (mm/dd/yyyy)

SEGIP contact

Please give the original to your agency HR Representative. HR Representative, please send the original completed form with your signature section completed 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

For HR Use Only

Forward completed form to SEGIP/MMB only. Retain a copy for your records.

Date sent: __________ (MMB Fax: 651-296-5445)

For SEGIP/MMB Use Only

Copies sent to: ___Health Plan ___Dental Plan

EID initials: ________

Enrollment Instructions

All sections of this form must be completed entirely regardless of your continuation status. Failure to place a check mark in all sections will result in a delay in processing your retirement continuation elections.

Complete the form and send it to your HR Representative for their signature.

Section 1 – General Information

- Complete this section entirely
- Include spouse information if applicable (if no spouse, check "No" for spouse coverage)

Section 2 – Continuation of Health Insurance Coverage

- Indicate if you and/or your spouse are eligible for Medicare
- Indicate if you and/or your spouse have Medicare now, or have applied for Medicare
- If you or a spouse will be age 65 or over, you must have Medicare A & B to enroll in the Senior Plan. Your carrier will mail the Senior Plan Enrollment kit to your home address. The Senior Plan enrollment form(s) must be received by your carrier prior to the 1st of the month, following your retirement date.
- Indicate the health carrier/plan you are currently enrolled in. Please list your current carrier/plan even if you exercise your option to change carriers/plans.

  If changing carriers/plans, complete an Application to Change Insurance Coverage in addition to this continuation form. Attach a copy of this form to the continuation form before forwarding.
- Elect if you wish to continue health insurance for yourself.

  Note: If you do not continue coverage, you cannot enroll at a future date.
- Elect if you wish to continue coverage for your spouse/dependents.

  If you are not currently covering a spouse or dependents, check "No".

  Note: If your spouse or dependents elects not to continue coverage, they cannot enroll at a future date (retirees may add newly married spouse or qualified dependents who lose other group coverage no later than 30-day from the event – contact SEGIP immediately).

Section 3 – Continuation for Dental Insurance Coverage

Note: You do not have to continue medical insurance to continue dental insurance.

- Indicate the dental carrier/plan you are currently enrolled in. List your current carrier/plan even if you exercise your option to change carriers/plans.

  If changing carriers/plans, complete an Application to Change Insurance Coverage in addition to this continuation form. Attach a copy of this form to the continuation form before forwarding.
- Elect if you wish to continue dental insurance for yourself. Check the "Yes" box for your own single coverage even if you intend to continue other family members as well.

  Note: If you do not continue coverage, you cannot enroll at a future date.
- Elect if you wish to continue coverage for your spouse/dependents.

  Note: If your spouse/dependents elect not to continue coverage, they cannot enroll at a future date (retirees may add newly married spouse or qualified dependents who lose other group coverage no later than 30-day from the event – contact SEGIP immediately). If you are not currently covering spouse/dependents, check "No".

Section 4 – Continuation of Group Life Insurance Coverage

- Indicate if you wish to continue your term group life insurance policy (basic or managerial) for 18 months. If you complete the 18 months, you may convert to an individual life insurance policy.

- Indicate if you wish to continue term child life insurance for 18 months if your children are still eligible. After that, child life may be converted to an individual policy. If you do not have child life insurance coverage, check "No".
- Indicate if you and/or your spouse wish to continue the optional life insurance policy.

  Note: You may be eligible for the post retirement paid-up life insurance benefit. Please contact SEGIP to determine eligibility.

  * Complete the Post Retirement Application form for you and/or your spouse whether or not you and/or your spouse wish to continue. If you do not have spouse life insurance, check "No".
- If you or your spouse are immediately eligible for the paid-up death benefit, contact SEGIP regarding the ability to retain the other 85% of the policy under your COBRA option.

Section 5 – Continuation of Medical Dental Expense Account (MDEA)

- Please indicate if you wish to continue participation in the medical/dental expense account.

  Note: By indicating yes this account will be continued on a post-tax basis. Also note that this account is separate from the Health Care Savings Plan (HCSP) or any HSA/HRA administered by MSRS or your pension plan.

Please sign and date the bottom of the form. Also provide a home phone number.

After signing the form, please make a copy for yourself and return the completed form to your HR Representative in your agency.

Your HR Representative will sign the form and forward the completed, signed form to SEGIP. SEGIP will send a copy of the form to your health plan/carrier and dental plan/carrier. Additionally, your HR Representative will retain a copy for their records, and you will retain a copy of the form for your records.

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.
February 2018