

Continuation of Coverage Upon Retirement Form and Enrollment Instructions



Before completing this Continuation of Coverage Upon Retirement form, you must read the Enrollment Instructions. You must acknowledge that you have read the instructions before signing the form and submitting to your Human Resources office.

NOTE: If you or your spouse are or going to be 65 years of age just prior to or at retirement, you **MUST** begin this process at least 45 to 60 days prior to becoming 65 and eligible for Medicare

All sections of this form must be completed entirely regardless of your continuation status. Failure to check any of the “Yes” “No” boxes in all sections will result in a delay in processing your retirement continuation elections.

Complete the form and send it to your Human Resource Representative (HR) for their signature. Your HR will submit the completed form, with verification information to SEGIP on your behalf. It is wise to ask your HR for a copy of your form.

Section 1 – General Information

- Complete this section in its entirety.
- Include spouse information if applicable (write N/A in the “spouse” name line and check “No” for any spouse coverage questions).
- Provide both home and work email address.

Section 2 – Continuation of Medical Insurance Coverage

1. Indicate if you and/or your spouse are eligible (or will be eligible soon) for Medicare.
2. Indicate if you and/or your spouse have Medicare now by listing the effective date from your Medicare A & B card. If you have applied for Medicare, indicate, “pending”.
3. If you and/or a spouse are or will be age 65 or greater, you must have Medicare A & B to enroll in the Senior Plan. Your Health Plan Administrator/plan will mail the Senior Plan Enrollment packet to your home address. The Senior Plan enrollment form(s) must be received by your Health Plan Administrator/plan prior to the end of the month in which you retire. If you are going to be 65 years of age just prior to retirement, you **MUST** begin this process at least 45 to 60 days prior to becoming 65 and eligible for Medicare.
4. Indicate the medical Health Plan Administrator/plan you are currently enrolled in. Please list your current Health Plan Administrator/plan even if you exercise your option to change Health Plan Administrators/plans.
 - a. If changing Health Plan Administrators/plans, complete a Qualifying Status Change form in addition to this continuation form.
 - b. Attach a copy of the Qualifying Status Change form to this continuation form before forwarding.

5. Indicate if you wish to continue medical insurance for yourself. You must elect single coverage to elect continuation of dependent coverage.

Note: If you do not continue medical coverage, you cannot enroll at a future date.

6. Indicate if you wish to continue coverage for your spouse/dependents in addition to single coverage.
 - a. If you are not currently covering a spouse or dependents, check “No” (you may need to mark all 3 “No”).
7. A child loses eligibility at the end of the month in which they turn age 26. It is your responsibility to contact SEGIP to obtain COBRA continuation information for this dependent.

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

Section 3 – Continuation for Dental Insurance Coverage

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

1. Indicate the Dental Plan Administrator/plan you are currently enrolled in. List your current Dental Plan Administrator/plan even if you exercise your option to change Dental Plan Administrators/plans.
 - a. If changing Dental Plan Administrators/plans, complete a Qualifying Status Change form in addition to this continuation form. Attach a copy of the Qualifying Status Change form to this continuation form before forwarding.

2. Indicate if you wish to continue dental insurance for yourself. You must elect single coverage to elect continuation of dependent coverage.

Note: If you do not continue dental coverage, you cannot enroll at a future date.

3. Indicate if you wish to continue coverage for your spouse/dependents in addition to single coverage.
4. A child loses eligibility at the end of the month in which they turn age 26. It is your responsibility to contact SEGIP to obtain COBRA continuation information for this dependent.

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

Section 4 – Continuation of Group Vision Insurance Coverage

Indicate if you wish to continue your vision policy for a maximum of 18 consecutive months following your retirement date. Billing will come directly from SEGIP for the vision continuation.

1. Elect if you wish to continue Vision insurance for yourself. You must elect single coverage to elect continuation of dependent coverage.

Note: If you do not continue coverage, you cannot enroll at a future date.

2. Elect if you wish to continue vision coverage for your spouse/dependents in addition to single coverage.
 - a. If you are not currently covering a spouse or dependents, check “No”.

3. If you cover a child, they will lose eligibility at the end of the month in which they turn age 26. It is your responsibility to contact SEGIP to obtain COBRA continuation information for this dependent.

Note: If your spouse or dependent(s) elects not to continue coverage, they cannot enroll at a later date.

Section 5 – Continuation of Group Life Insurance Coverage

1. Indicate if you wish to continue your group term life insurance policy (basic or managerial) for 18 months. After completion of 18 consecutive months, you may convert to an individual life insurance policy (contact information regarding conversion policies will be sent to you as you near the end of the 18-months of continued coverage).
2. Indicate if you wish to continue child term life insurance for 18 months if your children/young adults are still eligible. Children/young adults are defined as through age 25, unless disabled. After completing the 18 consecutive months of participation, child life may be converted to an individual policy. If you don't have child life insurance coverage, check "No".
3. Indicate if you and/or your spouse wish to continue the optional life insurance policy. If you and/or your spouse do not have optional life insurance, check "No".

Note: You may be eligible for the post-retirement paid-up life insurance benefit. Please contact SEGIP to determine eligibility. If you are eligible for the 20-percent paid-up death benefit, you must indicate "Yes" I want to continue on this form. If you are under age 65, you will receive an invoice from Securian Financial.

If you have employee or spouse optional life, you must also complete the Post Retirement Application(s) whether or not you and/or your spouse wish to continue.

If you or your spouse are 65 or greater in age and you elect to continue the policy, you will NOT be invoiced for additional premiums. If you and/or your spouse are immediately eligible for the 20 percent paid-up death benefit, you will be offered the ability to continue the remaining 80-percent of the policy by electing COBRA (COBRA letter is mailed directly to your home address at the time of retirement).

4. If you and/or a spouse are eligible for Post-Retirement Life, the beneficiary form on the Post Retirement Application, must be completed and submitted with this form.

Section 6 – Continuation of Medical Dental Expense Account (MDEA)

Indicate if you wish to continue participation in the Medical/Dental Expense Account (MDEA). Please contact the pre-tax administrator or the SEGIP office if you have further questions.

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.

If you do not wish to continue MDEA on a post-tax basis, but would prefer to pursue an aggregate deduction, you must contact SEGIP with this request at least one month prior to retirement. Email requests should be submitted to segip.mmb@state.mn.us for consideration.

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 agency HR Representative.

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 medical and dental plan. Additionally, your HR Representative will retain a copy for their records, and you will retain a copy of the form for your records.

Retiree: This is available to all employees covered under the State Employee Group Insurance Program (SEGIP) who meet retirement insurance eligibility requirements. You must acknowledge reading the instructions prior to completing all sections below. **Your HR representative will forward the original signed copy to Minnesota Management and Budget (MMB).** Retain a copy for your records.

Questions? Call us at 651-355-0100

NOTICE OF INTENT TO COLLECT PRIVATE DATA

Minnesota Management and Budget (MMB) administers the State Employee Group Insurance Program (SEGIP). As an individual seeking to or participating in a group insurance program, you are asked to provide certain data for the purpose of the administration of group insurance benefits. This notice explains why MMB is requesting private data, how the data will be used, who has access to the data, and what may happen if you do not provide the requested data.

Use of Data. The data requested by MMB may be used for the following purposes:

- To determine eligibility for group insurance benefits
- To administer group insurance benefits
- As required by State and federal law, rule, or regulation

Right of Refusal. You are not required to provide any of the requested data, however, if you do not provide the requested data, group insurance program benefits may be denied or delayed for you, your spouse, or your dependent(s), as applicable.

Access to Data. The data that you provide may be shared with:

- Authorized personnel whose jobs reasonably require access
- Insurance and service providers, and other contracted vendors
- Any other person or entity authorized by federal or state law to access the data, including but not limited to the Office of the Legislative Auditor, the Minnesota Department of Health, the Minnesota Department of Commerce, or others as authorized by a court order.

The parents of a minor may access private data about the minor unless there is a law, court order, or other legally binding instrument that blocks the parent from accessing the data.

Continuation of Coverage Upon Retirement Form

1. Employee Information – All Information is required

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

Address _____ Phone: Work _____ Home: _____

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

Personal email _____ Work email _____

Spouse Information – If applicable

Name _____ SSN _____
(Last, First, Middle Initial)

Date of Birth _____
(mm/dd/yyyy)

2. Continuation of Medical Insurance Coverage

I and/or my spouse are eligible for benefits under Medicare.

Self	Yes	No	Spouse	Yes	No
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I and/or my spouse are currently covered under or have applied for Medicare:

Self	Yes	No	Pending	Spouse	Yes	No	Pending
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1. Part A Hospitalization

Self: Employee Pending If pending, effective date: _____

Spouse: Spouse Pending If pending, effective date: _____

2. Part B Medical

Self: Employee Pending If pending, effective date: _____

Spouse: Spouse Pending If pending, effective date: _____

If you or your spouse are 65 or over, you are required to enroll in and submit Medicare information to your medical plan. Enrollment packet(s) from the Health Plan Administrator will be mailed to your home address.

Enrollments must be completed and returned to the Health Plan Administrator/plan prior to the first of the month following retirement.

Current Medical Health Plan Administrator/plan:

BlueCross and BlueShield MN HealthPartners

I wish to continue single medical insurance coverage (must be “Yes” if continuing family coverage)	Self	Yes	No
My spouse is age 64 or under and I wish to continue family medical insurance coverage.	Spouse	Yes	No
My spouse is age 65 or over and I wish to continue family medical insurance coverage.	Spouse	Yes	No
My spouse is age 65 or over but will remain on the Minnesota Advantage Health Plan because dependent child(ren) will continue to be covered.	Spouse	Yes	No

List dependent (child/young adult) names:

3. Continuation of Dental Insurance Coverage

Current Dental Health Plan Administrator/plan: Delta Dental Grp 216 HealthPartners

I wish to continue single dental. (Must be yes if continuing family coverage).	Self	Yes	No
I wish to continue dependent dental insurance for my spouse and dependents in addition to my single coverage.	Spouse	Yes	No

List dependent(s) names:

4. Continuation of Group Vision Plan (18 months)

Member will be billed directly for the vision continuation through SEGIP.

I wish to continue single vision plan coverage.	Self	Yes	No
I wish to continue dependent vision plan coverage for my spouse and/or dependents in addition to my single coverage.	Spouse	Yes	No

List dependent(s) names:

