Continuation of Coverage Upon Retirement Form and Enrollment Instructions

MANAGEMENT AND BUDGET
STATE EMPLOYEE GROUP INSURANCE PROGRAM

Instructions for the Employer

Indicate which incentive the employee is retiring under. Include a copy of the incentive language in effect at the time of the employee's retirement.

Indicate the Bargaining Unit, the anniversary date (the date the employee started under the incentive they are retiring from), the Pension Plan at the time of retirement, and the number of years in the current pension plan.

Include Department information, the last day on payroll, the SEMA4 retirement date, and the Employer contribution end date.

Instructions for the Employee

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

Note: If you or your spouse are or going to be 65 years of age just before or at retirement, you ***MUST*** begin this process at least 45 to 60 days before 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" or "No" boxes in any section will cause a delay in processing your retirement continuation elections.

Complete the form and send it to your Human Resource Representative (HR) for their signature. Include any additional forms as needed. 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 completed form.

Section 1 – Employee Information

- All information in this section is required.
- Include your spouse's information if applicable, or write N/A in the "spouse" name line. If there is no spouse check "No" for any spouse coverage questions.
- Provide both your home and work email addresses.

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 already have Medicare 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 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 before

the end of the month in which you retire. If you are going to be age 65 just before retiring, you MUST begin this process at least 45 to 60 days before turning 65 and being eligible for Medicare.

4. Indicate the medical Health Plan Administrator you are currently enrolled in. List your current Health Plan Administrator even if you choose to change Health Plan Administrators.
    a. If you are changing Health Plan Administrators, complete a *Qualifying Status Change* form in addition to this continuation form.
    b. Attach a copy of the completed *Qualifying Status Change* form to this continuation form before forwarding it to your HR for finalization.
5. Indicate if you wish to continue medical insurance for yourself. You must choose single coverage to continue coverage for your spouse or other eligible dependent(s).

    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 or dependents in addition to single coverage.
    a. If you are not currently covering a spouse or dependents, check "No". You may need to mark the remaining items in this section "No".
7. A child loses eligibility at the end of the month they turn 26. You are responsible for contacting SEGIP to obtain COBRA continuation information for this dependent.

    Note: If your spouse or 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.

Section 3 – Continuation of Dental Insurance Coverage

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

1. Indicate the Dental Plan Administrator you are currently enrolled in. List your current Dental Plan Administrator even if you choose to change Dental Plan Administrators.
    a. If you are changing Dental Plan Administrators, complete a *Qualifying Status Change* form in addition to this continuation form.
    b. Attach a copy of the completed *Qualifying Status Change* form to this continuation form before forwarding it to your HR for finalization.
2. Indicate if you wish to continue dental insurance for yourself. You must choose single coverage to continue coverage for your spouse or other eligible dependent(s).

    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 or dependents in addition to single coverage.
    a. If you are not currently covering a spouse or dependents, check "No".
4. A child loses eligibility at the end of the month they turn 26. You are responsible for contacting SEGIP to obtain COBRA continuation information for this dependent.

    Note: If your spouse or 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.

Section 4 – Continuation of Group Vision Insurance Coverage

Vision coverage can be continued for a maximum of 18 consecutive months following your retirement date.

1. Indicate if you wish to continue Vision insurance for yourself. You must choose single coverage to continue coverage for your spouse or other eligible dependent(s).

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

2. Indicate if you wish to continue vision coverage for your spouse or dependents in addition to single coverage.

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

3. A child loses eligibility at the end of the month they turn 26. You are responsible for contacting SEGIP to obtain COBRA continuation information for this dependent.

   Note: If your spouse or dependent(s) elect not to continue coverage, they cannot enroll at a future 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 a maximum of 18 consecutive months. After 18 consecutive months, you may convert this policy 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 or young adults are still eligible. Children or young adults are defined as through age 25, unless disabled. After 18 consecutive months, child life may be converted to an individual policy. Contact information regarding conversion policies will be sent to you as you near the end of the 18 months of continued coverage. If you don't currently have child life insurance coverage, check "No".

3. Indicate if you or your spouse wish to continue the optional life insurance policy. If you 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. Contact SEGIP to determine eligibility. If eligible for the 20-percent paid-up death benefit, you must indicate "Yes" 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 age 65 or greater and you elect to continue the policy, you will NOT be invoiced for additional premiums. If you or your spouse are immediately eligible for the 20 percent paid-up death benefit, you will have the option to continue the remaining 80 percent of the policy by electing COBRA. The COBRA letter will be mailed directly to your home address at the time of retirement.

4. If you 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). Contact the pre-tax administrator or SEGIP Member Services if you have further questions.

Note: Indicating "Yes" will continue the account on an after-tax basis. 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 your MDEA on an after-tax basis, but would prefer to pursue an aggregate deduction, you must contact SEGIP with this request at least one month before retirement. Email requests should be submitted to segip.mmb@state.mn.us for consideration.

Sign and date the bottom of the form. Include your home phone number.

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

Your HR Representative will complete and sign the form and forward it to SEGIP. Additionally, your HR Representative will retain a copy for their records, and you will retain a copy of the form for your records.

You will be billed directly from SEGIP for insurance premiums for coverage you have elected.

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.

MANAGEMENT AND BUDGET
STATE EMPLOYEE GROUP INSURANCE PROGRAM

400 Centennial Building
658 Cedar Street
St. Paul, MN 55155
651-355-0100

Continuation of Coverage Upon Retirement Form – Special Retirement

To Be Completed by the Employer

The employee is retiring under the following retirement incentive. Attach a copy of the incentive language in effect at the time of the employee's retirement:

◯ Faculty ◯ Corrections ◯ DHS MOU ◯ Law Enforcement

◯ Other If other: _____

Contract ◯ Yes ◯ No Statute ◯ Yes ◯ No

Bargaining Unit _____ Anniversary Date _____

Pension Plan at the time of Retirement (if applicable) _____

Years of Service in Current Pension Plan (if applicable) _____

Department Name _____ Last Date on Payroll _____

SEMA4 Retirement Date _____ Employer Paid Contribution to Continue until (date) _____

Human Resources Approval _____ Phone Number _____ Date _____

To Be Completed by the Employee

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

Member will be billed directly for the medical continuation through SEGIP. To change Health Plan Administrators, complete and attach a *Qualifying Status Change* form

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

Self ◯ Yes ◯ No Spouse ◯ Yes ◯ No

I and/or my spouse are currently covered under or have applied for Medicare:

Self ◯ Yes ◯ No ◯ Pending Spouse ◯ Yes ◯ No ◯ Pending

1. Part A Hospitalization

   Self: ☐ Employee ☐ Pending Effective date: _____

   Spouse: ☐ Spouse ☐ Pending Effective date: _____

2. Part B Medical

   Self: ☐ Employee ☐ Pending Effective date: _____

   Spouse: ☐ Spouse ☐ 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 before the first of the month following retirement.

Current Medical Health Plan Administrator:

◯ 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

Member will be billed directly for the dental continuation through SEGIP. To change Dental Plan Administrators, complete and attach a *Qualifying Status Change* form

Current Dental Plan Administrator: ◯ 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 dependents in addition to my single coverage. Spouse ◯ Yes ◯ No

List dependent(s) names:

5. Continuation of Group Life Insurance Coverage (18 months)

Member will be billed directly for the optional life continuation through SEGIP.

I wish to continue my current basic or 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

*Refer to Enrollment Instructions Section 5 for optional life post-retirement benefits forms.

6. Continuation of Medical/Dental Expense Account (MDEA)

Member will be billed directly for the MDEA through SEGIP.

This is a pre-tax expense account administered by BRI Benefits

I wish to continue participation in the MDEA on a post-tax basis. ◯ Yes ◯ No

Enrollment in the MDEA continues if monthly payments are made timely or until the end of the plan year, whichever occurs first.

By completing the above, I request that insurance coverage be continued at my own expense.

I understand that this request must be submitted no later than 30 days following my retirement date. I understand this form can be submitted before my retirement date. If I do not continue insurance coverage at my retirement, I cannot re-enroll at a future date.

☐ By checking this box, I am acknowledging that I have read the Enrollment Instructions prior to completing and signing this form.

Employee Signature	Date	
Human Resource Signature:	HR Contact Phone Number	Email Date

For Human Resource Use Only

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

Date sent:_____ MMB fax 651-797-1313

For SEGIP/MMB Use Only: Copies sent to: _____

☐ Medical Plan ☐ Dental Plan SEGIP initials:_____