



SHOP Employer Change Form

October 2014

Please complete this form to update existing employer information only. All changes and modifications requested will be reflected on the next invoice.

For employee changes, please complete the [SHOP Employee Change Form](#)
For broker changes, please complete the [Agent of Record Designation Form](#)

Instructions for completion of SHOP Employer Change Form:

- An asterisk (*) indicates a required field/section
- Type or print clearly with a pen
- All dates should be written in mm/dd/yyyy format
- When reporting effective dates, use contractual start and stop guidelines as defined in your contract (i.e., 1st of month, end of month or actual dates)
- Before submitting the completed form, review to ensure you have provided all necessary information
- Include employer signature

If you have an update to your business name or FEIN, changes must be sent via a secure email to MNSure_shop@state.mn.us

Employer Information

*Employer Name:		Doing Business As Name:	

*FEIN _____			
Address:			<input type="checkbox"/> Check if new address

Address Line 1:		Address Line 2:	

City:	State:	Zip Code:	County:
_____	_____	_____	_____

Primary Contact Information Changes

Prefix:	*First Name:	*Last Name:	Suffix:
_____	_____	_____	_____
*Phone Number:	*Email:		
_____	_____		
Paper Notices:	Preferred Spoken or Written Language, if not English:		
<input type="checkbox"/> Yes <input type="checkbox"/> No	_____		

Secondary Contact Information Changes

Prefix:	*First Name:	*Last Name:	Suffix:
_____	_____	_____	_____
*Phone Number:	*Email:		
_____	_____		
Paper Notices:	Preferred Spoken or Written Language, if not English:		
<input type="checkbox"/> Yes <input type="checkbox"/> No	_____		

Cancellation of Group Coverage

Requested Date of cancellation (mm/dd/yyyy): _____

*Reason: _____

Future Coverage:

*Medical Carrier Name:	*Medical Plan Name:	*Date of Coverage (mm/dd/yyyy):
_____	_____	_____
*Dental Carrier Name:	*Dental Plan Name:	*Date of Coverage (mm/dd/yyyy):
_____	_____	_____



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Employer Signature

I am signing this application under penalty of perjury, which means I have provided true answers to all of the questions to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.

By signing this application, I agree the following statements are true:

- My primary business is located in Minnesota
- I employed an average of at least one employee, working a minimum of 20 hours per week, who was not a sole proprietor, but not more than 50 current employees, working a minimum of 20 hours per week, on business days during the preceding calendar year (January to December) and employed at least one current employee who is not a sole proprietor on the first day of the plan year.
- I am offering health coverage to all of my full-time employees who work an average of 30 hours a week or more
- I know that my information on this form will only be used to determine eligibility for health coverage and will be kept private as required by law. If my business or organization is eligible, this information will be used to facilitate enrollment.
- I know that I must tell the SHOP if anything changes (and is different than) what I wrote on this application. I can call my agent or broker, visit www.mnsure.org, or call 1.855.366.7873 to report changes.
- I have consent from everyone I will list on the application to include their personally identifiable information, like dates of birth, Social Security numbers, addresses, and phone numbers.
- I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I have read the Notice of Privacy Practices in Attachment A.

*Printed Name:

* Authorized Employer Signature:

*Date (mm/dd/yyyy):

Employer should send the completed form, including all supporting documentation, via a secure email to MNsurance_shop@state.mn.us or mail to MNsure SHOP, P.O. Box 64246, St. Paul, MN 55164