

SHOP Enrollment Life Events Form



Version 1.22.14

Please complete this form to update your existing employer-sponsored health coverage. Follow these instructions:

- Type or print clearly with a pen.
- Write all dates in MM/DD/YYYY format.
- To report effective dates, use contractual start and stop guidelines as defined in your contract (i.e., first of month, end of month, or actual dates).
- Review all sections to ensure you have provided all necessary information.
- Include employee signature that involves changes to employee and dependent changes.

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

Part A | Employer Information

Check if changes to employer information below.

Employer Name:

Employer Phone Number:

Employer Address:

Contact Name:

Contact Phone Number:

Contact Email:

Part B | Employee & Dependent Information

Valid life event reasons: Adoption, Birth, Loss of Coverage, Death, Marriage, Dependent No Longer Eligible, Divorce/Legal Separation, Medicare Eligible and Open Enrollment of Employee

1. Enroll Employee + Dependent Coverage
2. Modify Employee + Dependent Coverage
3. Cancel Employee + Dependent Coverage
4. Other, Please Describe:

Employee Name:

Check if new Name | Former Name:

Employee SSN:

Gender: Female Male

Date of Birth:

Date of Full-Time Employment:

Hours Worked per Week:

Date of Hire:



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Employee's Address: Check if new address

Address Line 1:

Address Line 2:

City:

State:

Zip Code:

Phone:

Marital Status:

Single

Married

Widowed

Divorced

Legally Separated

Date of Coverage Effective Date:

Qualifying Life Event Reason:

Qualifying Life Event Date:

Self + Dependent Information

Change Request	Name of Self + Dependent First, Middle and Last Name	Relationship (Self, Spouse, Dependent)	Gender	Date of Birth* MM/DD/YYYY	Social Security Number	Qualifying Event Date	Qualifying Life Event Code**	Tobacco Use***	Primary Care Clinic ****
ADD DROP			Male Female					No Yes	
ADD DROP			Male Female					No Yes	
ADD DROP			Male Female					No Yes	
ADD DROP			Male Female					No Yes	

Note: Attach more sheets as necessary to list your dependents.

* If your dependent is age 26 or older, are they incapacitated or incapable of self-sustaining employment because of physical disability, development disability, mental illness or mental health disorder and dependent on the employee for a majority of their financial support and maintenance? Yes No

**A=Adoption, B=Birth, C=Loss of Coverage, D=Death, E=Marriage, F=Dependent No Longer Eligible, G=Divorce/Legal Separation, M=Medicare Eligible, H=Open Enrollment

***Tobacco use for adding coverage for dependents 18 years of age and older. Tobacco use defined as non-ceremonial use and within the last 2 years.

****Primary Care Clinic for Medica Plans.

Plan Selection | Carrier Name:

Plan Name:

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Part C | COBRA Enrollment

Qualifying Reason for COBRA enrollment:

Employee Total Disability Employee eligible for Medicare Employee Death Employee Termination
Employee Change in Employment Status Divorce/Legal Separation Dependent no longer eligible

COBRA Coverage includes:

Employee Only Spouse Only Employee & Spouse Only
Employee and Dependents Listed Above (included in Dependent Information)
Dependents Only Listed Above (included in Part A | Dependent Information)

Part D | Employee Signature

- 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 and state law if I intentionally provide false or untrue information.
- I know that my information on this form will only be used to determine eligibility for health coverage and will be kept private or nonpublic 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 visit www.mnsure.org or call 1-855-366-7873 to report changes.
- I have permission from everyone I have listed 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.

Employee Signature

Date (MM/DD/YYYY)

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Part E | 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.
- 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 visit www.mnsure.org or call 1-855-366-7873 to report changes.
- I have permission from everyone I have listed 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.

Employer Signature	Date (MM/DD/YYYY)
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