EMPLOYEE CHANGE

Minnesota Public Employees Insurance Program

EMPLOYER USE ONLY ❑ **Change Coverage** ❑ **Change Address/Name**	**OFFICE USE ONLY** **Effective date** _____ **Termination date** _____

EMPLOYEE NAME OR ADDRESS CHANGE INFORMATION

Name ❑ Name Change			Employer		
Former Name			Work Phone		
Address ❑ Address Change			Home Phone		
City	State	Zip	❑ Male ❑ Female		Birth date
Social Security Number			❑ Single ❑ Married		Marriage date

DEPENDENT ADDRESS CHANGE

Dependent Name	Dependent Social Security Number	Dependent Birthdate
New Address		

Note: To add dependents or cancel coverage, there must be a family status change consistent with your request. This must have occurred within the last 30 days. Any changes in status not listed below must be verified through the Administrator. Please check the appropriate boxes and supply all necessary information.

ADD COVERAGE

Add:
❑ Spouse
❑ Child

Reason:
❑ Your marriage Date_____
❑ Birth/adoption of child Date_____
❑ Spouse lost other group coverage Date_____ (Attach copy of employment termination notice from spouse's employer)
❑ Other _____

Name of individual(s) to be added: (Last name, First name, MI)	Relationship to employee	Date of birth M	D	Y	Social Security number	Full-time student YES	NO	Health clinic choice,*(Include PCC#)*
					- -			
					- -			

CANCEL COVERAGE

Cancel:
❑ Self (Employee)
❑ Spouse
❑ Child

Date _____

Reason:
❑ Your divorce Date _____
❑ Death of eligible dependent Date_____
❑ Change in spouse employment status that affects insurance. Specify type of change: _____
❑ Change in child's eligibility Date_____
❑ Child has reached his/her 26th birthday. Birth date_____
❑ Other_____

Name of individual(s) to be canceled: (Last name, First name, MI)	Relationship to employee	Date of birth M	D	Y	Social Security number
					- -
					- -

SIGNATURE

I am applying for a change in coverage in the Minnesota *Public Employees Insurance Program* subject to approval of eligibility. I authorize my employer to disclose the foregoing information to the Minnesota *Public Employees Insurance Program*, the insurance carrier indicated, and any other agent for use in determining eligibility to participate in the Program, in processing my application, and for any other reasons as set forth on the reverse of this application. This authorization is valid until revoked by operation of law. If paid through the payroll system, I authorize payroll deduction for my share of the premiums.

_____ _____
Employee signature Date

There are laws to protect your rights to:
INFORMATION AND PRIVACY

INFORMATION AND PRIVACY

Several state and federal laws aid in protecting your right to privacy and make it easier for you to review information in your insurance file. Under one of these laws, the Minnesota Government Data Practices Act (Minnesota Statutes 13.01-13.43), you have the right to know:

A. Why the information is needed:

The information we request about you, your employment, and family members is needed for one or more of the following reasons:

- To determine whether you are eligible for the Minnesota *Public Employees Insurance Program (PEIP)*.
- To establish the amount of insurance coverages you and/or your family members are eligible for.

B. Your rights regarding supplying information:

Minnesota Statute 13.04. You may refuse to provide the information we request; however, without certain minimal information, we may be unable to process your application for insurance coverage under the group plan.

Federal Privacy Act of 1974: Public Law 93-579. Disclosure of your social security number is voluntary. It is being requested to identify your records in the Minnesota *Public Employees Insurance Program* system maintained by the administrative organization responsible for enrollment, and claims processing procedures for the Program. It is also used for the records maintained by insurance companies. While you are not legally required to furnish this information, processing of your application for group benefits may be delayed without it.

C. Who the information is used by and how it is used:

The information we collect will be used by employees of the Minnesota *Public Employees Insurance Program*'s administrative organization operating the group insurance program, federal and state tax authorities, and will be shared with the insurance carrier(s) and administrator involved in providing your benefits.

Depending on the coverage you request (and are eligible for), information may be used to:

- Provide enrollment and/or change information to your insurance carrier(s) and the Minnesota *Public Employees Insurance Program* administrative organization so they can provide benefits and pay claims.
- When required, provide underwriting information to insurance carrier(s) necessary to acquire insurance coverage.
- Prepare statistical reports and evaluative studies.

When you are no longer an active participant under the group insurance plan, your file will be kept until state document retention requirements are met.

D. What information you have access to:

You may request in writing to be shown insurance information about yourself that is maintained by your employer.

E. How can you obtain information on your benefit files:

Questions regarding your eligibility, level of coverage, and premium rates should be directed to the designated insurance representative for your employer. Questions regarding medical, dental or life insurance claims should be directed to the specific plan chosen.