Qualifying Status Change Form – Life Event

MANAGEMENT AND BUDGET
STATE EMPLOYEE GROUP INSURANCE PROGRAM

Instructions: Refer to the Change my Coverage page mn.gov/mmb/segip/change-my-coverage for reasons to change and the Family Eligibility page mn.gov/mmb/segip/family-eligibility for documentation requirements on the SEGIP website mn.gov/mmb/segip prior to completing, signing and dating this document. Do not delay sending this form if you are missing information or documents. There are strict deadlines for requesting these changes and late requests cannot be processed.

Employee Information – All Information is required.

Name _____ SSN:last four digits _____ Employee ID # _____
(Last, First, Middle Initial)

Address _____ Phone: Work _____ Home _____

City, State, Zip code _____ Email _____

Advantage Medical Coverage – A Primary Care Clinic (PCC) ID for you or your dependent is required. To find a Clinic ID# go to: mn.gov/mmb/segip/find-a-clinic. If you are making a mid-year enrollment change you cannot change your plan administrator at this time.

- NOTE: If you or your dependent/s have Medicare complete **Part C**.

Advantage Medical Coverage: ◯ Employee only ◯ Family (complete dependent information below)

Plan Administrator: ◯ Blue Cross Blue Shield of MN ◯ HealthPartners

PCC Clinic Id # (Required for employees) _____

State Dental Coverage – A Primary Care Clinic (PCC) is not required. An in-network Dental Directory is available at mn.gov/mmb/segip. If you are making a mid-year enrollment change you cannot change your plan administrator at this time.

Dental coverage level: ◯ Employee only ◯ Family (complete dependent information below)

◯ Delta Dental - Group 216 ◯ HealthPartners

Vision Coverage – A Primary Care Clinic (PCC) is not required. Fully funded by employee and to be used for hardware only.

Vision coverage level: ◯ Employee only ◯ Family (complete dependent information below)

See the Rate Guide (mn.gov/mmb-stat/segip/doc/rate-guide.pdf) for premium information.

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Dependent Information and Relationship to you – All information requested is required for enrollment.

**Do not delay submitting this form while waiting to receive a Social Security Number. Write "Applied for" and send the form to SEGIP by the deadline.

	Name/ Relationship*	Date of birth (mm/dd/yyyy)	Gender (M/F/Other)	**Social Security # (9 digits)	Clinic ID # Required	Medical Plan	Dental Plan	Vision Plan
1						◯ Add ◯ Drop	◯ Add ◯ Drop	◯ Add ◯ Drop
2						◯ Add ◯ Drop	◯ Add ◯ Drop	◯ Add ◯ Drop
3						◯ Add ◯ Drop	◯ Add ◯ Drop	◯ Add ◯ Drop
4						◯ Add ◯ Drop	◯ Add ◯ Drop	◯ Add ◯ Drop
5						◯ Add ◯ Drop	◯ Add ◯ Drop	◯ Add ◯ Drop

*If adding a Spouse, complete Part B

If dependent address is different than employee, complete the address information below:

Dependent Name: _____

Address: _____

City, State, Zip: _____

If dependent address is different than employee, complete the address information below:

Dependent Name: _____

Address: _____

City, State, Zip: _____

If more than two dependents have a different address, use an additional page if necessary.

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Part A. Reason for changes in coverage

SEGIP can allow you to make changes to your insurance coverage outside an annual open enrollment period if you experience a qualifying life event. This life event must have occurred within the last 30 days if you are requesting to add coverage and the last 60 days if you are asking to cancel coverage.

Date of Life Event: _____ Change affects: ☐ You ☐ Spouse ☐ Child

Please check the appropriate box:

☐ Birth/Adoption/Placement for adoption

☐ Change in eligibility through a government program (Medical Assistance, MN Care) 60-day period to add coverage

☐ Change in yours/dependent employment status that affects Insurance

☐ Child turned aged 26

☐ Death of dependent

☐ Divorce

☐ Foster Child/Grandchild

☐ Marriage

☐ Military Active Duty – enrollment in Tricare required

Other (please explain): _____

BEFORE allowing a change, SEGIP will request proof to add or cancel coverages for you or your dependents such as a divorce decree or official letter (on letterhead) from the employer/group verifying the event and date of the event. You may be required to contact the employer of your spouse or dependent before we make a change. Do not delay sending in this application while waiting for any documentation.

Part B. Spouse eligibility

Use the following questions to determine if your spouse may be eligible for coverage on your health insurance (medical, dental and vision coverages). Complete the section below that applies to your spouse's employment.

☐ My spouse is an employee of the State of Minnesota or other organization participating in the State Employee Group Insurance Plan (SEGIP).

Members cannot be covered both as an employee and as a dependent for any health coverage.
SEGIP Family Eligibility FAQs

Answer the following questions to determine eligibility in these health plans:

a) Has Medical coverage been waived or will coverage be waived ◯ Yes ◯ No

b) Has Dental coverage been waived or will coverage be waived ◯ Yes ◯ No

c) Has Vision coverage been waived or will coverage be waived ◯ Yes ◯ No

If you answered "No" to any of the questions above, your spouse is not eligible for that specific coverage.

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My spouse is employed by a private employer or other organization that does not participate in the State Employee Group Insurance Plan (SEGIP).

1. Is your spouse employed full-time by an employer with 100 or more employees and eligible for health insurance? ◯ Yes ◯ No
2. Has your spouse chosen to receive any of the following from their employer? ◯ Yes ◯ No
    - Cash instead of health insurance or
    - Credit towards the purchase of some other benefit instead of health insurance or
    - Is enrolled in a High Deductible Health insurance plan (as defined by the IRS) that includes a contribution to an HSA.

If you answered "Yes" to questions, 1 and 2, your spouse is not eligible.

You must notify SEGIP if your spouse's eligibility for insurance changes.

NOTE: If your spouse is eligible for their own full employer contribution toward health coverage through SEGIP they must submit a Waiver of Medical Coverage form (https://mn.gov/mmb-stat/segip/doc/Waiver_of_medical_coverage_form.pdf) and proof of other coverage. Submit the waiver and proof by secure fax: 651-797-1313; Mail: MMB/SEGIP, 400 Centennial Building, 658 Cedar Street, St. Paul, MN 55155; Scan and email (secure only when sent from an @state.mn.us account) segip.mmb@state.mn.us. If the form is not submitted, your spouse will not be enrolled in your coverage and will be automatically enrolled in their own single health coverage. No form is required for dental or vision coverage or if your spouse is not eligible for the full employer contribution.

NOTE: If your spouse or dependent has a high deductible health plan (HDHP) and is contributing to a Health Savings Account (HSA), then you cannot have a MDEA for general medical expenses but may choose a Limited Purpose MDEA. Please contact your spouse's or dependent's employer to understand these HSA eligibility rules.

Part C. Medicare Information

Reason for Medicare coverage: (check one):

◯ Age ◯ Disability ◯ End stage renal disease or ALS (Lou Gehrig's Disease)

Name of Medicare-enrolled member(s): _____ Medicare # _____

Type of Medicare Coverage:

☐ Part A (Hospital Insurance) Part A Effective Date _____

☐ Part B (Medical Insurance) Part B Effective Date _____

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Part D. Important Plan Information and Employee Authorization

Statement of Fraud or Intentional Misrepresentation

Each Member must notify SEGIP immediately of the date the Member knew or should have known that information either is or has become incorrect due to an affirmative statement of information, an omission of information, or a change in circumstances, information as follows:

1. Contained in the enrollment form pertaining to the Member or any individual related to the Member receiving or seeking benefits under the Plan, or
2. Related to a claim for benefits.

SEGIP may rescind or cancel the coverage of a Member and/or each individual enrolled in the Plan under the Member upon thirty (30) days prior written notice if it is determined that the Member or individual made an intentional misrepresentation of material fact or was involved in fraud concerning any matter relating to eligibility for coverage or claim for benefits under the Plan.

Coverage for each individual identified in a Notice of Rescission of Coverage will be rescinded as of the date specified in the Notice of Rescission of Coverage, which may be to the effective date of individual's coverage. The Member and any individual involved in the misrepresentation or fraud may be liable for all claims paid by the Plan on behalf of such individuals.

By signing this form, I am attesting that my spouse/dependents are eligible for coverage according to the eligibility rules as defined in the SEGIP Summary Plan Description and/or applicable union contract or compensation plan. I understand that attempting to enroll or enrollment of ineligible dependents may be considered fraud or intentional misrepresentation of a material fact. I further understand, that both myself and any individual involved in fraud or intentional misrepresentation of a material fact, may be liable for all claims paid by the Plan on behalf of such individuals and may be subject to employment discipline, up to and including discharge and may also be subject to criminal penalties.

I am applying for coverage or changes in coverage in the MN State Employee Group Insurance Program, and Health and Dental Premium Account, subject to approval by SEGIP. I authorize my employer to disclose the foregoing information to the insurance carrier(s) indicated, for use in determining my eligibility and in processing my application. This authorization is valid until revoked by operation of law. If paid through the State of Minnesota central payroll system, I authorize payroll deductions for my share of the premiums on a before-tax basis.

To have premiums taken on a post-tax basis, contact SEGIP at 651-355-0100.

If there is a change in my spouse or dependent's eligibility for insurance, I understand that it is my responsibility to notify SEGIP in writing of such a change.

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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. 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.

I have read and agree to the above information.

Print Name _____

Your signature _____ Date _____

Submit your form to SEGIP: Secure fax 651-797-1313;
Mail MMB/SEGIP, 400 Centennial Building, 658 Cedar Street, Saint Paul, MN 55155;
Scan and email (secure only when sent from a @state.mn.us account) segip.mmb@state.mn.us.

Questions? Call us at 651-355-0100