

Dependent Change Form



Use this form if you have family coverage and want to add or drop a spouse or dependent(s) but still keep coverage for your other eligible family members. If you want to drop all family coverage, complete a Basic Application.

Read the Employee and General Information section below and Dependent Eligibility section on page 3 of this form. You must completely fill out this form including your signature and the date and return to: SEGIP, 658 Cedar Street, St. Paul, MN 55155, fax this form to: 651-296-5445 or scan and email to segip.mmb@state.mn.us. For help, call SEGIP at 651-355-0100. **This form must be received at SEGIP by the deadline date. Do not delay sending the form because you are waiting for information or documents or SEGIP will not be able to make your requested change.**

Employee and General Information:

All information is required if you are adding a spouse/dependent. **If adding a spouse or dependent(s) proof of eligibility will be required. A separate request for proof of eligibility will be sent.** To see a list of required documents go to our web page at <http://mn.gov/mmb/segip/medical-dental/current-employees/elect-change-benefits/>. If dropping a spouse/dependent include the name and date of birth. SEGIP will follow up to request proof of a life event.

Name _____ (Last, First, Middle Initial)	Employee/COBRA ID Number _____
Work Phone _____	Home Phone _____
Work email address _____	
Effective Date of Change _____	Reason for Change _____

Health Plan Enrollment **If dependent is disabled and age 26, contact plans for additional forms to cover disabled dependent.

Current Health Plan: Blue Cross, HealthPartners or PreferredOne :

*A search tool to find your health clinic ID number is located at: http://mn.gov/mmb/segip/medical-dental/current-employees/choose_your_clinic/

Add or Drop Coverage	Name and Address <input type="checkbox"/> Check if address is same as employee, otherwise list address below	Relationship to employee	Sex	Date of Birth	SSN	Health Clinic ID Number*

Dental Plan Enrollment **If dependent is disabled and age 26, contact plans for additional forms to cover disabled dependent.

Current Dental Plan, Delta Dental or Health Partners Dental:

Add/Drop	Name and Address <input type="checkbox"/> Check if address is same as employee, otherwise list address below	Relationship to employee	Date of Birth	SSN

Spouse eligibility: Please provide the following information if adding a spouse:

- Is your spouse employed full-time by an employer with 100 or more employees? Yes No
- Is your spouse eligible to receive health insurance from his/her employer? Yes No
- Has your spouse chosen to receive from their employer
 - Cash instead of health insurance, or Yes No
 - Credit towards the purchase of some other benefit instead of health insurance, or Yes No
 - Cash and a health insurance plan with a deductible of \$750 or more. (See next page)

This includes a high deductible plan.

Yes No

4a. Is your spouse eligible for insurance benefits as an employee of the State of Minnesota or another organization participating in the State Employee Group Insurance Plan (SEGIP) ? Yes No

4b. If yes, has coverage been waived or will coverage be waived? Yes No

- Your spouse is NOT eligible for coverage on your health coverage if you answered "Yes" to questions, 1, 2 and 3.
- Your spouse is NOT eligible if you answered "Yes" to question 4a and "No" to question 4b.

NOTE: If your spouse has a high deductible health plan (HDHP) and an HSA, HSA rules prohibit your spouse from certain SEGIP coverage. Please contact your spouse's employer to understand these eligibility rules. If your spouse has a health savings account (HSA), you cannot have a general purpose MDEA but rather a limited purpose MDEA. This Limited MDEA allows your spouse to maintain HSA eligibility.

Medicare Enrolled: if you or your dependent is enrolled in Medicare, please provide the following information:

Name of Medicare enrolled member _____		
Does the covered member have Medicare Hospital Coverage (Part A)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, effective date _____ Medicare # _____		
Does the covered member have Medicare Hospital Coverage (Part B)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, effective date _____ Medicare (HICN) # _____		
Reason for Medicare coverage	<input type="checkbox"/> Age	<input type="checkbox"/> Disability <input type="checkbox"/> End stage renal disease

Statement of Fraud or Intentional Misrepresentation

Each Member must notify the Plan Administrator immediately of the date the Member knew or should have known that information either:

- Contained in the enrollment form pertaining to the Member or any individual related to the Member receiving or seeking benefits under the Plan, or
- Related to a claim for benefits, or
- Has become incorrect due to an affirmative statement of information, an omission of information, or a change in circumstances.

The Plan Administrator 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 the Plan Administrator determines 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 dependents are eligible for coverage according to the dependent eligibility rules as defined in the Summary of Benefits or applicable labor agreement or compensation plan. I understand the attempted or actual 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. 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.

I understand I must notify the SEGIP if my spouse or dependent's eligibility for insurance changes.

Employee's Signature _____ Date _____

Dependent Coverage Restrictions. If both spouses work for the State or another organization participating in SEGIP, either spouse, but not both, may cover their eligible dependent children or grandchildren. This restriction also applies to two divorced, legally separated, or unmarried employees who share legal responsibility for their eligible dependent children. If both spouses work for the State or another organization participating in SEGIP, neither spouse may be covered by the other as a dependent by the other unless one is not eligible for a full employer contribution as defined in the contracts. This also applies to dependents eligible for coverage under SEGIP through their own employment, with another organization or agency that participates in SEGIP.

Ex-Spouse Policy

When an employee divorces his/her spouse state law requires that the ex-spouse be allowed to continue as a SEGIP member. To be eligible the ex-spouse must be on the employee's family policy at the time of the divorce (a spouse may not be removed from the plan in anticipation of a divorce). If the employee has claimed no dependents other than the ex-spouse at the time of the divorce, or when all children in common lose their eligibility, the employee may cancel family coverage and the ex-spouse will remain in SEGIP as a paying member. The ex-spouse continues to be covered even if the employee remarries; an employee may cover both the current and ex-spouse. Newly hired employees and newly insurance eligible employees may not cover an ex-spouse. The ex-spouse will lose eligibility if either of the following occur:

- The ex-spouse acquires other group health insurance that has no pre-existing condition exclusion.
- The ex-spouse requests to be taken off the employee's policy.



Dependent Eligibility for Medical and Dental Coverage State Employee Group Insurance Program (SEGIP)

Eligible Dependents	Definition of an Eligible Dependent	Required Documentation
Spouse	<ul style="list-style-type: none"> Must be legally married under Minnesota law to an insurance eligible employee, and Your spouse is not eligible if he/she works full-time for an employer (with more than 100 people) and elects to receive cash or credits (1) in place of health insurance, or (2) in addition to a health plan with a deductible of \$750 or greater 	<ol style="list-style-type: none"> Copy of your certified marriage certificate and Copy of the front page for your most recent federal tax return confirming this dependent is your spouse OR a document dated within the last 60 days showing current relationship status such as a household bill. The document must include your spouse's name, the date and your mailing address. and Completed Spouse/Former Spouse Certification Form
Former Spouse	<ul style="list-style-type: none"> The divorce must occur while the employee is covered, and Must have been covered on the employee's plan at the time of the divorce, and May not have obtained other group coverage since the divorce, and Not eligible if he/she works full-time for an employer (with more than 100 people) and elects to receive cash or credits (1) in place of health insurance, or (2) in exchange for a health plan with a deductible of \$750 or greater 	<ol style="list-style-type: none"> Copy of your divorce decree signed by a judge or court administrator and Completed Spouse/Former Spouse Certification Form
Biological Children	<ul style="list-style-type: none"> To age 26 	<ol style="list-style-type: none"> Copy of your child's certified birth certificate naming you as the child's parent
Adopted children	<ul style="list-style-type: none"> To age 26 if adopted or To age 18 if placed with you for adoption 	<ol style="list-style-type: none"> Final copy of your court documentation showing the names of both you (or your spouse) and the child confirming the adoption or Copy of the child's certified birth certificate naming you (or your spouse) as the child's parent
Step Children	<ul style="list-style-type: none"> To age 26 You must be legally married to the child's parent 	<ol style="list-style-type: none"> Copy of the child's certified birth certificate naming your spouse as the child's parent and Copy of your certified marriage certificate and a current financial document naming both you and your spouse
Foster Children (ward, legal guardian, legal custody)	<ul style="list-style-type: none"> To age 26 Full and permanent legal and physical custody 	<ol style="list-style-type: none"> Completed Foster Child Certification Form and Final copy of court document showing your name (and/or your spouse) confirming the permanent custodial relationship and Copy of the front page of your (or your spouse's) most recent federal tax return confirming this dependent is your (or your spouse's) tax dependent
Grandchildren	<ul style="list-style-type: none"> To age 25 Unmarried, dependent upon you for principal support and maintenance and lives with you; your child must be unmarried and less than age 19 or Financially dependent upon you and has resided with you continuously from birth -OR- If you have legally adopted your grandchild or are the foster parent of your grandchild follow the eligibility rules for each above 	<ol style="list-style-type: none"> Completed Grandchild Certification Form and Copy of your grandchild's certified birth certificate, naming your (or your spouse's) child as your grandchild's parent and Copy of your child's certified birth certificate naming you (or your spouse) as the parent and Document dated within the last 6 months establishing this grandchild currently resides with you and Copy of your most recent federal tax return listing this child as your (or your spouse's) tax dependent If your grandchild has lived with you continuously from birth a copy of your federal tax return from the year this grandchild was born
Disabled Children	<ul style="list-style-type: none"> Any age or marital status, includes dependent children incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability, and Chiefly dependent upon you for principal support and maintenance, and You must provide proof of such incapacity and dependency annually as requested by your health plan administrator 	<ol style="list-style-type: none"> Copy of the child's certified birth certificate naming you or your spouse as the child's parent, OR appropriate court order / adoption decree naming you as the child's legal guardian

Also covered: any other person required by state or federal law to be treated as a dependent for purpose of health care coverage.

Change in status or dependent eligibility: It is your responsibility to notify SEGIP of any change in a dependent's status (life event). Spouses and dependents losing eligibility may qualify for COBRA. An eligible spouse or dependent may be added within 30 days of a life event or during Open Enrollment. You must notify SEGIP within 60 days of your divorce from a covered spouse or if a covered dependent loses eligibility. After the 60-day period ends, continued failure to report a loss of eligibility may be considered fraud or intentional misrepresentation of a material fact and the employee may be liable for all claims paid by the Plan on behalf of such individuals and you may be subject to criminal penalties. Instances of fraud, intentional misrepresentation of a material fact or non-payment of premiums may result in the retroactive cancellation of coverage. Upon a 30-day notice, ineligible dependents may be dis-enrolled. Details are in *Your Employee Benefits* <http://mn.gov/mmb/images/2015-Your-EE-Benefits.pdf>

Notice of Privacy Practices Minnesota Management & Budget (MMB) administers the State Employee Group Insurance Program (SEGIP). This notice explains why we are requesting the private data about you, your spouse, and dependents, how we will use it, who will see it, and your obligation to provide the data.

Why we ask you for this data? We ask for this data so that we can successfully administer SEGIP. This information is used to process your request to add or change coverage for yourself, your spouse, or dependents. The requested information helps us to determine eligibility, to identify you and your spouse, and dependents, and to contact you or your spouse, and dependents. The information is also used to develop new programs, ensure current programs effectively and efficiently meet member needs, and to comply with federal and state law and rules. We need the social security numbers and birth dates of your spouse and dependent to offer insurance continuation, process a death benefit, to ensure we are matching them to the correct insurance benefit transaction and to comply with federal Medicare coordination laws (in compliance with Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173)). If you provide any data about you, your spouse, or dependents that is not necessary, we will not use it for any purpose.

Do you have to provide the private data requested? You are not required to provide all of the data but certain data must be collected. If you do not provide the requested data, your dependent(s) may not be approved to participate in the program or may lose coverage under the program. If you do provide the data, it will be used as described.

Who else may see this data about you and your spouse and dependents? We may give data about you, your spouse, and dependents to the plan administrator you have chosen, SEGIP's other representatives, vendors and actuary; the Legislative Auditor; the Department of Health; the Department of Commerce; and any law enforcement agency or other agency with the legal authority to the information; and anyone authorized by a court order. In addition, the parents of a minor may see data on the minor unless there is a law, court order, or other legally binding instrument that blocks the parent from that data.

How else may this data be used? We can use or release this data only as stated in this notice unless you give us your written permission to release the data for another purpose or to release it to another individual or entity. The data may also be used for another purpose if Congress or the Minnesota Legislature passes a law allowing or requiring us to release the data or to use it for another purpose.

Minnesota Management & Budget
NOTICE OF COLLECTION OF PRIVATE DATA

Minnesota Management & Budget (MMB) administers the State Employee Group Insurance Program (SEGIP). This notice explains why we may request information (data) about you, your spouse, and dependents, how we will use it, who will see it, and your obligation to provide that information.

What information will we use?

We will use the information you provide us at this time, as well as information previously provided us, about yourself, your spouse, or dependent(s). If you provide any information about that is not necessary, we will not use it for any purpose.

SEMA4, the information system used to administer employee benefits, contains required information fields that may not be necessary for us to process your request. We only need your dependent's date of death to process a death benefit claim or to discontinue the dependent's coverage due to his or her death. Student status and disability status are needed only to determine eligibility for insurance continuation for your dependent. We need the social security numbers and birth dates of your spouse and dependent to offer insurance continuation, process a death benefit, to ensure we are matching them to the correct insurance benefit transaction and to comply with federal Medicare coordination laws.

Why we ask you for this information?

We ask for this information so that we can successfully administer SEGIP. This information is used to process your request to add or change coverage for yourself, your spouse, or dependents. The requested information helps us to determine eligibility, to identify you and your spouse, and dependents, and to contact you or your spouse, and dependents. The information is also used to develop new programs, ensure current programs effectively and efficiently meet member needs, and to comply with federal and state law and rules. We may ask for information about you, your spouse or dependents that we have already collected, including all or part of your social security number, in order to ensure we are matching you to the correct insurance benefit transaction.

Do you have to answer the questions we ask?

You may not be legally required to provide any of the information requested.

What will happen if you do not answer the questions we ask?

If you do not answer these questions, the insurance benefit transaction you requested for you or your spouse, dependent or other insurance benefit transaction may be delayed or denied.

Who else may see this information about you and your spouse and dependents?

We may give data about you and your spouse, and dependents to the insurance carrier you have chosen, SEGIP's other representatives, vendors and actuary; the Legislative Auditor; the Department of Health; the Department of Commerce; and any law enforcement agency or other agency with the legal authority to the information; and anyone authorized by a court order. In addition, the parents of a minor may see information on the minor unless there is a law, court order, or other legally binding instrument that blocks the parent from that information.

How else may this information be used?

We can use or release this information only as stated in this notice unless you give us your written permission to release the information for another purpose or to release it to another individual or entity. The information may also be used for another purpose if Congress or the Minnesota Legislature passes a law allowing or requiring us to release the information or to use it for another purpose.