

# Dependent Change Form



**Directions:** Use this form if you currently have family coverage and want to add an additional dependent, or drop a dependent and still maintain coverage for your other dependent(s). **If you want to add or drop family coverage, complete a Basic Application.** If you are making a clinic change, contact the plan directly. If your change involves legal documentation (such as an adoption or a divorce), include a copy of the legal document with this form. For other eligibility rules, please reference the *Dependent Eligibility* section on page 3 of this form. **Completely fill out this form, sign, date and return it to:** MMB, Employee Insurance Division, 658 Cedar Street, St. Paul, MN 55155 or fax this form to: 651-797-1313. For questions, call 651-355-0100.

## Employee Information

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

General: To add or drop a dependent, complete all sections below. If adding a dependent all information is required for SEGIP to process the enrollment. If a change in dependent eligibility for insurance occurs, I understand that it is my responsibility to notify SEGIP in writing of such a change.

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

Current Health Plan:						
Add/Drop	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*

\*A search tool to find your health clinic ID number is located at: [http://www.mmb.state.mn.us/insdir/provider\\_directory.aspx](http://www.mmb.state.mn.us/insdir/provider_directory.aspx)

## Dental Plan Enrollment

Dependent must be unmarried, FT student age 19 to 25 to qualify for dental coverage. Complete one copy of this section for each full time student dependent between ages 19 and 25 that you are requesting to enroll in dental coverage.

Current Dental Plan:				
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

Full-time Student?     Yes         No    Indicate dates of attendance \_\_\_\_\_

Indicate accredited school where dependent is enrolled \_\_\_\_\_

## Spousal Eligibility Section: to add your spouse, please provide the following information:

Marital Status	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	Do you have common dependent children?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No	1. Is your spouse employed full-time by an employer with 100 or more employees?			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	2. Is your spouse eligible to receive health insurance from his/her employer?			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	3. Has your spouse chosen to receive from his/her employer (Question #3 continued on page 3):			



**Dependent Eligibility for Health Coverage**  
**State Employee Group Insurance Program (SEGIP)**  
*Effective January 1, 2011*



Dependent	Eligibility Terms
Biological children*	<ul style="list-style-type: none"> <li>to age 26</li> </ul>
Adopted children*	<ul style="list-style-type: none"> <li>to age 26</li> <li>adopted or placed with you for adoption</li> </ul>
Step children*	<ul style="list-style-type: none"> <li>to age 26</li> <li>you must be legally married to the child's parent</li> </ul>
Foster children* (includes ward or legal guardian)	<ul style="list-style-type: none"> <li>to age 26</li> <li>you must submit a completed Foster Child Certification form</li> </ul>
Grandchildren*	<ul style="list-style-type: none"> <li>to age 19, full-time student to age 25 and</li> <li>financially dependent upon and has resided with you continuously from birth, or</li> <li>legally adopted or placed with you for adoption, or</li> <li>placed in your legal custody and dependent upon you for principal support and maintenance and lives with you, or</li> <li>unmarried, dependent upon you for principal support and maintenance and lives with you; and your child is unmarried and financially dependent upon you</li> </ul>
Disabled children	<ul style="list-style-type: none"> <li>any age or marital status</li> <li>incapable of self-sustaining employment by reason of development disability, mental illness or disorder, or physical disability</li> <li>chiefly dependent upon you for principal support and maintenance</li> </ul>
QMCSO	<ul style="list-style-type: none"> <li>your children who are required to be covered by a Qualified Medical Child Support Order</li> </ul>
Spouse	<ul style="list-style-type: none"> <li>must be legally married under Minnesota law to an insurance eligible state employee</li> <li>may not be legally separated</li> <li>limited eligibility for spouses with other employer provided coverage</li> </ul>

Also covered is any other person whom state or federal law requires to be treated as a dependent for purposes of health plans.

\*Not eligible if the adult child is eligible for other employer based group health coverage, may be eligible for other parental employer based coverage

**Change in status or dependent eligibility: It is your responsibility to notify SEGIP of any change in a dependent's status** (life event). You must notify SEGIP within 60 days of your divorce or legal separation from a covered spouse or if a covered dependent loses eligibility. Spouses and dependents losing eligibility may qualify for COBRA. An eligible spouse or dependent must be added within 30 days of a life event or during Open Enrollment. After the 60-day period lapses continued failure to report may be considered fraud or intentional misrepresentation of a material fact. Upon a 30-day notice, ineligible dependents will be un-enrolled. Instances of fraud, intentional misrepresentation of a material fact or non-payment of premiums may result in the retroactive cancellation of coverage. The member and any individual involved in fraud or misrepresentation may be liable for all claims paid by the Plan on behalf of such individuals and may be subject to criminal penalties. Details are in *Your Employee Benefits* ([www.mmb.state.mn.us/doc/ins/yeb/yeb.pdf](http://www.mmb.state.mn.us/doc/ins/yeb/yeb.pdf)).

**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 not 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.