

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 the back of this form. **Completely fill out this form** and return it to: MMB, Employee Insurance Division, 658 Cedar Street, St. Paul, MN 55155 or fax this form to: 651-296-5445. For questions, call 651-355-0100.

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

General: to add or drop a dependent, please complete this section and, if applicable also complete a section below:

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 Number*

*A search for your health clinic's number can be found at: http://www.doer.state.mn.us/insdir/provider_directory.aspx

Spousal Eligibility: to add or drop 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:			
a) cash instead of health insurance, or b) credit towards the purchase of some other employee benefit instead of health insurance, or c) cash and a health insurance plan with a deductible of \$750 or more instead of a plan with a smaller deductible? (This includes a high deductible health plan.)					
<input type="checkbox"/> Yes	<input type="checkbox"/> No	4. Does your spouse receive insurance benefits as an employee of the State of Minnesota or another organization participating in the State Employee Group Insurance Program (SEGIP)?			
Your spouse is NOT eligible for coverage as a dependent on your health insurance if:					
(a) you answered "yes" to questions, 1, 2, <u>and</u> 3 OR (b) you answered "yes" to question 4.					
NOTE: If you have an MDEA (FSA) your spouse is may not be eligible for an health savings account (HSA). If your spouse has a high deductible health plan, that plan may prohibit your spouse from certain SEGIP coverage. Please contact your spouse's employer to understand these eligibility rules.					
I have read the above statements relating to my spouse's eligibility for health insurance and certify that:					
<input type="checkbox"/> My spouse is eligible			<input type="checkbox"/> My spouse is not eligible		

Dependent Over 19: to add or drop a dependent over age 19, please provide the following additional information:

Name of Dependent _____	
Name of School _____	Date Student First Enrolled: Month ____ Year ____
Is Student Full-time <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Student Expects to Graduate _____
Child's Marriage Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced	Last Date Attended _____
Child is Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Marriage or Divorce _____

Your health plan will verify student eligibility on an on-going basis. Failure to reply to their inquiry will result in the student's termination of coverage. Members are required to notify SEGIP if your dependent has a change in status.

Complete one copy of this section for each dependent over age 19 you are requesting to enroll.

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 # _____	
Reason for Medicare coverage <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> End stage renal disease	

If there is a change in my dependent's eligibility for insurance, I understand that it is my responsibility to notify the Employee Insurance Division in writing of such a change. By using this form to add dependents, I verify that my dependents are eligible for coverage according to the dependent eligibility rules. Insurance claims incurred by ineligible dependents will be denied.

Employee's Signature _____ Date _____

Dependent Eligibility

Spouse. The spouse of an eligible employee may be covered unless he/she is legally separated from the employee. The other spouse eligibility rules are detailed in the "Spousal Eligibility" section above.

Children and Grandchildren. An eligible employee's unmarried dependent children and unmarried dependent grandchildren through age 18 or through age 24 if he/she is a full-time student at an accredited educational institution. A disabled child may be covered regardless of age or marital status if the child if he/she meets the qualifications listed below.

"Dependent child" includes an employee's biological child, child legally adopted by or placed for adoption with the employee, foster child, and step-child. To be considered a dependent child, a step-child or foster child must maintain residence with the employee and be dependent upon the employee for his/her principal support and maintenance. To be considered a dependent child, a foster child must be placed by the court in the custody of the employee. You must complete a Foster Child Verification form to verify eligibility. The form can be obtained by calling SEGIP at 651.355.0110.

"Dependent grandchild" includes an employee's grandchild placed in the legal custody of the employee, grandchild legally adopted by the employee or placed for adoption with the employee, or grandchild who is the dependent child of the employee's unmarried dependent child. Grandchildren placed in the employee's legal custody and those who are the dependent child of the employee's unmarried dependent child must be dependent upon the employee for the principal support and maintenance and live with the employee.

"Disabled dependent," is a child or grandchild, regardless of age or marital status, who is incapable of self-sustaining employment by reason of mental or physical disability and is chiefly dependent on the employee for support. The disabled dependent is eligible for coverage as long as he/she continues to be disabled and dependent, unless coverage terminates under the contract. The disability status is determined by the member's health plan.

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.

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:

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

Minnesota Management & Budget NOTICE OF COLLECTION OF PRIVATE DATA

Minnesota Management & Budget administers the State Employee Group Insurance Program (SEGIP). This notice explains why we may request information (data) about you, your dependents and beneficiaries, 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 you have previously provided us about yourself, your dependent(s), and/or your beneficiary. If you provide any information about yourself or your dependent or beneficiary 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 do not need the gender or marital status for your beneficiary designation, so you may enter "unknown" in these fields. 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 only need your dependent's social security number to offer insurance continuation or process a death benefit.

Why we ask you for this information?

We ask for this information to process your request to add or change coverage for yourself, your dependent or a beneficiary. The requested information helps us to determine eligibility, to identify you and your dependents and beneficiaries, and to contact you or your dependents and beneficiaries. We use the information so that we can successfully administer SEGIP, including analyzing unidentifiable aggregate data to develop new programs and ensure current programs are effectively and efficiently meeting member needs. We may ask for information about you 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 change request or other insurance benefit transaction.

Do you have to answer the questions we ask?

You are 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 dependent or other insurance benefit transaction may be delayed or denied.

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

We may give information about you and your dependents and beneficiaries to the insurance carrier you have chosen, SEGIP's representatives, vendors, and actuary, the Legislative Auditor, the Department of Health, 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. We can use or relates this information only as stated in this notice unless you give your written consent to authorize release of the information to another person/entity, or if Congress or the Minnesota Legislature passes a law allowing or requiring us to release the information or to use it for another purpose.

Minnesota Management & Budget
NOTICE OF COLLECTION OF PRIVATE DATA

We ask for this information to process your request to add or change coverage for yourself, your dependent or beneficiary. The requested information helps us to determine eligibility, identify you and your dependents and beneficiaries, and contact you or your dependents and beneficiaries. We use the information so that we can successfully administer SEGIP, including using unidentifiable, aggregate data to develop new programs and ensure current programs effectively and efficiently meet member needs. We can use or release this information only as stated in this notice unless you give us your written permission to release the information or to use it for another purpose.

You are not legally required to provide us any of this information and you may refuse to provide the information. However, if you do not provide us the requested information, the insurance transaction you requested for you or your dependent or other insurance benefit transaction may be delayed or denied.

We may give information about you and your dependents and beneficiaries to the insurance carrier you have chosen, SEGIP's representatives, vendors, and actuary, the Legislative Auditor, the Department of Health, 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. This information may also be used or released if Congress or the Minnesota Legislature passes a law allowing or requiring us to release the information or to use it for another purpose.