**Minnesota Public Employees Insurance Program**

# EMPLOYEE ENROLLMENT

**EMPLOYER USE ONLY**

❑ **New Employee** ❑ **Annual Enrollment** ❑ **Late Entrant (Complete Health History Form)**

**Date of Hire** ❑ **COBRA** ❑ **Early Retiree**

_____ ❑ **Return from Leave** ❑ **Other (attach letter of explanation)**

**Effective Date**

## EMPLOYEE INFORMATION

| Social Security Number | Employer | | |
|---|---|---|---|
| Name | | Work Phone | Home Phone |
| Address | | ❑ Male ❑ Female | Date of Birth |
| City | State | Zip | ❑ Single ❑ Married |

Do you or your spouse have other health coverage or Medicare? ❑ Yes ❑ No If yes, complete the following:

| Spouse Name | Name of Health Plan | Spouse Date of Birth |
|---|---|---|

## WAIVER OF COVERAGE

***Complete this section only if you are NOT enrolling in the Minnesota Public Employees Insurance Program.***

**Check appropriate box:**

❑ I am waiving coverage in the Minnesota *Public Employees Insurance Program* at this time because I have coverage under another plan.

❑ I am waiving coverage in the Minnesota *Public Employees Insurance Program* and do not have coverage under another plan

| Employee Signature | Date |
|---|---|

## COVERAGE OPTIONS

**Health Plan choice: (one per family)**
- ❑ HealthPartners
- ❑ Blue Cross Blue Shield
- ❑ Preferred One

**Benefit Level: (choose one):**
- ❑ Advantage High Plan
- ❑ Advantage Value Plan
- ❑ Advantage HSA Plan

**Who do you wish to cover? Check all that apply.**
- ❑ Employee Only
- ❑ Employee + One
- ❑ Family

**LIFE**

❑ Basic Life/AD&D Insurance (check with your employer for amount) ❑ Dependent/Spouse Life Insurance

❑ Employee Supplemental Life/AD&D Insurance - Amount: _____ (increments of $5,000 upon approval)

Life Insurance Beneficiary Designation:

Primary: Relationship:

Secondary: Relationship:

**DENTAL** If dependent coverage is offered, family dental will be packaged with family medical (employees who choose family medical must choose family dental).

❑ Employee Dental Coverage ❑ Employee and Dependent Dental Coverage

## EMPLOYEE/DEPENDENTS

| Last Name, First Name, Middle Initial (use additional paper if necessary) | Date of Birth (Month/Date/Year) | Sex | Full-time Student Yes | Full-time Student No | Social Security Number | Primary Care Clinic Name & Clinic # |
|---|---|---|---|---|---|---|
| Employee | | | | | | |
| Spouse | | | | | | |
| Child | | | | | | |
| Child | | | | | | |
| Child | | | | | | |

## SIGNATURE

I am applying for coverage in the Minnesota *Public Employees Insurance Program* subject to approval of my 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 my 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:

- 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.