Minnesota Public Employees			
	Minnesota	Public	Employees
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Insurance Program	Insurance	Progra	m

EMPLOYEE CHANGE

EMPLOYER USE ONLY		ange verage		Change Addres	e ss/Na	me	(OFFIC	E USI	E ONL	Y Ef	fect	ive	date		Termi	nation	date
EMPLOYEE NAME OR ADDRE Name Name Change				RESS CHANGE INFORMATION Employer														
Former Name					`	Work Phone												
Address Address Change						ł	Home Phone											
City	State Zip					(Male Female						Birth date					
Social Security Number		I		I			1	Singl	e	• М	arried		1	Marri	age da	ate		
To add dependents or cancel coverage, there must be a family status change consistent with your request. This must have occurred within the last 30 days. Any changes in status not listed below must be verified through the Administrator. Please check the appropriate boxes and supply all necessary information.																		
					AD	D C	OVI	ERAGE	C									
Add: Spouse Child	Reason: Your marriage Birth/adoption of child Spouse lost other group coverage (Attach copy of employ- ment termination notice from spouse's employer)								ther									
	Dat	te		Date			I	Date			<u></u>	pous	50 5 1	cilipio	yci)			
	Name of individual(s) to be added: (Last name, First name, MI)Relationship to employeeDate of birth				Y	Social Security Full number stud						Healt		clinic choice,(<i>Include</i>)				
					М	D	Y		-	-	YES	NO)					
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Gamali	р.			C	CAN	CEL	CO	VERA	GE									
Cancel: Self (Employee)		ason: Your di	vorce	Date					Cha	nge in c	hild's e	eligil	oility	/ Date	e			
□ Spouse		Death o depende	f eligible ent	eligible Date nt					Chil	d has re	ached	his/h	er 2	6 th bir Birt	thday h date			
Child		Change affects i	in spouse on surance.	in spouse employment status that surance. Specify type of changes					at Other									
Date																		
Name of individual(s) to be canceled:						Relatio	onship			Da	te	Social Security number						
(Last name, First name, MI)							to emp				-	birth D	Y			5	
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SIGNATURE I am applying for a change in coverage in the Minnesota Public Employees Insurance Program subject to approval of 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 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																		
Employee signature	(Driginal - A	dministrato	r		(lreen	- Employ	er	Da	te Yello	w - F	mplo	ovee				

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:

- To 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.