



**CONTINUATION HEALTH INSURANCE CHANGE FORM
STATE OF MINNESOTA GROUP INSURANCE PROGRAM**

Name _____ Date of Birth _____
Social Security # _____ - _____ - _____ Phone Number _____
Address _____
City _____ State _____ Zip Code _____
Employee Name (If other than applicant) _____ Employee ID # _____
Employee Social Security # _____

Are you enrolled in Medicare, Parts A or B? Yes No If yes, complete Medicare information on bottom.

Former Agency: State U of M

| Spouse/Dependent Information (please print) | Enrolled in Medicare Parts A or B? Yes or No | Social Security No. | Date of Birth |
|---|--|---------------------|--------------------|
| 1. _____ | _____ | ____ - ____ - ____ | ____ / ____ / ____ |
| 2. _____ | _____ | ____ - ____ - ____ | ____ / ____ / ____ |

* Please note that you may not add any new dependents.

Current Health Insurance Carriers: _____

Reason for Change: _____

Effective Date of Change: _____

New Health Insurance Carrier (Please select only one of the following):

| Retiree Plan Choice | Clinic # | Dependent Plan Choice | Clinic # |
|---|----------|---|----------|
| BCBS Group | | BCBS Group | |
| <input type="checkbox"/> Advantage – BCBS | _____ | <input type="checkbox"/> Advantage – BCBS | _____ |
| <input type="checkbox"/> Coordinated Plan | _____ | <input type="checkbox"/> Coordinated Plan | _____ |
| HealthPartners Group | | HealthPartners Group | |
| <input type="checkbox"/> Advantage – HealthPartners | _____ | <input type="checkbox"/> Advantage – HealthPartners | _____ |
| <input type="checkbox"/> HealthPartners 65+ | _____ | <input type="checkbox"/> HealthPartners 65+ | _____ |
| PreferredOne Group | | PreferredOne Group | |
| <input type="checkbox"/> Advantage – PreferredOne | _____ | <input type="checkbox"/> Advantage – PreferredOne | _____ |
| <input type="checkbox"/> Ucare for Seniors | _____ | <input type="checkbox"/> Ucare for Seniors | _____ |

Signature _____ Date _____

Medicare Information

Name of Medicare-enrolled member(s):* _____

Does the covered member have Medicare Hospital Coverage (Part A)? Yes No

If yes, effective date _____ Medicare # _____

Does the covered member have Medicare Medical Coverage (Part B)? Yes No

If yes, effective date _____ Medicare # _____

Reason for Medicare coverage: (check one): age disability end stage renal disease

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 relate 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.