



Health and Dental Premium Pre-Tax Account

Mid-year Change in Participation

Name *(Please Print)* _____ Daytime Phone Number _____

Employee ID # _____ Department Name _____ Date _____

I want to waive participation in the Health and Dental Premium Pre-tax Account due to a family status change that is consistent with this request. _____
Event Date

(State the change in family status and explain how the requested change is consistent with the event.)

I have read the preceding information and by signing this document acknowledge that I hereby waive my right to participate in the State's Health and Dental Premium Pre-tax Account. I understand that this waiver will stay in effect continuously unless I revoke it.*

Employee Signature _____ Date _____

*You may revoke your waiver during open enrollment to be effective with the first day of the new insurance plan year or within 30 days following a family status change that is consistent with the change.

I want to revoke the waiver to participate in the Health and Dental Premium Pre-tax Account due to a family status change that is consistent with this request. _____
Event Date

(State the change in family status and explain how the requested change is consistent with the event.)

I have read the preceding information and by signing this document acknowledge that I hereby revoke the waiver to participate in the State's Pre-tax Health and Dental Premium Account.

Employee Signature _____ Date _____

This form must be received by **Minnesota Management & Budget within 30 days** following the family status change. The change to your premium account will be effective on the date received by the State Employee Group Insurance Program.

Send original to the State Employee Group Insurance Program, Employee Insurance Division, Minnesota Management & Budget, 400 Centennial Office Bldg., 658 Cedar Street, St. Paul, MN 55155.