2017 Open Enrollment Form

NAME:	EMPLOYEE ID:	SOCIAL SECURITY #:
ADDRESS:		WORK PHONE:
CITY, STATE, ZIP CODE:		HOME PHONE:

1. Medical Insurance Carrier and Primary Care Clinic

(Designate coverage level and your desired clinic number in the applicable boxes, and dependent information in later table)

Medical carrier	Specify Employee or Family coverage	Employee clinic number
BlueCross BlueShield		
HealthPartners		
PreferredOne		

**Review the SEGIP Clinic Directory for cost level information: http://mn.gov/insdir/provider_directory_openenrollment.aspx*

Dependent information and clinic selections for family coverage

Complete all requested information in this table if you elect family coverage. It is your responsibility to enroll all eligible dependents and to notify SEGIP of any changes in eligibility. Please note that you will receive instruction on how to verify your added dependent following Open Enrollment. The enrollment of dependents is not complete until the proper verification documents are submitted and approved.

Name (required) Address (if different from employee)	Relationship to employee	Social Security Number	Birth date MM/DD/YYYY	Gender (M or F)	Primary Care Clinic #
#1 NAME: ADDRESS					
#2 NAME: ADDRESS					
#3 NAME: ADDRESS					
#4 NAME: ADDRESS					

If you have more dependents include a separate sheet with the same information. Be sure to include your name and social security number and employee ID # on the page with the names of additional dependents.

2. Long-term Disability Insurance

Name: _____ **Employee ID**: _____

Minimum Monthly Benefit is $300.00. Maximum Monthly Benefit is $7,000.00 (Do not enroll for more than approximately 60% of your monthly gross salary)	Plan Code = 001 Enrollment amount $ _____

Continued on reverse side

3. Pre-tax Accounts

Medical/Dental Expense Account	
Minimum Annual Contribution is $100.00 Maximum Annual Contribution is $2,600.00	Plan Code = 001 Enrollment amount $ _____
Dependent Care Expense Account	
Minimum Annual Contribution is $100.00 Maximum Annual Contribution is $5,000.00 per family	Plan Code = 001 Enrollment amount $ _____
Transit Expense Account – Parking	
Minimum Annual Contribution is $50.00 Maximum Annual Contribution – See 121 Benefits website	Plan Code = 001 Enrollment amount $ _____
Transit Expense Account – Bus Pass/Van Pool	
Minimum Annual Contribution is $50.00 Maximum Annual Contribution – See 121 Benefits website	Plan Code = 001 Enrollment amount $ _____

4. Child Life Insurance

◯ Add coverage ◯ Drop coverage

5. Managers Income Protection Plan (check your choice below from the appropriate plan)

Plan A (Employer paid life insurance 1.5 times salary with long-term disability insurance)	**Plan B** (Employer paid life insurance 2 times salary with long-term disability insurance)
◯ 150 day elimination period	◯ 150 day elimination period
◯ 120 day elimination period	◯ 120 day elimination period
◯ 90 day elimination period	◯ 90 day elimination period
◯ 60 day elimination period	◯ 60 day elimination period
◯ 30 day elimination period	◯ 30 day elimination period

The completed enrollment form must be received by SEGIP by 11:59pm on Friday, November 18, 2016. Because of the limited window, do not send this form in the mail. Use one of the three submission methods:

- Email to segip.mmb@state.mn.us (to protect the privacy of your personal data, only send from another @state.mn.us email account)
- Fax to: 651-296-5445
- Drop off at SEGIP offices (Minnesota Management & Budget, 658 Cedar Street, 4th floor, St. Paul)

Call SEGIP at 651-355-0100 if you have questions or need other information.

Your signature is required:

By typing my name below, I am applying for coverage in the Minnesota State Employee Group Insurance Program, subject to approval of eligibility. I authorize my employer to disclose the foregoing information to those carriers who have contracted to provide these benefits to participants in the program for use in determining my eligibility and processing my application for coverage. I authorize payroll deduction for my portion of the premium for this coverage.

Signature: _____ **Date**: _____

Open Enrollment 2017 Waive Coverage Form

Complete this form if you are electing to waive insurance coverage and enroll on your spouse or parent's SEGIP coverage during Open Enrollment.

To waive your coverage so that your spouse or parent may solely cover you, you must complete and **return this form to SEGIP by 11:59pm on Friday, November 18**. Do not mail this form—instead, use one of the following three submission methods:

- Email to: segip.mmb@state.mn.us (to protect the privacy of your personal data, only send from another @state.mn.us email account)
- Fax to: 651-296-5445
- Drop off at SEGIP offices (Minnesota Management & Budget, 658 Cedar Street, 4th floor, St. Paul)

Call SEGIP at 651-355-0100 if you have questions or need other information.

Employee A: Information about you, the state employee who is waiving medical coverage.

Print Name:_____ State ID:_____

Employee B: Information about your **spouse / parent (please circle one**) with SEGIP coverage who will enroll you on his/her medical coverage. If there is family coverage, Employee B should be sure to enroll each dependent.

Name: _____ State ID:_____

You may waive insurance coverage and enroll under another employee's insurance coverage only during annual Open Enrollment, upon a change in job status, or due to a qualifying life event. SEGIP must be notified in writing of such changes by the end of the Open Enrollment period or within 30 days of the event.

Employees are required to show proof of eligibility to successfully enroll their dependents. A follow-up letter; "Required Documentation for Proof of Eligibility" will be mailed to your home address by MMB/SEGIP when Open Enrollment ends. The employee who chooses the family coverage (Employee B) must sign and return the letter along with the required eligibility documents described in the letter. The required document(s) must be received at the SEGIP office by the deadline printed in the letter. Do not send documents before they are requested.

If your spouse/parent does not verify your eligibility by the due date, you will be returned to employee-only medical coverage. In addition, the coverage of any other dependents who are not verified will be cancelled. The next chance to enroll will be Open Enrollment for 2018, or upon a change in job status, or due to a qualifying life event.

By typing my name below, I am agreeing to the above statement and information.

Signature:_____Date: _____

Notice of Collection of Private Data

Minnesota Management & Budget (MMB) administers the State Employee Group Insurance Program (SEGIP). This notice explains why we are requesting the private data about you, your spouse, and dependents, how we will use it, who will see it, and your obligation to provide the data.

Why we ask you for this data? We ask for this data so that we can successfully administer SEGIP. This data is used to process your request to add or change coverage for yourself, your spouse, or dependents. The requested data helps us to determine eligibility, to identify you and your spouse, and dependents, and to contact you or your spouse, and dependents. The data is also used to develop new programs, ensure current programs effectively and efficiently meet member needs, and to comply with federal and state law and rules. We need the social security numbers and birth dates of your spouse and dependent to offer insurance continuation, process a death benefit, to ensure we are matching them to the correct insurance benefit transaction and to comply with federal Medicare coordination laws (in compliance with Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173)). If you provide any data about you, your spouse, or dependents that is not necessary, we will not use it for any purpose.

Do you have to provide the private data requested? You are not required to provide all of the data but certain data must be collected. If you do not provide the requested data, your dependent(s) may not be approved to participate in the program or may lose coverage under the program. If you do provide the data, it will be used as described.

Who else may see this data about you and your spouse and dependents? We may give data about you, your spouse, and dependents to the plan administrator you have chosen, SEGIP's other representatives, vendors and actuary; the Legislative Auditor; the Department of Health; the Department of Commerce; and any law enforcement agency or other agency with the legal authority to have the data; and anyone authorized by a court order. In addition, the parents of a minor may see data on the minor unless there is a law, court order, or other legally binding instrument that blocks the parent from that data.

How else may this data be used? We can use or release this data only as stated in this notice unless you give us your written permission to release the data for another purpose or to release it to another individual or entity. The data may also be used for another purpose if Congress or the Minnesota Legislature passes a law allowing or requiring us to release the data or to use it for another purpose.