Minnesota Public Employees Insurance Program

EMPLOYEE CHANGE

EMPLOYER USE ONLY	☐ Change Coverage	☐ Change Address/Name	OFFICE USE ONLY	Effective date	Termination date

EMPLOYEE NAME OR ADDRESS CHANGE INFORMATION

Name ☐ Name Change			Employer	
Former Name			Work Phone	
Address ☐ Address Change			Home Phone	
City	State	Zip	☐ Male ☐ Female	Birth date
Social Security Number			☐ Single ☐ Married	Marriage date

DEPENDENT ADDRESS CHANGE

Dependent Name	Dependent Social Security Number	Dependent Birthdate
New Address		

Note: 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.

ADD COVERAGE

Add:
☐ Spouse
☐ Child

Reason:
☐ Your marriage Date__________
☐ Birth/adoption of child Date__________
☐ Spouse lost other group coverage Date__________ (Attach copy of employment termination notice from spouse's employer)
☐ Other ________

Name of individual(s) to be added: (Last name, First name, MI)	Relationship to employee	Date of birth M	D	Y	Social Security number	Full-time student YES	NO	Health clinic choice, *(Include PCC#)*
					- -			
					- -			

CANCEL COVERAGE

Cancel:
☐ Self (Employee)
☐ Spouse
☐ Child

Date __________

Reason:
☐ Your divorce Date__________
☐ Death of eligible dependent Date__________
☐ Change in spouse employment status that affects insurance. Specify type of change: __________
☐ Change in child's eligibility Date__________
☐ Child has reached his/her 26th birthday. Birth date__________
☐ Other__________

Name of individual(s) to be canceled: (Last name, First name, MI)	Relationship to employee	Date of birth M	D	Y	Social Security number
					- -
					- -

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 __________