Minnesota Public Employees Insurance Program

EMPLOYEE ENROLLMENT

EMPLOYER USE ONLY
❑ New Employee ❑ Annual Enrollment
Date of Hire ❑ COBRA ❑ Early Retiree
❑ Return from Leave ❑ Other (attach letter of explanation)
____

Effective Date

EMPLOYEE INFORMATION

Social Security Number	Employer	
Name	Work Phone	Home Phone
Address	❑ Male ❑ Female	Date of Birth
City / State	Zip	❑ Single ❑ Married

Will you or your spouse be covered under another health plan or Medicare while covered under PEIP? ❑ Yes ❑ No If yes, complete the following:

Spouse Name	Name of Health Plan	Spouse Date of Birth

WAIVER OF COVERAGE

Complete this section only if you are NOT enrolling in the Minnesota Public Employees Insurance Program.

Check appropriate box:

❑ I am waiving coverage in the Minnesota *Public Employees Insurance Program* at this time because I have coverage under another plan.

❑ I am waiving coverage in the Minnesota *Public Employees Insurance Program* and do not have coverage under another plan. I understand that if I wish to enter the *Public Employees Insurance Program* at a later date, I can only enroll at annual enrollment or with a qualifying event under the Special Enrollment rules.

Employee Signature	Date

COVERAGE OPTIONS

Health Plan choice: (one per family)	Benefit Level: (choose one):	Who do you wish to cover? Check all that apply.
❑ HealthPartners	❑ Advantage High Plan	❑ Employee Only
❑ Blue Cross Blue Shield	❑ Advantage Value Plan	❑ Employee + One
❑ Preferred One	❑ Advantage HSA Plan	❑ Family

EMPLOYEE/DEPENDENTS

Last Name, First Name, Middle Initial (use additional paper if necessary)	Date of Birth (Month/Date/Year)	M/F	Social Security Number	Primary Care Clinic Name & Clinic Code #
Employee				
Spouse				
Child				
Child				
Child				
Child				

SIGNATURE

I am applying for coverage in the Minnesota *Public Employees Insurance Program* subject to approval of my 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 my 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 ____________