# Step by Step Instructions for Enrollment in the Public Employees Insurance Program Advantage Plan

To help explain your options in the Public Employees Insurance Program, we have created the following guide.

## Step 1 – Choose Your Plan Level

The Public Employees Insurance Program Advantage Plan has cost sharing features that will help you and your employer to better control health care costs while maintaining flexibility in access to doctors and clinics. The Public Employees Insurance Program offers three Plan choices:

- **Advantage (High)**
- **Value (Medium)**
- **HSA (Low)**

Choose the Benefit Level that best fits your needs. The premium and cost sharing will vary based on the Benefit Level you choose. You may change your Benefit Level each year during your group's annual open enrollment.

## Step 2 – Choose Your Health Plan/Network

The Public Employees Insurance Program offers three different Health Plans/Networks to choose from:

- **HealthPartners**
- **Blue Cross Blue Shield**
- **Preferred One**

Choose the network carrier that best fits your needs. **Your network selection will not affect the cost of the plan; nor will it affect the premium rate.** The benefits are similar under each network (HP includes a benefit for treatment of infertility). You may change your Health Plan/Network level each year during your group's annual renewal.

## Step 3 – Choose Your Primary Care Clinic

Primary Care Clinics have been placed into one of four cost levels, depending on the care system in which the provider participates and that care system's total cost/quality of delivering health care. The amount of cost sharing that is paid for health care services varies depending upon the cost level of the Health Plan and Network that you choose.

- **Select a primary care clinic (PCC) for each family member**

Each family member must select a primary care clinic (PCC). Family members may choose different PCCs – even in a different cost level, but all family members must enroll with the same Plan Level and Network choice. Your enrollment form should include the primary care clinic # associated with your network carrier.

All primary care clinics are broken into four tier levels that determine the benefits received by that family member. A list of participating clinics is available online to help you make your primary care clinic selection. This list includes your primary care clinic's clinic number that you will need in order to enroll. You can change clinics by calling the phone number on your ID card (changes are effective on the 1st day of the following month).

Most medical care is coordinated through a Primary Care Clinic (PCC) and you will generally need a referral to see a specialist (referrals to a specialist's office will be covered at the same cost level as your PCC). **You may self-refer to certain specialists including OBGYN, chiropractors, and mental health/chemical dependency practitioners, providing the practitioner is part of the carrier's self-referral network. No referrals needed for urgent care and emergencies.**

A statewide primary care clinic listing and health plan documents, including the Summary Benefit Comparisons (SBC's) for all plan levels, are available online at **www.innovomn.com/plan_information.html.**

**IMPORTANT!** Once enrolled, you will receive **TWO** ID cards. One card will be sent from your health plan (HP, BCBS, POne) which is to be used for **medical services**. The second card from CVS is to be used for all **pharmacy charges**. If you have questions please call us at 952.746.3101 or 800.829.5601 or email us at shawn@innovomn.com.

# Minnesota Public Employees Insurance Program (PEIP) Advantage Health Plan 2018 - 2019 Benefits Schedule

| Benefit Provision | Cost Level 1 – You Pay | Cost Level 2 – You Pay | Cost Level 3 – You Pay | Cost Level 4 – You Pay |
|---|---|---|---|---|
| **A. Preventive Care Services**<br>• Routine medical exams, cancer screening<br>• Child health preventive services, routine immunizations<br>• Prenatal and postnatal care and exams<br>• Adult immunizations<br>• Routine eye and hearing exams | Nothing | Nothing | Nothing | Nothing |
| **B. Annual First Dollar Deductible *** (single/family) | $150/300 | $250/500 | $550/1,100 | $1,250/2,500 |
| **C. Office visits for Illness/Injury, for Outpatient Physical, Occupational or Speech Therapy, and Urgent Care**<br>• Outpatient visits in a physician's office<br>• Chiropractic services<br>• Outpatient mental health and chemical dependency<br>• Urgent Care clinic visits (in or out of network) | $25 copay per visit<br>annual deductible applies | $30 copay per visit<br>annual deductible applies | $60 copay per visit<br>annual deductible applies | $80 copay per visit<br>annual deductible applies |
| **D. Network Convenience Clinics & online care** | $0 copay | $0 copay | $0 copay | $0 copay |
| **E. Emergency Care** (in or out of network)<br>• Emergency care received in a hospital emergency room | $100 copay<br>annual deductible applies | $100 copay<br>annual deductible applies | $100 copay<br>annual deductible applies | 25% coinsurance<br>annual deductible applies |
| **F. Inpatient Hospital Copay** | $100 copay<br>annual deductible applies | $200 copay<br>annual deductible applies | $500 copay<br>annual deductible applies | 25% coinsurance<br>annual deductible applies |
| **G. Outpatient Surgery Copay** | $60 copay<br>annual deductible applies | $120 copay<br>annual deductible applies | $250 copay<br>annual deductible applies | 25% coinsurance<br>annual deductible applies |
| **H. Hospice and Skilled Nursing Facility** | Nothing | Nothing | Nothing | Nothing |
| **I. Prosthetics and Durable Medical Equipment** | 20% coinsurance | 20% coinsurance | 20% coinsurance | 25% coinsurance<br>annual deductible applies |
| **J. Lab** (including allergy shots), **Pathology, and X-ray** (not included as part of preventive care and not subject to office visit or facility copayments) | 5% coinsurance<br>annual deductible applies | 5% coinsurance<br>annual deductible applies | 20% coinsurance<br>annual deductible applies | 25% coinsurance<br>annual deductible applies |
| **K. MRI/CT Scans** | 5% coinsurance<br>annual deductible applies | 10% coinsurance<br>annual deductible applies | 20% coinsurance<br>annual deductible applies | 25% coinsurance<br>annual deductible applies |
| **L. Other expenses not covered in A – K above, including but not limited to:**<br>• **Ambulance**<br>• **Home Health Care**<br>• **Outpatient Hospital Services** (non-surgical)<br>  • Radiation/chemotherapy<br>  • Dialysis<br>  • Day treatment for mental health and chemical dependency<br>  • Other diagnostic or treatment related outpatient services | 5% coinsurance<br>annual deductible applies | 5% coinsurance<br>annual deductible applies | 20% coinsurance<br>annual deductible applies | 25% coinsurance<br>annual deductible applies |
| **M. Prescription Drugs**<br>30-day supply of Tier 1, Tier 2, or Tier 3 prescription drugs, including insulin; or a 3-cycle supply of oral contraceptives. | $14 tier one<br>$25 tier two<br>$50 tier three | $14 tier one<br>$25 tier two<br>$50 tier three | $14 tier one<br>$25 tier two<br>$50 tier three | $14 tier one<br>$25 tier two<br>$50 tier three |
| **N. Plan Maximum Out-of-Pocket Expense for Prescription Drugs** (excludes Infertility) (single/family) | $800/1,600 | $800/1,600 | $800/1,600 | $800/1,600 |
| **O. Plan Maximum Out-of-Pocket Expense** (excluding prescription drugs) (single/family) | $1,200/2,400 | $1,200/2,400 | $1,600/3,200 | $2,600/5,200 |

*Emergency care or urgent care at a hospital emergency room or urgent care center out of the plan's service area or out of network is covered as described in sections C and E above.*

*This chart applies only to in-network coverage. Point of Service coverage is available only for members whose permanent residence is outside the State of Minnesota and outside the service areas of the health plans participating in Advantage. This category includes employees temporarily residing outside Minnesota on temporary assignment or paid leave [including sabbatical leaves] and college students. It is also available to all dependent children and spouses permanently residing outside the service area. These members pay a $350 single or $700 family deductible (separate and distinct from the deductibles listed in section B above) and 30% coinsurance to the out-of-pocket maximums described in section O above. Members pay the drug copayment described at section M above to the out-of-pocket maximum described at section N.*

*A standard set of benefits is offered in all PEIP Advantage Plans. There are still some differences from plan to plan in the way that benefits, including the transplant benefits, are administered, in the referral and diagnosis coding patterns of primary care clinics, and in the definition of Allowed Amount.*

** This Plan uses an **embedded deductible**: If any family member reaches the individual deductible then the deductible is satisfied for that family member. If any combination of family members reaches the family deductible, then the deductible is satisfied for the entire family.*

# *Minnesota Public Employees Insurance Program (PEIP) Advantage Health Plan 2018 - 2019 Benefits Schedule*
# *Value Option*

| Benefit Provision | **Cost Level 1** – You Pay | **Cost Level 2** – You Pay | **Cost Level 3** – You Pay | **Cost Level 4** – You Pay |
|---|---|---|---|---|
| **A. Preventive Care Services**<br>• Routine medical exams, cancer screening<br>• Child health preventive services, routine immunizations<br>• Prenatal and postnatal care and exams<br>• Adult immunizations<br>• Routine eye and hearing exams | Nothing | Nothing | Nothing | Nothing |
| **B. Annual First Dollar Deductible *** (single/family) | $500/1,000 | $700/1,400 | $1,100/2,200 | $1,800/3,600 |
| **C. Office visits for Illness/Injury, for Outpatient Physical, Occupational or Speech Therapy, and Urgent Care**<br>• Outpatient visits in a physician's office<br>• Chiropractic services<br>• Outpatient mental health and chemical dependency<br>• Urgent Care clinic visits (in or out of network) | $30 copay per visit annual deductible applies | $35 copay per visit annual deductible applies | $95 copay per visit annual deductible applies | $120 copay per visit annual deductible applies |
| **D. Network Convenience Clinics and online care** | $0 copay | $0 copay | $0 copay | $0 copay |
| **E. Emergency Care** (in or out of network)<br>• Emergency care received in a hospital emergency room | $125 copay annual deductible applies | $125 copay annual deductible applies | $125 copay annual deductible applies | 30% coinsurance annual deductible applies |
| **F. Inpatient Hospital Copay** | $150 copay annual deductible applies | $325 copay annual deductible applies | $750 copay annual deductible applies | 30% coinsurance annual deductible applies |
| **G. Outpatient Surgery Copay** | $100 copay annual deductible applies | $175 copay annual deductible applies | $350 copay annual deductible applies | 35% coinsurance annual deductible applies |
| **H. Hospice and Skilled Nursing Facility** | Nothing | Nothing | Nothing | Nothing |
| **I. Prosthetics and Durable Medical Equipment** | 20% coinsurance | 20% coinsurance | 25% coinsurance | 35% coinsurance annual deductible applies |
| **J. Lab** (including allergy shots), **Pathology, and X-ray** (not included as part of preventive care and not subject to office visit or facility copayments) | 10% coinsurance annual deductible applies | 10% coinsurance annual deductible applies | 20% coinsurance annual deductible applies | 35% coinsurance annual deductible applies |
| **K. MRI/CT Scans** | 10% coinsurance annual deductible applies | 10% coinsurance annual deductible applies | 20% coinsurance annual deductible applies | 35% coinsurance annual deductible applies |
| **L. Other expenses not covered in A – K above, including but not limited to:**<br>• **Ambulance**<br>• **Home Health Care**<br>• **Outpatient Hospital Services** (non-surgical)<br>  • Radiation/chemotherapy<br>  • Dialysis<br>  • Day treatment for mental health and chemical dependency<br>  • Other diagnostic or treatment related outpatient services | 10% coinsurance annual deductible applies | 10% coinsurance annual deductible applies | 20% coinsurance annual deductible applies | 35% coinsurance annual deductible applies |
| **M. Prescription Drugs** 30-day supply of Tier 1, Tier 2, or Tier 3 prescription drugs, including insulin; or a 3-cycle supply of oral contraceptives. | $20 tier one<br>$40 tier two<br>$65 tier three | $20 tier one<br>$40 tier two<br>$65 tier three | $20 tier one<br>$40 tier two<br>$65 tier three | $20 tier one<br>$40 tier two<br>$65 tier three |
| **N. Plan Maximum Out-of-Pocket Expense for Prescription Drugs** (excludes Infertility) (single/family) | $1,000/2,000 | $1,000/2,000 | $1,000/2,000 | $1,000/2,000 |
| **O. Plan Maximum Out-of-Pocket Expense** (excluding prescription drugs) (single/family) | $2,200/4,400 | $2,200/4,400 | $3,200/6,400 | $4,200/8,400 |

*Emergency care or urgent care at a hospital emergency room or urgent care center out of the plan's service area or out of network is covered as described in sections C and E above.*

*This chart applies only to in-network coverage. Point of Service coverage is available only for members whose permanent residence is outside the State of Minnesota and outside the service areas of the health plans participating in Advantage. This category includes employees temporarily residing outside Minnesota on temporary assignment or paid leave [including sabbatical leaves] and college students. It is also available to all dependent children and spouses permanently residing outside the service area. These members pay a $350 single or $700 family deductible (separate and distinct from the deductibles listed in section B above) and 30% coinsurance to the out-of-pocket maximums described in section O above. Members pay the drug copayment described at section M above to the out-of-pocket maximum described at section N.*

*A standard set of benefits is offered in all PEIP Advantage Plans. There are still some differences from plan to plan in the way that benefits, including the transplant benefits, are administered, in the referral and diagnosis coding patterns of primary care clinics, and in the definition of Allowed Amount.*

** This Plan uses an **embedded deductible**: If any family member reaches the individual deductible then the deductible is satisfied for that family member. If any combination of family members reaches the family deductible, then the deductible is satisfied for the entire family.*

***Minnesota Public Employees Insurance Program (PEIP)***
***Advantage Health Plan 2018 - 2019 Benefits Schedule - HSA Compatible***

| **Benefit Provision** | **Cost Level 1** – You Pay | **Cost Level 2** – You Pay | **Cost Level 3** – You Pay | **Cost Level 4** – You Pay |
|---|---|---|---|---|
| **A. Preventive Care Services**<br>• Routine medical exams, cancer screening<br>• Child health preventive services, routine immunizations<br>• Prenatal and postnatal care and exams<br>• Adult immunizations<br>• Routine eye and hearing exams | Nothing | Nothing | Nothing | Nothing |
| **B. Annual First Dollar Deductible ***<br>Combined Medical/Pharmacy (**single coverage**) | $1,500 | $2,000 | $3,000 | $4,000 |
| Combined Medical/Pharmacy (**family coverage**) | $2,600 per family member<br>$3,000 per family | $3,200 per family member<br>$4,000 per family | $4,800 per family member<br>$6,000 per family | $6,400 per family member<br>$8,000 per family |
| **C. Office visits for Illness/Injury, for Outpatient Physical, Occupational or Speech Therapy, and Urgent Care**<br>• Outpatient visits in a physician's office<br>• Chiropractic services<br>• Outpatient mental health and chemical dependency<br>• Urgent Care clinic visits (in or out of network) | $40 copay per visit<br>annual deductible applies | $50 copay per visit<br>annual deductible applies | $100 copay per visit<br>annual deductible applies | $120 copay per visit<br>annual deductible applies |
| **D. Network Convenience Clinics & online care** | $0 copay<br>annual deductible applies | $0 copay<br>annual deductible applies | $0 copay<br>annual deductible applies | $0 copay<br>annual deductible applies |
| **E. Emergency Care** (in or out of network)<br>• Emergency care received in a hospital emergency room | $150 copay<br>annual deductible applies | $150 copay<br>annual deductible applies | $150 copay<br>annual deductible applies | 50% coinsurance<br>annual deductible applies |
| **F. Inpatient Hospital Copay** | $400 copay<br>annual deductible applies | $650 copay<br>annual deductible applies | $1,500 copay<br>annual deductible applies | 50% coinsurance<br>annual deductible applies |
| **G. Outpatient Surgery Copay** | $250 copay<br>annual deductible applies | $400 copay<br>annual deductible applies | $800 copay<br>annual deductible applies | 50% coinsurance<br>annual deductible applies |
| **H. Hospice and Skilled Nursing Facility** | Nothing after<br>annual deductible | Nothing after<br>annual deductible | Nothing after<br>annual deductible | Nothing after<br>annual deductible |
| **I. Prosthetics and Durable Medical Equipment** | 20% coinsurance<br>annual deductible applies | 25% coinsurance<br>annual deductible applies | 30% coinsurance<br>annual deductible applies | 50% coinsurance<br>annual deductible applies |
| **J. Lab** (including allergy shots), **Pathology, and X-ray** (not included as part of preventive care and not subject to office visit or facility copayments) | 20% coinsurance<br>annual deductible applies | 25% coinsurance<br>annual deductible applies | 30% coinsurance<br>annual deductible applies | 50% coinsurance<br>annual deductible applies |
| **K. MRI/CT Scans** | 20% coinsurance<br>annual deductible applies | 25% coinsurance<br>annual deductible applies | 30% coinsurance<br>annual deductible applies | 50% coinsurance<br>annual deductible applies |
| **L. Other expenses not covered in A – K above, including but not limited to:**<br>• **Ambulance**<br>• **Home Health Care**<br>• **Outpatient Hospital Services** (non-surgical)<br>  • Radiation/chemotherapy<br>  • Dialysis<br>  • Day treatment for mental health and chemical dependency<br>  • Other diagnostic or treatment related outpatient services | 20% coinsurance<br>annual deductible applies | 25% coinsurance<br>annual deductible applies | 30% coinsurance<br>annual deductible applies | 50% coinsurance<br>annual deductible applies |
| **M. Prescription Drugs**<br>30-day supply of Tier 1, Tier 2, or Tier 3 prescription drugs, including insulin; or a 3-cycle supply of oral contraceptives. | $25 tier one<br>$40 tier two<br>$65 tier three<br>annual deductible applies | $25 tier one<br>$40 tier two<br>$65 tier three<br>annual deductible applies | $25 tier one<br>$40 tier two<br>$65 tier three<br>annual deductible applies | $25 tier one<br>$40 tier two<br>$65 tier three<br>annual deductible applies |
| **N. Plan Maximum Out-of-Pocket Expense****<br>(including prescription drugs) **Single Coverage** | $3,000 | $3,000 | $4,000 | $5,000 |
| **Family Coverage** | $5,000 per family member<br>$6,000 per family | $5,000 per family member<br>$6,000 per family | $6,850 per family member<br>$8,000 per family | $6,850 per family member<br>$10,000 per family |

*Emergency care or urgent care at a hospital emergency room or urgent care center out of the plan's service area or out of network is covered as described in sections C and E above.*

*This chart applies only to in-network coverage. Point of Service coverage is available only for members whose permanent residence is outside the State of Minnesota and outside the service areas of the health plans participating in Advantage. This category includes employees temporarily residing outside Minnesota on temporary assignment or paid leave [including sabbatical leaves] and college students. It is also available to all dependent children and spouses permanently residing outside the service area. These members pay a $1,500 single or $3,000 family deductible (separate and distinct from the deductibles listed in section B above) and 30% coinsurance to the out-of-pocket maximums described in section N above. Members pay the drug copayment described at section M above to the out-of-pocket maximum described at section N.*

*A standard set of benefits is offered in all PEIP Advantage Plans. There are still some differences from plan to plan in the way that benefits are administered, and in the referral and diagnosis coding patterns of primary care clinics.*

**The family Deductible is the **maximum amount** that a family has to pay in deductible expenses in any one calendar year. The family Deductible is **not** the amount of expenses a family must incur before any family member can receive benefits. Individual family members only need to satisfy their individual deductible once to be eligible for benefits. Once the family Deductible has been met, deductible expenses for the family are waived for the balance of the year.*

***The family Out-of-Pocket Maximum is the **maximum amount** that a family has to pay in any one calendar year. The per-family member embedded Out-of-Pocket Maximum is the maximum amount that a family has to pay in any one calendar year on behalf of any individual family member.*

# PUBLIC EMPLOYEES INSURANCE PROGRAM
# HEALTH COVERAGE RATES

**(Effective 7/1/18)**

| | Monthly Premium | Minus District Contribution of $650.00/month |
|---|---|---|
| **ADVANTAGE PLAN** | | |
| Single | $833.22 | $183.22 |
| Family | $2,224.58 | $1,574.58 |
| **VALUE PLAN** | | |
| Single | $744.72 | $94.72 |
| Family | $1,988.36 | $1,338.36 |
| **HSA PLAN** | | |
| Single | $570.08 | $0.00 |
| Family | $1,522.04 | $872.04 |

**Minnesota Public Employees Insurance Program**

# EMPLOYEE ENROLLMENT

| **EMPLOYER USE ONLY** | | | **Effective Date** |
|---|---|---|---|
| ❑ **New Employee** | ❑ **Annual Enrollment** | ❑ **Late Entrant (Complete Health History Form)** | |
| **Date of Hire** ________ | ❑ **COBRA** | ❑ **Early Retiree** | |
| | ❑ **Return from Leave** | ❑ **Other (attach letter of explanation)** | |

## EMPLOYEE INFORMATION

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

Do you or your spouse have other health coverage or Medicare? ❑ 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 if, at a later date, I request any coverage under the Minnesota *Public Employees Insurance Program*, I may be subject to a pre-existing condition exclusion or I may have to provide proof of prior continuous coverage.

| 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) | Sex | Social Security Number | Primary Care Clinic Name & Clinic code # |
|---|---|---|---|---|
| Employee | | | | |
| Spouse | | | | |
| 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 ____________

**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