Minnesota Public Employees Insurance Program

EMPLOYEE ENROLLMENT

EMPLOYER USE ONLY

❑ **New Employee** ❑ **Annual Enrollment** ❑ **Late Entrant (Complete Health History Form)**

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

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

Employee Signature	Date

COVERAGE OPTIONS

Health Plan choice: (one per family)
- ❑ HealthPartners
- ❑ Blue Cross Blue Shield
- ❑ Preferred One

Benefit Level: (choose one):
- ❑ Advantage High Plan
- ❑ Advantage Value Plan
- ❑ Advantage HSA Plan

Who do you wish to cover? Check all that apply.
- ❑ Employee Only
- ❑ Employee + One
- ❑ Family

LIFE

❑ Basic Life/AD&D Insurance (check with your employer for amount) ❑ Dependent/Spouse Life Insurance

❑ Employee Supplemental Life/AD&D Insurance - Amount: _____ (increments of $5,000 upon approval)

Life Insurance Beneficiary Designation:

Primary: Relationship:

Secondary: Relationship:

DENTAL If dependent coverage is offered, family dental will be packaged with family medical (employees who choose family medical must choose family dental).

❑ Employee Dental Coverage ❑ Employee and Dependent Dental Coverage

EMPLOYEE/DEPENDENTS

Last Name, First Name, Middle Initial (use additional paper if necessary)	Date of Birth (Month/Date/Year)	Sex	Full-time Student Yes	Full-time Student No	Social Security Number	Primary Care Clinic Name & Clinic #
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