

Dependent Change Form

Directions: Use this form if 1) you have dependent coverage already and want to add on an additional dependent; or 2) you want to drop a dependent and still maintain coverage for your other dependent(s). Changes made with this form will not affect your insurance premium payments. **If you want to add or drop dependent coverage, please use a Basic Application.** If you are making a clinic change, please contact the plan(s) directly. Please return this form to: Employee Insurance Division, 658 Cedar Street, St. Paul, MN 55155. For questions, call 651-296-2457 (TTY: 651-297-7959).

Employee Name: _____ SSN: _____ - _____ - _____
Last First MI

Work phone: _____ - _____ Employee ID Number _____

Current Health Plan: _____ Current Dental Plan: _____

Date of change: ____/____/____ Reason for Change: _____

Add/ Drop*	Name and Address <input type="checkbox"/> Check if address is same as employee, otherwise list address below	Relation to you	Sex	Date of Birth	SSN	Health Clinic Number	Dental Clinic Number**

* By using this form to add dependents you verify that your dependents are eligible for coverage according to the dependent eligibility rules. Insurance claims incurred by ineligible dependents will be denied.

** Dental Clinic Number is not needed for enrollment in the State Dental Plan.

If your requested change involves a dependent over the age of 19, please provide the following additional information:

Name of Student: _____ Name of School: _____
 Address of School: _____
 Date student first enrolled: month ____ year ____ Date student expects to graduate: month ____ year ____
 Is student full-time? Yes No Last date attended: _____
 Circle One: Single Married Divorced Date of marriage or divorce: _____

If you or your dependent is enrolled in Medicare, please provide the following information:

Name of Medicare enrolled member: _____
 Does the covered member have Medicare Hospital Coverage (Part A)? Yes No
 If yes, effective date _____ Medicare # _____
 Does the covered member have Medicare Medical Coverage (Part B)? Yes No
 If yes, effective date _____ Medicare # _____
 Reason for Medicare coverage (check one): Age Disability End stage renal disease

If there is a change in my dependent's eligibility for insurance, I understand it is my responsibility to notify the Employee Insurance Division in writing of such changes.

Employee's Signature _____ Date _____

Information and Privacy

Several state and federal laws help protect your right to privacy and make it easier for you to review information in your insurance file. Under one of these laws - the Minnesota Government Data Practices Act, you have the right to know the following:

Why the information is needed

The information we request about you, your employment and family members is needed for one or more of the following reasons:

- To determine whether your dependent is eligible for State of Minnesota group insurance benefits.
- To determine whether you are an eligible participant in the State Employee Group Insurance Program.

Supplying information - your rights

You may refuse to provide the information we request; however, without certain minimal information, we may be unable to process your request for coverage in the group plan.

Disclosure of your Social Security number is voluntary. It is being requested to identify your records in the insurance computer system. While you are not legally required to furnish this information, processing of your spouse's coverage in the insurance group will be delayed without it.

Who uses the information and how it is used

The information we collect may be used by state employees operating the group insurance program, the federal and state tax authorities and shared with the insurance plan you have chosen to provide your health insurance benefits.

Information will be used to:

- Provide enrollment and/or change information to your health insurance plan so they can provide benefits and pay claims.
- Prepare statistical reports and evaluative studies.

When you are no longer an active participant under the group insurance program, we will keep your file until state retention requirements are met.

What information you can obtain

You may request, in writing, to be shown information about yourself that is maintained by our department. There is no cost for this service, but there is a small copy charge.

How to obtain information on your file

Questions about your eligibility, your dependent's eligibility, type of coverage, and premium rates may be obtained by contacting the insurance representative (DDIR) assigned to your agency or department.

Dependent Eligibility

1) **Spouse.** The spouse of an eligible employee (if not legally separated). For the purposes of health insurance coverage, if that spouse works full-time for an organization employing more than one hundred people and elects to receive either credits or cash (a) in place of health coverage or (b) in addition to a health plan with a \$750 or greater deductible through his/her employing organization, he/she is not eligible to be a covered dependent for the purposes of this Article. If both spouses work for the State or another organization participating in the State's Group Insurance Program, neither spouse may be covered by the other as a dependent by the other unless one is not eligible for a full Employer Contribution as defined in the contracts.

2) **Children and Grandchildren.** An eligible employee's unmarried dependent children and unmarried dependent grandchildren: (a) through age 18, or (b) through age 24 if the child or grandchild is a full-time student at an accredited educational institution; or (c) a child or grandchild, regardless of age or marital status who is incapable of self-sustaining employment by reason of mental retardation, mental illness or physical disability and is chiefly dependent on the employee for support. The handicapped dependent shall be eligible for coverage as long as he/she continues to be handicapped and dependent, unless coverage terminates under the contract.

"Dependent Child" includes an employee's (a) biological child, (b) child legally adopted by or placed for adoption with the employee, (c) foster child, and (d) step-child. To be considered a dependent child, a foster child must be dependent upon the employee for his/her principal support and maintenance and be placed by the court in the custody of the employee. To be considered a dependent child, a step-child or child must maintain residence with the employee and be dependent upon the employee for his/her principal support and maintenance.

"Dependent Grandchild" includes an employee's: (a) grandchild placed in the legal custody of the employee, (b) grandchild legally adopted by the employee or placed for adoption with the employee, or (c) grandchild who is the dependent child of the employee's unmarried dependent child. Under (a) and (c) above; the grandchild must be dependent upon the employee for the principal support and maintenance and live with the employee.

3) **Dependent Coverage Restrictions.** If both spouses work for the state or another organization participating in the State's Group health Insurance Program, either spouse, but not both, may cover their eligible dependent children or grandchildren. This restriction also applies to two divorced, legally separated, or unmarried employees who share legal responsibility for their eligible dependent children.