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

Social Security Number	Employer	Contract Group	Employee ID #
	Osseo School District		

Last Name	First Name	MI ☐ **Name Change**	Former Name	Primary Phone

Address ☐ **Address Change**	☐ Male ☐ Female	Date of Birth

City	State	Zip	☐ Single ☐ Married	Marriage Date

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: **Reason Date**_____

☐ Your Marriage ☐ Other (explain)

☐ Birth/Adoption of a child _____

☐ Spouse lost other group coverage (provide documentation)

Name of individual(s) to be added: (Last Name, First Name, Middle Initial)	**Relationship to Employee**	**Date of Birth** (Month/Date/Year)	**Sex**	**Social Security Number**	**Health Clinic Choice** (Include PCC #)

CANCEL COVERAGE

Cancel:

☐ Self (Employee)

☐ Spouse ☐ Child

Effective Date_____

Reason: **Reason Date**_____

☐ Your Divorce ☐ Child reached age 26

☐ Death of eligible dependent Birth Date_____

☐ Change in spouse's insurance status ☐ Other:

☐ Change in child's eligibility _____

Name of individual(s) to be canceled: (Last Name, First Name, Middle Initial)	**Relationship to Employee**	**Date of Birth** (Month/Date/Year)	**Sex**	**Social Security Number**

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

☐ **Authorize Electronic Submission**

By checking this box and typing my name, I acknowledge that this constitutes a legal signature confirming that I agree to the these terms.