Minnesota Public Employees Insurance Program

OPEN ENROLLMENT 2024

EMPLOYER USE ONLY

☐ New Employee Date of Hire _____
☒ Annual Enrollment
☐ COBRA
☐ Return from Leave
☐ Qualifying Event
☐ Early Retiree
☐ Other_____

Effective Date: Jan 1, 2024

EMPLOYEE INFORMATION

Social Security Number - -	Employer: Osseo School District	Employee Group	Employee ID #
Last Name	First Name	M.I.	Primary 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

Benefit Level: (choose one)
☐ Advantage Value Plan
☐ Advantage HSA Plan

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

☐ **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.