



**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 NAME/ADDRESS CHANGE									
Dependent Current Name				Dependent Social Security Number				Dependent Birthdate	
Dependent New Name									
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:		Reason:							
☐ Spouse		☐ Your marriage		☐ Birth/adoption of child		☐ Spouse lost other group coverage		(Attach copy of employment termination notice from spouse's employer)	
☐ Child		Date _____		Date _____		Date _____		☐ Other _____	
Name of individual(s) to be added: (Last name, First name, MI)		Relationship to employee		Date of birth		Social Security number		Full-time student	
				M D Y				YES NO	
						- -			
						- -			
CANCEL COVERAGE									
Cancel:		Reason:							
☐ Self (Employee)		☐ Your divorce		Date _____		☐ Change in child's eligibility		Date _____	
☐ Spouse		☐ Death of eligible dependent		Date _____		☐ Child has reached his/her 26 th birthday.		Birth date _____	
☐ Child		☐ Change in spouse employment status that affects insurance. Specify type of change:		☐ Other _____					
Date _____									
Name of individual(s) to be canceled: (Last name, First name, MI)		Relationship to employee		Date of birth		Social Security number			
				M D Y					
						- -			
						- -			
SIGNATURE									
I am applying for a change in coverage in the Minnesota <i>Public Employees Insurance Program</i> subject to approval of eligibility. I authorize my employer to disclose the foregoing information to the Minnesota <i>Public Employees Insurance Program</i> , 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 _____			