

**Request for Continuation of Coverage upon Retirement**  
**Minnesota State Employees Group Insurance Program**

**Enrollment Instructions**

***All sections of this form must be completed entirely regardless of your continuation status. Failure to place a check mark in all sections will result in a delay in processing your retirement continuation elections.***

***Complete the form and send completed form to your HR Representative for their signature.***

**Section 1 – General Information**

- Complete this section entirely
- Include spouse information if applicable (if no spouse, check “No” for spouse coverage)

**Section 2 – Continuation of Health Insurance Coverage**

- Indicate if you and/or your spouse are eligible for Medicare
- Indicate if you and/or your spouse have Medicare now, or have applied for Medicare.
- Contact the health plan you will be a member of if you or a spouse will be age 65 or greater and request the plan’s Medicare enrollment packet.
- Indicate the health plan you are currently enrolled in. Please list your current plan even if you exercise your option to change plans.
- If changing plans, please complete a **Basic Application for Insurance Coverage** in addition to this continuation form. Attach a copy of the Basic Application to the continuation form before forwarding.
- Elect if you wish to continue health insurance for yourself. **Note: If you do not continue coverage, you cannot enroll at a future date.**
- Elect if you wish to continue coverage for your spouse. **Note: If your spouse elects not to continue coverage, he/she cannot enroll at a future date. If you are not currently covering a spouse or dependents, check “No”.**

**Section 3 – Continuation for Dental Insurance Coverage**

- **Note:** You do not have to continue health insurance to continue dental insurance.
- Indicate the dental plan you are currently enrolled in. Please list your current plan even if you exercise your option to change plans.
- If changing plans, please complete a **Basic Application for Insurance Coverage** in addition to this continuation form. Attach a copy of the Basic Application to the continuation form before forwarding.
- Elect if you wish to continue dental insurance for yourself. Check the “Yes” box for your own coverage even if you intend to continue other family members as well. **Note: If you do not continue coverage, you cannot enroll at a future date.**

- Elect if you wish to continue coverage for your spouse. **Note: If your spouse elects not to continue coverage, he/she cannot enroll at a future date. If you are not currently covering a spouse, check “No”.**

#### **Section 4 – Continuation of Group Life Insurance Coverage**

- Indicate if you wish to continue your term group life insurance policy (basic or managerial) for 18 months. After that, you may convert to an individual life insurance policy.
- Indicate if you and/or your spouse wish to continue the optional life insurance policy. **Note: You may be eligible for the post retirement paid-up life insurance benefit. Please contact your HR Representative to determine eligibility. Please complete the post retirement application form for you and/or your spouse whether or not you and/or your spouse wish to continue. If you do not have spouse life insurance, check “No”.**
- **If you or your spouse is immediately eligible for the paid-up death benefit, contact SEGIP regarding the ability to retain the other 85% of the policy under your COBRA option.**
- Please indicate if you wish to continue child term life insurance for 18 months if your children are still eligible. After that, child life may be converted to an individual policy. If you do not have child life insurance coverage, check “No”.

#### **Section 5 – Continuation of Medical Dental Expense Account (MDEA)**

- Please indicate if you wish to continue participation in the medical/dental expense account. **Note: By indicating yes this account will be continued on a post-tax basis. Also note that this account is separate from the Health Care Savings Plan (HCSP) or any HSA/HRA administered by MSRS or your pension plan.**

Please sign and date the bottom of the form. Also provide a home phone number.

**After signing the form, please make a copy for yourself and return the completed form to your HR Representative in your agency.**

**Your HR Representative will sign the form and forward the completed, signed form to SEGIP. SEGIP will send a copy of the form to your health plan and dental plan. Additionally, your HR Representative will retain a copy for their records, and you will retain a copy of the form for your records.**

# Request for Continuation of Coverage Upon Retirement

## Minnesota State Employee Group Insurance Program



**Retiree:** This is available to all employees covered under the Minnesota State Employee Group Insurance Program who are taking regular retirement (including regular early retirement) and who are interested in maintaining their coverage. Be sure to complete all sections below. **Your HR representative will forward the original signed copy to Minnesota Management & Budget (MMB).** Retain a copy for your records.

### 1. GENERAL INFORMATION

Name (Last, First Middle Initial)	Employee SSN	Employee ID No.	Employee Date of Birth
Street Address	City	State	Zip Code
Name of Spouse (Last, First, Middle Initial)	Spouse SSN	Spouse Date of Birth	

### 2. CONTINUATION OF HEALTH INSURANCE COVERAGE

Are you or your spouse eligible for benefits under Medicare?  Yes  No  Yes  No

Do you or your spouse have or applied for Medicare:

Part A Hospitalization?	Date: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Part B Medical?	Date: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**If you or your spouse are over 65, you will be required to submit Medicare information to your health plan. Call your plan for application forms.**

I currently have coverage with the following health insurance plan: \_\_\_\_\_

<b>Yes</b>	<b>No</b>	
<input type="checkbox"/>	<input type="checkbox"/>	I wish to continue single health insurance coverage.
<input type="checkbox"/>	<input type="checkbox"/>	My spouse is under age 65 and wishes to continue health insurance coverage. (This would also include coverage for eligible dependent children.)
<input type="checkbox"/>	<input type="checkbox"/>	My spouse is age 65 or older and wishes to continue health insurance coverage.

### 3. CONTINUATION OF DENTAL INSURANCE COVERAGE

I currently have coverage with the following dental insurance plan: \_\_\_\_\_

<b>Yes</b>	<b>No</b>	
<input type="checkbox"/>	<input type="checkbox"/>	I wish to continue single dental insurance coverage.
<input type="checkbox"/>	<input type="checkbox"/>	I wish to continue family dental insurance coverage.

### 4. CONTINUATION OF GROUP LIFE INSURANCE COVERAGE (18 months) \*See directions for optional life post-retirement benefits.

<b>Yes</b>	<b>No</b>	
<input type="checkbox"/>	<input type="checkbox"/>	I wish to continue my current basic/manager group life insurance for 18 months.
<input type="checkbox"/>	<input type="checkbox"/>	I wish to continue child life insurance.
<input type="checkbox"/>	<input type="checkbox"/>	I wish to continue employee optional life insurance.*
<input type="checkbox"/>	<input type="checkbox"/>	I wish to continue spouse optional life insurance.*

### 5. CONTINUATION OF MEDICAL/DENTAL EXPENSE ACCOUNT (MDEA) This is a pre-tax expense account administered by Eide Bailly.

<b>Yes</b>	<b>No</b>	
<input type="checkbox"/>	<input type="checkbox"/>	I wish to continue participation in the medical/dental expense account on a post-tax basis. Enrollment in the MDEA continues as long as monthly payments are made timely or until the end of the plan year, whichever occurs first.

*By completing the above, I request that insurance coverage be continued or converted at my own expense. I understand that this request must be submitted within 30 days of my retirement. If I do not continue insurance coverage, I cannot re-enroll at a future date.*

Employee's Home Phone Number \_\_\_\_\_ Signature of Employee \_\_\_\_\_ Date \_\_\_\_\_

HR Representative Phone Number \_\_\_\_\_ Signature of HR Representative \_\_\_\_\_ Date \_\_\_\_\_

Department/Employer \_\_\_\_\_ Last Date on Payroll \_\_\_\_\_ SEMA4 Retirement Date \_\_\_\_\_

**For HR Use Only**

Forward completed form to SEGIP/MMB only.  
Retain a copy for your records.  
Date sent: \_\_\_\_\_ (MMB Fax: 651-296-5445)

**For MMB Use Only**

Copies sent to: \_\_\_Health Plan \_\_\_Dental Plan  
EID initials: \_\_\_\_\_

## **SEGIP contact**

---

If you completed Section 4 and/or Section 5, please give original to your agency HR Representative. HR Representative, please send original completed form to:

**State of Minnesota**  
**Minnesota Management & Budget**  
Employee Insurance Division  
400 Centennial Office Building  
658 Cedar Street  
St. Paul, MN 55155  
651-355-0100  
Fax: 651-296-5445

**Minnesota Management & Budget**  
**NOTICE OF COLLECTION OF PRIVATE DATA**

---

Minnesota Management & Budget (MMB) administers the State Employee Group Insurance Program (SEGIP). This notice explains why we may request information (data) about you, your dependents and beneficiaries, how we will use it, who will see it, and your obligation to provide that information.

**What information will we use?**

We will use the information you provide us at this time, as well as information you have previously provided us about yourself, your dependent(s), and/or your beneficiary. If you provide any information about yourself or your dependent or beneficiary that is not necessary, we will not use it for any purpose.

SEMA4, the information system used to administer employee benefits, contains required information fields that may not be necessary for us to process your request. We do not need the gender or marital status for your beneficiary designation, so you may enter "unknown" in these fields. We only need your dependent's date of death to process a death benefit claim or to discontinue the dependent's coverage due to his or her death. Student status and disability status are needed only to determine eligibility for insurance continuation for your dependent. We need your dependent's social security number and birth to offer insurance continuation, process a death benefit and to comply with federal Medicare coordination laws.

**Why we ask you for this information?**

We ask for this information to process your request to add or change coverage for yourself, your dependent or a beneficiary. The requested information helps us to determine eligibility, to identify you and your dependents and beneficiaries, and to contact you or your dependents and beneficiaries. We use the information so that we can successfully administer SEGIP, including analyzing unidentifiable aggregate data to develop new programs and ensure current programs are effectively and efficiently meeting member needs. We may ask for information about you that we have already collected, including all or part of your social security number, in order to ensure we are matching you to the correct change request or other insurance benefit transaction.

**Do you have to answer the questions we ask?**

You are not legally required to provide any of the information requested.

**What will happen if you do not answer the questions we ask?**

If you do not answer these questions, the insurance benefit transaction you requested for you or your dependent or other insurance benefit transaction may be delayed or denied.

**Who else may see this information about you and your dependents and beneficiaries?**

We may give information about you and your dependents and beneficiaries to the insurance carrier you have chosen, SEGIP's representatives, vendors, and actuary, the Legislative Auditor, the Department of Health, any law enforcement agency or other agency with the legal authority to the information, and anyone authorized by a court order. In addition, the parents of a minor may see information on the minor unless there is a law, court order, or other legally binding instrument that blocks the parent from that information. We can use or relate this information only as stated in this notice unless you give your written consent to authorize release of the information to another person/entity, or if Congress or the Minnesota Legislature passes a law allowing or requiring us to release the information or to use it for another purpose.