

Minnesota Public Employees Insurance Program



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|---------------------------------------|--------------------------------------------|----------------------------------------------------------------------|----------------|
| EMPLOYER USE ONLY | | | Effective Date |
| <input type="checkbox"/> New Employee | <input type="checkbox"/> Annual Enrollment | <input type="checkbox"/> Late Entrant (Complete Health History Form) | |
| Date of Hire | <input type="checkbox"/> COBRA | <input type="checkbox"/> Early Retiree | |
| | <input type="checkbox"/> Return from Leave | <input type="checkbox"/> Other (attach letter of explanation) | |

| EMPLOYEE INFORMATION | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|------------------------------------------------------------------|---------------------------------------------------------------------|
| Social Security Number | | Employer | |
| Name | | Work Phone | Home Phone |
| Address | | <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of Birth |
| City | State | Zip | <input type="checkbox"/> Single <input type="checkbox"/> Married |
| Do you or your spouse have other health coverage or Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the following: | | | |
| Spouse Name | | Name of Health Plan | Spouse Date of Birth |

| WAIVER OF COVERAGE | |
|-----------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <i>Complete this section only if you are NOT enrolling in the Minnesota Public Employees Insurance Program.</i> | |
| Check appropriate box: | <input type="checkbox"/> I am waiving coverage in the Minnesota Public Employees Insurance Program at this time because I have coverage under another plan. <input type="checkbox"/> I am waiving coverage in the Minnesota Public Employees Insurance Program and do not have coverage under another plan. I understand if, at a later date, I request any coverage under the Minnesota Public Employees Insurance Program, I may be subject to a pre-existing condition exclusion or I may have to provide proof of prior continuous coverage. |
| Employee Signature | Date |

| COVERAGE OPTIONS | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Health Plan choice: (one per family) <input type="checkbox"/> First Plan <input type="checkbox"/> HealthPartners <input type="checkbox"/> Mayo <input type="checkbox"/> PreferredOne | Managed Care/POS <input type="checkbox"/> \$10/\$100 <input type="checkbox"/> \$15/\$100 <input type="checkbox"/> \$10/90 <input type="checkbox"/> \$15/\$90 <input type="checkbox"/> \$10/80 <input type="checkbox"/> \$15/\$80 | | Comprehensive Major Medical Plan <input type="checkbox"/> \$100 deductible <input type="checkbox"/> \$250 deductible <input type="checkbox"/> \$500 deductible <input type="checkbox"/> \$1000 deductible | | Who do you wish to cover? Check all that apply. <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + One <input type="checkbox"/> Family |

| | |
|------------------------------------------------------------------------------------------|----------------------------------------------------------|
| LIFE | |
| <input type="checkbox"/> Basic Life/AD&D Insurance (check with your employer for amount) | <input type="checkbox"/> Dependent/Spouse Life Insurance |
| <input type="checkbox"/> Employee Supplemental Life/AD&D Insurance - Amount: _____ | (increments of \$5,000 upon approval) |

| | |
|-----------------------------------------|---------------------|
| Life Insurance Beneficiary Designation: | |
| Primary: _____ | Relationship: _____ |
| Secondary: _____ | Relationship: _____ |

| | |
|---------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| DENTAL | If dependent coverage is offered, family dental will be packaged with family medical (employees who choose family medical must choose family dental). |
| <input type="checkbox"/> Employee Dental Coverage | <input type="checkbox"/> Employee and Dependent Dental Coverage |

| EMPLOYEE/DEPENDENTS | | | | | | |
|------------------------------------------------------------------------------|------------------------------------|-----|-------------------|----|------------------------|-------------------------------------|
| Last Name, First Name, Middle Initial (use additional paper if necessary) | Date of Birth (Month/Date/Year) | Sex | Full-time Student | | Social Security Number | Primary Care Clinic Name & Clinic # |
| | | | Yes | No | | |
| Employee | | | | | | |
| Spouse | | | | | | |
| 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 |

**There are laws to protect your rights to:
INFORMATION AND PRIVACY**

INFORMATION AND PRIVACY

Several state and federal laws aid in protecting 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 (Minnesota Statutes 13.01-13.43), you have the right to know:

A. 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:

- Determine whether you are eligible for the Minnesota *Public Employees Insurance Program* (PEIP).
- To establish the amount of insurance coverages you and/or your family members are eligible for.

B. Your rights regarding supplying information:

Minnesota Statute 13.04. You may refuse to provide the information we request; however, without certain minimal information, we may be unable to process your application for insurance coverage under the group plan.

Federal Privacy Act of 1974: Public Law 93-579. Disclosure of your social security number is voluntary. It is being requested to identify your records in the Minnesota *Public Employees Insurance Program* system maintained by the administrative organization responsible for enrollment, and claims processing procedures for the Program. It is also used for the records maintained by insurance companies. While you are not legally required to furnish this information, processing of your application for group benefits may be delayed without it.

C. Who the information is used by and how it is used:

The information we collect will be used by employees of the Minnesota *Public Employees Insurance Program's* administrative organization operating the group insurance program, federal and state tax authorities, and will be shared with the insurance carrier(s) and administrator involved in providing your benefits.

Depending on the coverage you request (and are eligible for), information may be used to:

- Provide enrollment and/or change information to your insurance carrier(s) and the Minnesota *Public Employees Insurance Program* administrative organization so they can provide benefits and pay claims.
- When required, provide underwriting information to insurance carrier(s) necessary to acquire insurance coverage.
- Prepare statistical reports and evaluative studies.

When you are no longer an active participant under the group insurance plan, your file will be kept until state document retention requirements are met.

D. What information you have access to:

You may request in writing to be shown insurance information about yourself that is maintained by your employer.

E. How can you obtain information on your benefit files:

Questions regarding your eligibility, level of coverage, and premium rates should be directed to the designated insurance representative for your employer. Questions regarding medical, dental or life insurance claims should be directed to the specific plan chosen.

A. Health Coverage Rates Revised 9/4/03

**HMO \$15/100%
Monthly Premium
for Active Employees**

Preferred One

| | |
|--------|----------|
| Single | \$358.65 |
| Family | \$838.81 |

HealthPartners

| | |
|--------|----------|
| Single | \$342.24 |
| Family | \$801.06 |

B. Dental Coverage Rates

Delta Dental Preventive Plan

| | Monthly Rate If Employer Pays <u>90% or More of Cost</u> | Monthly Rate If Employer Pays <u>50-89% of Cost</u> |
|-----------|----------------------------------------------------------------|-----------------------------------------------------------|
| Employee: | \$ 8.26 | \$ 9.00 |
| Family: | \$24.97 | \$27.67 |



Delta Dental Comprehensive Plan

| | Monthly Rate If Employer Pays <u>90% or More of Cost</u> | Monthly Rate If Employer Pays <u>50-89% of Cost</u> |
|-----------|----------------------------------------------------------------|-----------------------------------------------------------|
| Employee: | \$28.23 | \$31.16 |
| Family: | \$67.26 | \$73.78 |



The dental rates for retirees are the same as the active employee rates.

| | | | |
|------------------------------|----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | \$15 Office Visit | | |
| | 100% Hospitalization | | |
| | | HealthPartners Option 952/883-5000 or 800/828-1159 <i>(Services must be received from or directed by your designated HealthPartners primary care clinic)</i> | Preferred One Option 763/372/3555 or 800/997/1750 <i>(Services must be received from or directed by your designated Preferred One primary care clinic)</i> |
| Preventive Care | 100% coverage | 100% coverage | 100% coverage |
| Physician Services | | | |
| Office Visit | \$15 copay | \$15 copay | \$15 copay |
| Urgent Care | \$15 copay | \$15 copay | \$15 copay |
| Surgery/Delivery | 100% coverage | 100% coverage | 100% coverage |
| Hospital Services | | | |
| Inpatient/Outpatient | 100% coverage | 100% coverage | 100% coverage |
| Prescription Drugs | \$15 copay | \$15 copay | \$15 copay |
| Mental Health | | | |
| Inpatient | 100% coverage | 100% coverage | 100% coverage |
| Outpatient | \$15 copay | \$15 copay | \$15 copay |
| Chemical Dependency | | | |
| Inpatient | 100% coverage | 100% coverage | 100% coverage |
| Outpatient | \$15 copay | \$15 copay | \$15 copay |
| Emergency Room | | | |
| At Plan Hospital | \$50 copay, waived if admitted | \$50 copay, waived if admitted | \$50 copay, waived if admitted |
| Out-of-Area | 80% of first \$2,500, then 100% | 80% of first \$2,500, then 100% | 80% of first \$2,500, then 100% |
| Out of Pocket Maximum | \$1,000 per person \$2,000 family maximum | \$1,000 per person \$2,000 family maximum | \$1,000 per person \$2,000 family maximum |

This is a summary of benefits. Refer to each plan's certificate of coverage for a complete description of benefits and exclusions or contact the plan's customer service department number.