Enroll / Change Form

MDEA / DCEA

MANAGEMENT AND BUDGET
STATE EMPLOYEE GROUP INSURANCE PROGRAM

Employee Name

Plan Year
2023

Employer
State of Minnesota

Hire Date *(MM/DD/YYYY)*

State of Minnesota Employee ID Number

Email Address

Street or PO Box

Phone Number

City | State | ZIP

Qualifying Event Date *(for election changes only)*

ELECTION INFORMATION

This is a: ☐ New enrollment ☐ Change in previous enrollment

Plan Year Election Amount
Note: Only expenses from your effective date through the end of the year, or the date your coverage ends, if earlier, will be eligible.

☐ **Medical/Dental Expense Account (MDEA)** $
Note: If you or your spouse has a Health Savings Account (HSA), contributions cannot be made to the HSA while there is coverage under a general purpose MDEA. See below for how to convert the account to a Limited MDEA.
Note: Minimum annual election of $100 required to participate; maximum annual election is $3050 (for 2023).

☐ **Dependent Care Expense Account (DCEA)** $
Note: This account is for daycare expenses only, NOT medical expenses.
Note: Minimum annual election of $100 required to participate; maximum annual election is $5000 per household.

☐ **Limited MDEA** (For those who have an HSA. Reimburses dental, vision and / or post-deductible expenses as allowed by your plan) $
***IMPORTANT**: To convert your MDEA to a Limited MDEA, you must complete and return to BRI the "MDEA/HRA to Limited Account Change Form" available on BenefitResource.com/state-of-minnesota*

If this is a change in enrollment, please check the event that triggered this change:

NOTE: Please be aware of the following:
- *The change must be made within 30 days of the event date and cannot be made retroactively.*
- *Election change must be consistent with the status change that affects insurance eligibility for coverage under the plan, e.g. birth of a child – you may increase your MDEA account, not decrease it.*
- *The effective date of the change is the later of the event date or the first day of the pay period in which SEGIP receives your completed and signed Change Form.*

☐ Change in employment status of spouse or dependent that affects insurance eligibility (including termination or commencement of employment).

☐ Change in employee's legal marital status (including marriage, divorce, death of spouse, legal separation, annulment).

☐ Change in number of tax dependents (including birth, adoption, placement for adoption, death).

☐ Change in employment status that affects insurance eligibility for You, your spouse or dependent (including a switch between full-time/part-time or hourly/salaried, your unpaid leave of absence/lay off/unpaid FMLA/PPL, spouse commencement of unpaid leave of absence/lay off).

☐ Changes to decrees, judgments, or orders. Enrollment or dis-enrollment in Medicare, Medicaid, or Medical Assistance.

☐ Dependent satisfies or ceases to satisfy dependent eligibility requirements (attainment of age, student status, etc.).

☐ Change in dependent care cost or provider (for DCEA elections only).

Explanation:

Please continue to Page 2.

Enroll / Change Form

MDEA / DCEA

PLEASE CERTIFY THE FOLLOWING:

I have received and read the printed material which explains my plan and my options under it. I understand that any expenses paid under this plan must be eligible expenses as governed by Internal Revenue Service (IRS) regulations, must be for services provided for me or a qualifying individual and must not be reimbursed from any other source. I also understand that by signing and submitting this enrollment form, I am making an irrevocable election for the current plan year. Any choices above may be modified only as defined in the plan. Moreover, I authorize the amount(s) above to be deducted from payroll as indicated. I also understand that unused amounts in any of the pre-tax plans may be forfeited after the time frame indicated in the Plan Highlights.

I understand that Federal law requires financial institutions to obtain, verify and record information that identifies each person with an account. I also understand that I may be required to provide identifying information (e.g. Employee ID number, address and date of birth) when making inquiries about my account. I understand that any personal information obtained will not be shared with anyone, including non-affiliated third parties, except as permitted by law.

If a Beniversal® Prepaid Mastercard® is associated with my Account:

- I authorize the issuance of a Beniversal Card. I agree to use this card only for eligible medical expenses under the plan for me or a qualifying individual and to be bound by all provisions of the Cardholder Agreement and card promises sent to me with my card. Furthermore, I understand that if my Beniversal Card is used for expenses other than eligible medical expenses or if I violate the terms of the Cardholder Agreement, my account may be suspended and I will reimburse the plan for the expenses. I also authorize expenses for replacement cards to be deducted from my account balance as needed.
- Since the IRS requires that certain purchases made with the Beniversal Card be verified for eligibility, I agree to acquire and retain sufficient documentation for any expense paid with the card and to submit such followup documentation to Benefit Resource upon request.

Signature

Date *(MM/DD/YYYY)*

This form must be returned to SEGIP, fax to 651-797-1313, email to segip.mmb@state.mn.us, or mail to SEGIP, 400 Centennial Office Building, 658 Cedar Street, St. Paul, MN 55155

MINNESOTA MANAGEMENT AND BUDGET

NOTICE OF COLLECTION OF PRIVATE DATA

Minnesota Management and Budget 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 only need your dependent's social security number to offer insurance continuation or process a death benefit.

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 relates 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.

MINNESOTA MANAGEMENT AND BUDGET

NOTICE OF COLLECTION OF PRIVATE DATA

We ask for this information to process your request to add or change coverage for yourself, your dependent or beneficiary. The requested information helps us to determine eligibility, identify you and your dependents and beneficiaries, and contact you or your dependents and beneficiaries. We use the information so that we can successfully administer SEGIP, including using unidentifiable, aggregate data to develop new programs and ensure current programs effectively and efficiently meet member needs. We can use or release this information only as stated in this notice unless you give us your written permission to release the information or to use it for another purpose.

You are not legally required to provide us any of this information and you may refuse to provide the information. However, if you do not provide us the requested information, the insurance transaction you requested for you or your dependent or other insurance benefit transaction may be delayed or denied.

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. This information may also be used or released if Congress or the Minnesota Legislature passes a law allowing or requiring us to release the information or to use it for another purpose.