Claim Form

BRI An Inspira Financial Solution

MANAGEMENT AND BUDGET
STATE EMPLOYEE GROUP INSURANCE PROGRAM

MINNESOTA STATE

YOU COULD BE GETTING YOUR REIMBURSEMENT FASTER! File your claim online via the employee portal (BRIWEB) or via the BRIMOBILE app.

Employee Name _____ Employer State of Minnesota

State of Minnesota Employee ID Number ☐☐☐☐☐☐☐☐☐

What are you requesting a reimbursement for? *(One claim type per form.)*

☐ Medical/Dental Expense Account (MDEA) ☐ Dependent Care Expense Account (DCEA)

☐ Transit Expense Account (TEA - Parking or Vanpool) ☐ Health Reimbursement Arrangement (HRA)

Provider & Type of Service *(i.e. RX, Co-pay, Dental, Child care, Parking)*	Start and End Dates *(MM/DD/YYYY)*	Person Receiving Service *(First and Last Name)*	Amount	Office Use
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			$ ☐☐☐☐.☐☐	
			$ ☐☐☐☐.☐☐	
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CERTIFICATION AND AUTHORIZATION: By submitting the claim form, I certify that: (1) The information on this form is accurate and complete. (2) I am requesting reimbursement for eligible expenses provided to myself or qualifying individuals while a participant in the plan. (3) I have already received these products and services and confirm that by requesting reimbursement here that I have not and will not seek reimbursement of this expense from any other plan or party. If I am covered under more than one healthcare account, reimbursement will be made according to the payment order determined by those plans and as stated in my plan documentation. (4) Use of this service indicates my acceptance of the terms and conditions associated with my plan and available through my secure login at BRIWEB.

Signature _____ Date *(MM/DD/YYYY)* _____

WHAT YOU NEED TO KNOW WHEN SUBMITTING YOUR CLAIM:

- Provide an itemized receipt or an EOB if required by your plan. Credit card receipts are generally not accepted.
- Check your plan highlights to determine what expenses are eligible, required documentation for claim submissions, and when claims must be submitted by.
- Additional forms you might need (Available on BenefitResource.com/state-of-minnesota)
  - *Dependent Care Receipt:* Submit this fill-in form with a completed claim form when requesting reimbursement from your Dependent Care Expense Account if you do not have an itemized receipt, invoice, bill, or statement from the care provider.
  - *Mileage Expense Certification Form:* Submit this fill-in form with a completed claim form when requesting reimbursement for transportation expenses related to essential medical care (Rate subject to IRS changes), parking, and tolls from your MDEA or HRA.
  - *Certification of Medical Necessity:* Submit this fill-in form with a completed claim form once per year to receive reimbursement for dual-purpose items from your MDEA or HRA.
- Visit BenefitResource.com/ClaimsHelp for further assistance in filling out this form.

SUBMIT CLAIM BY MAIL OR FAX:

MAILING ADDRESS: Benefit Resource, LLC | PO BOX 642 | Willow Grove, PA 19090
FAX NUMBER: (877) 918-3622

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.

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