SAINT LOUIS COUNTY MINNESOTA

Group Vision Plan

for St. Louis County & Affiliated Employers

Required Information

First Name:_____

Middle Name:_____

Last Name:_____

Street: _____

City:_____

State: _____ ZipCode: _____

☐ Active Employee #_____

☐ Retiree/Retiree Spouse

☐ Surviving Spouse

Birth Date: _____/_____/_____

Home/Cell:_____

Work Phone:_____

☐ I am not enrolled in the St. Louis County Self Insured Health plan
or
this is my Health Plan Member ID number:

Gender: M F

☐ Check if you are reporting a new address

☐ Check if you are reporting a name change (see back top)

Email:_____

Married?: ☐ Yes; Date of Marriage: ____/____/_____ Location of marriage (County & State): _____

☐ No

I currently have these ***family members*** enrolled:

- ☐ None
- ☐ Spouse & no other family members
- ☐ One child & no other family members
- ☐ Two or more family members

I want to change & cover these ***family members***:

- ☐ None
- ☐ Cover my spouse and no children
- ☐ Cover only one child and no spouse
- ☐ Cover two or more family members

Employee/Retiree	Effective Date ____/____/____ to ☐ Add ☐ Drop ☐ Waive ☐ Move subgroups
Spouse	Effective Date ____/____/____ to ☐ Add ☐ Drop ☐ Waive ☐ Move subgroups
Children	Effective Date ____/____/____ to ☐ Add ☐ Drop ☐ Waive ☐ Move subgroups

Effective Dates:

- **New spouse or child:** effective on the date of marriage/birth/adoption
- **Retirement and divorce:** effective the first of the month following the event date
- **Open enrollment:** effective on January 1st of the following year
- **New Employee**: effective the first of the month following one full calendar month of employment
- **Loss of other vision coverage**: effective the first of the month following loss of other coverage

Check ALL that apply:

Date of any event you checked below: _____

- ☐ New Employee
- ☐ Open Enrollment
- ☐ Rehire/LOA
- ☐ Gain/Loss of other vision coverage; attach or follow up with documentation verifying date other coverage was gained/lost
- ☐ Other: _____
  _____
  _____
  _____
- ☐ Marriage;
- ☐ Birth/Adoption; County:_____
  State: _____
- ☐ Death
- ☐ Name or Address Change
- ☐ Newly Medicare eligible; Who? _____
- ☐ Retirement
- ☐ Divorce/legal separation
  Ex-spouse address: _____
  _____

Revision Date 01/2020

Dependents (when reporting a name change, drop old name and add new name)

CHECK ONE	NAME	Gender (M/F)	Birth Date (mm/dd/yyyy)	Relation to Applicant Spouse, Child, Stepchild, etc.
☐ Add ☐ Drop	First_____ Middle_____ Last _____			
☐ Add ☐ Drop	First_____ Middle_____ Last _____			
☐ Add ☐ Drop	First_____ Middle_____ Last _____			
☐ Add ☐ Drop	First_____ Middle_____ Last _____			
☐ Add ☐ Drop	First_____ Middle_____ Last _____			
☐ Add ☐ Drop	First_____ Middle_____ Last _____			
☐ Add ☐ Drop	First_____ Middle_____ Last _____			

Authorization

I hereby apply for coverage for which I am or may become eligible for under the group contract(s) issued by my employer. I also authorize my employer to deduct from my pay any contributions that may be required for the cost of enrolled coverage. By signing this form, I certify that the information provided in this application is true and correct and I authorize my employer to share required information with the insurance provider. I further understand that should any of my dependents at any time not meet the coverage eligibility requirements, whether due to divorce or other reasons, I will inform the County Human Resources department within 30 days of the event which results in the loss of eligibility. I understand that St. Louis County may periodically ask for substantiation of dependent status, and that claims paid for ineligible dependents may be retroactively denied.

Signature:_____ Date _____

After completing and signing, submit this form:

To be completed by Employer:

Employer Signature_____Date_____

Effective date: _____

Prior Group # _____

New Group # _____

Prior enrollment: IND E1D ESP ECH FAM NONE

New enrollment: IND E1D ESP ECH FAM NONE

Via USPS mail to:
Auditor's Office – Payroll Division
St. Louis County Court House
100 N. 5th Ave West Room 201
Duluth, MN 55802

OR

Email from internal email only to:
benefitforms@stlouiscountymn.gov

Employee SSN (if adding coverage and no health plan number was provided on front): _____

Notes: