



S A I N T LOUIS C O U N T Y M I N N E S O T A



Group Health Plan for St. Louis County & Affiliated Employers

Required Information

First Name: _____ Middle Name: _____ Last Name: _____ Street: _____ City: _____ State: _____ Zip Code: _____	<input type="checkbox"/> Active Employee # _____ <input type="checkbox"/> Retiree/Retiree Spouse <input type="checkbox"/> Surviving Spouse Birth Date: ____/____/____ Home/Cell: _____ Work Phone: _____	Social Security Number: _____-____-____ If coverage is already in place, leave this field blank. See back side of form for more on social security numbers.
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<input type="checkbox"/> Check if you are reporting a new address <input type="checkbox"/> Check if you are reporting a name change (see back)	Email: _____
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Married?: Yes; Either waive/drop coverage for spouse below or complete: Date of Marriage: ____/____/____
 No Location of marriage (County & State): _____

Add, Change or Waive Coverage

Employee/Retiree	Effective Date ____/____/____ to <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Waive <input type="checkbox"/> Move subgroups
Spouse	Effective Date ____/____/____ to <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Waive <input type="checkbox"/> Move subgroups
Children	Effective Date ____/____/____ to <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Waive <input type="checkbox"/> 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 health coverage:** effective the first of the month following loss of other coverage

Check ALL that apply:

Date of any event you checked below: _____

<input type="checkbox"/> New Employee, Hire date: _____ <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Rehire/LOA, Return date: _____ <input type="checkbox"/> Move spouse of retiree to Group Senior Gold Plan <input type="checkbox"/> Move retiree to Group Senior Gold plan <input type="checkbox"/> Change from Single to Family medical coverage <input type="checkbox"/> Change from Family to Single medical coverage <input type="checkbox"/> Add ____ (#) dependent(s) <input type="checkbox"/> Remove some dependents (how many? ____), but continue coverage for remaining ____ dependent(s) <input type="checkbox"/> Other: _____	<input type="checkbox"/> Marriage; <input type="checkbox"/> Birth/Adoption; County & State: _____ <input type="checkbox"/> Death <input type="checkbox"/> Name or Address Change <input type="checkbox"/> Newly Medicare eligible; Who? _____ <input type="checkbox"/> Retirement <input type="checkbox"/> Loss of other coverage <input type="checkbox"/> Divorce/legal separation Ex-spouse address: _____ <input type="checkbox"/> Gain/Loss of other health coverage (attach or follow up with documentation verifying date other coverage was gained/lost)
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Dependents (when reporting a name change, drop old name and add new name)

Add/Drop (circle one)	Name (first/middle/last)	Social Security Number*	Gender (M/F)	Birth Date (mm/dd/yyyy)	Relation to Applicant Spouse, Child, Stepchild, Grandchild, etc.
<input type="checkbox"/> Add <input type="checkbox"/> Drop					
<input type="checkbox"/> Add <input type="checkbox"/> Drop					
<input type="checkbox"/> Add <input type="checkbox"/> Drop					
<input type="checkbox"/> Add <input type="checkbox"/> Drop					
<input type="checkbox"/> Add <input type="checkbox"/> Drop					
<input type="checkbox"/> Add <input type="checkbox"/> Drop					

*Social Security Numbers are reportable to the federal government by BlueCross and BlueShield and St. Louis County per federal statute. If coverage is already in place, leave this field blank because your number is already on file. Failure to provide social security numbers upon application for coverage will make your health coverage unreportable and could result in a tax penalty and/or obstacles to Medicare at a later date. See this health plan's full privacy notice at www.stlouiscountymn.gov/benefits or by requesting it at 218-726-2422.

Dual Coverage or Prior Coverage (skip this section if you are only dropping coverage)

Name of policyholder	Name & phone number of Insurance company	Subscriber Number	Type of Coverage	Coverage Start Date	Coverage End Date	Reason Coverage Ended

Medicare enrollees, list parts A & B effective dates above & check reasons for Medicare entitlement: Age Disability End Stage Renal Disease

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. I reserve the right to revoke this deduction authorization at any time on written notice to my employer.

By signing this form, I certify that the information provided in this application is true and correct. I further understand that should any of my dependents at any time not meet the health coverage eligibility requirements, whether due to divorce or other reasons, I will inform either the County Employee Relations Department or the health insurance carrier Blue Cross/Blue Shield of Minnesota 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:

To be completed by Employer:

Employer Signature _____ Date _____

Effective date: _____

Prior Group # _____

New Group # _____

Prior enrollment: Single Family None

New enrollment: Single Family None

Notes: _____

**Auditor's Office – Payroll Division
St. Louis County Court House
100 N. 5th Ave West Room 201
Duluth, MN 55802 OR
benefitforms@stlouiscountymn.gov**