



S A I N T
LOUIS
COUNTY
M I N N E S O T A



Group Health Plan
for St. Louis County & Affiliated Employers

Required Information

Name		Birth Date	Gender	Active Employee # _____ Retiree/Retiree Spouse Surviving Spouse	Social Security Number
First: _____	_____	_____	_____	_____	_____
Middle: _____	_____	_____	_____	_____	_____
Last: _____	_____	_____	_____	_____	_____
<input type="checkbox"/> Check if this is a name change & write former name here: _____					(Required for coverage)

Employee/Retiree's Address		Home/Cell Phone: _____
Street Address: _____		Work Phone: _____
City: _____	State: _____ Zip: _____	Email: _____
<input type="checkbox"/> Check if this is a new address		

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 _____	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 health coverage:** effective the first of the month following loss of other coverage

Check ALL that apply:

<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"/> Other: _____ <input type="checkbox"/> Remove some dependents (how many? ___), but continue coverage for remaining ___ dependent(s)	Date of recent/upcoming event below: _____ <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: _____ _____ _____
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Dependents (when reporting a name change, drop old name and add new name)

Add/Drop (check one)	Name (first/middle/last)	Social Security Number*	Gender (M/F)	Birth Date (mm/dd/yyyy)	Relation to Applicant Spouse, Child, Stepchild, Grandchild, etc.
Add Drop					

*Social Security Number is required.

Dual Coverage/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:

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

Employer Signature _____ Date _____

Effective Date: _____

Prior Group # _____

New Group # _____

Prior enrollment: Single Family None

New enrollment: Single Family None

Notes: _____
