

Check reason you are completing this form:

Mid-Year Change

*(If had other coverage within last 63 days, provide Cert	ificate of Credible Coverage	e.) **(No	default for Reimbursement Accounts.)
	Employee	Information	
Name (Last,First, MI):		Social Security Number:	
Address:		City, State, Zip:	
Phone: Home: ()		Birth Date:	
Work: ()		Enrollment Status:	
Gender: L Male		☐ Married ☐ Single	Claiming an Adult Dependent Claiming an Adult Dependent Form)
	Mid-Year Cha	nge Information	In Declaration of Adult Dependent Form)
To add or delete dependents or make a plan char			hange and, (2) indicate the date of the
event below:			
Event allowing dependent addition and some consistent with the event.	plan changes (event m	ust have been within the last 63 o	days): The change in election must be
□ Marriage □ Birth of child □	Court-ordered custody/s	support/legal guardianship	□ Adoption/Pre-adoptive placement
(If dependent has or had other coverage within la.			
The Date of Event is the last date of the other cov	verage. Date		
Dependent transferring to you from a	nother University Plan m		
Specify from whom:	SS#:	Cam	pus:
Event allowing/requiring dependent deletion a Notify Campus Human Resources ASAP when a covered Notice for COBRA continuation within 60 days.		-	e consistent with the event.
	Divorce/legal separation	n 🛛 Change in support	order
 Other loss of dependent status due to 			
You went on leave without pay			
 Dependent became eligible for other OTHER (specify): 		ify):	
Date of Event:			
	Information About (Sther Croup Coverage	
Are you, your spouse or any dependents continuing cov		Other Group Coverage	are/Medicaid)
	plete below:		
Name (Last,First,MI):	Medical Dental	Other Employer	Name and Number of Plan
Employee			
Spouse/ Adult Dependent			
Dependents			
List Your Be	eneficiaries For Life	and AD&D Insurance Benefi	ciaries
Primary (Last, First, MI)		Relationship:	
Contingent (Last, First, MI) If more than one Primary or Contingent beneficiary is to b	e specified, attach benefici	Relationship:	Inless otherwise specified payment will be
shared equally by all primary beneficiaries who survive th unless otherwise stated. If you are married, but choose s beneficiary.	ne Insured; if none, by all co	ntingent beneficiaries who survive. The	ne right to change the beneficiaries is reserved
Spouse's Signature:			Date:
My signature indicates that I have read and understand t notices section of the Choices Enrollment Workbook. My materials). I understand that my salary will be reduced by premiums with before-tax dollars is intended to meet the understand that the tax advantage described may not be	 election or waiver of cover- the amount designated (or IRS requirements. If tax law 	age is binding and cannot be revoked I will forfeit any remaining Employer (or modified (other than as explained in the Contribution) and that the arrangement for paying
I authorize the MUS Plan, and their contracted Business claims for myself or my family. I declare that the informat previous forms I have submitted. If I have waived covera and Long Term Care insurance at a later date.	ion furnished on this form is ge, I understand that satisfa	true, correct and complete to the bes actory evidence of insurability may be	t of my knowledge. This form supersedes all
Employee's Signature:			Date:
Spouse's Signature:			Date:
Dependent Over 18 Signature:			Date:

MUSEB Montana University System Employee Benefits 2012/2013 Choices Enrollment Mid-Year Change Form

SS#:

* Indicates Mandatory Benefits Enrollment

	If you are enrolled in the	nexible spe	enuing program	n, se	e belo	w lor	IVIIa	rear	Chan		
Medical * Choo	ose a plan & coverage level	Employee	Emp + Sp	Emp	+ Child	(ren)	Em	np+ Fa	mily	Monthly Cost	
Traditional Plan	1	\$673.00	\$905.00				\$1,137.00				
Allegiance Man	aged Care	\$612.00	\$823.00	\$802.00			\$1,	033.00			
Blue Cross Blue	e Shield Managed Care	\$575.00	\$774.00		9	6754.00		\$	972.00		
Pacific Source		\$591.00	\$795.00		9	6774.00		\$	998.00		
	st here										*(A)
Dental * Choos	se a plan & coverage level	Employee	Emp + Sp	Emp	+ Child	(ren)	Em	np+ Fa	mily		
Premium Plan		\$44.00				\$84.00	\$119.00				
Basic Plan		\$17.00				\$32.00			\$46.00		
Enter your Cos	st here										*(B)
	Accidental Death & Dismemb			-							
Choose one:		\$10,000									
		\$20,000									
	st here										*(C)
Long Term Dis				1							
Choose one:		ay/6-month wait									
	•	ay/6-month wait									
		ay/4-month wait									+/
	st here		1				I _	_			*(D)
Vision		Employee	Emp + Sp	Emp	+ Child		Em	np+ Fa			
EyeMed Vision		\$6.76	\$12.76			\$13.43			519.70		
Enter your Cos	st here	- 1									(E)
	lental Death & Dismemberme		Choose one leve					~ =			
Amount	· · · /				np. Onl		Emp	.&Fam			
\$25,000.00		\$1.18	+ ,		\$3.7				\$7.05		
\$50,000.00		\$2.35			\$5.0				\$9.40		
\$75,000.00		\$3.53			\$6.2				\$11.75		
\$100,000.00			. ,		\$7.5	-			\$14.10		
	t here										(F)
Cost						. 10	otal L	ines	A-F		(G)
Total Month	nly Employer Contribution	on								-733	(J)
											. ,
TOTAL MONT	ly before-tax insurance						ne G	-			(K)
	Below List All E						Dental	, Visio	on,		
		Optional De	pendent Life or	Optio	nal AD	&D					
	Name	Birth Date	MANDATORY!	Gender Enrolled In:				Disabled Chi	ld		
		(Mo/Day/Year)	Social Security #	м	F Med	Den	l ife	Vis	AD&D	or Adult Dep) .
	(Last, First, MI)	(mo/bay/rear)				. Dem	Enc.	110.	ABGB	••••••	
Employee											
Spouse/ Adult [Dependent										
Dependent											
Dependent											
Dependent											
						-					
Dependent					_						
	If you run out of spac	es for additio	onal family mem	bers,	please	attac	h a lis	t to th	nis for	п.	
			Flass								
			Flex								
			Year Election Cl								
	ees are permitted to change ele										
	e change occurs). The requeste								nd the	Eloy Second	in ~
request for a ch	ange in elections is made within					-				Flex Spendi	
	t is amount of salary reduction;	Negative amou	nt can be applied to	a Meo	dical Fle	xible S	pendin	g Acct		Yes 🗌 No 🛛	
Positive amoun	the amount of salary reduction,	0									
(Note: Any nega	ative amount not spent on the N	ledical Flexible	Spending Acct. will	be for	feited)					Extra Form Requ	uired
(Note: Any nega <i>If you had a ne</i>	ative amount not spent on the Megative amount that you applied	ledical Flexible and to a Medical	Flex Spending A	ccoun	t when					Extra Form Requ	uired
(Note: Any nega If you had a ne your enrollme	ative amount not spent on the N	ledical Flexible and to a Medical ble for that amo	Flex Spending A	ccoun	t when					Extra Form Requ	uired