

## CHOICES 2018-2019 COBRA Annual Enrollment Form Montana University System Benefits Plan

<b>Medical Plan</b>					<b>Total Monthly Costs</b>
Choose one plan <b>and</b> indicate the number of covered adults and/or children:	<input type="checkbox"/> Employee/Spouse/Child <sup>1</sup> (each)/Survivor	<input type="checkbox"/> Employee + Spouse	<input type="checkbox"/> Employee/Survivor + Child(ren)	<input type="checkbox"/> Employee + Family	
<input type="checkbox"/> Allegiance Plan	\$813.00 Number _____	\$1,192.00	\$1,065.00	\$1,443.00	
<input type="checkbox"/> BlueCross BlueShield Plan	\$762.00 Number _____	\$1,096.00	\$1,013.00	\$1,353.00	
<input type="checkbox"/> PacificSource Plan	\$853.00 Number _____	\$1,249.00	\$1,117.00	\$1,513.00	
<b>Enter your monthly cost here</b>	→				\$ _____ (A)
<b>Dental Plan</b>					
Choose one plan <b>and one</b> coverage level:	<input type="checkbox"/> Employee/Spouse/Child <sup>1</sup> (each)/Survivor	<input type="checkbox"/> Employee + Spouse	<input type="checkbox"/> Employee/Survivor + Child(ren)	<input type="checkbox"/> Employee + Family	
<input type="checkbox"/> Basic Plan	\$18.00 Number _____	\$35.00	\$35.00	\$49.00	
<input type="checkbox"/> Select Plan	\$42.00 Number _____	\$81.00	\$81.00	\$115.00	
<b>Enter your monthly cost here</b>	→				\$ _____ (B)
<b>Vision Hardware Plan</b>					
<input type="checkbox"/> Yes	<input type="checkbox"/> Employee/Spouse/Child <sup>1</sup> (each)/Survivor -----	\$9.90			\$ _____ (C)
<input type="checkbox"/> No	<input type="checkbox"/> Employee + Spouse -----	\$18.70			
	<input type="checkbox"/> Employee/Survivor + Child(ren) -----	\$19.68			
	<input type="checkbox"/> Employee + Family -----	\$28.87			
<b>Your Total Monthly Costs</b> [Add up all your costs from right-hand column of this form (A) through (C)]					→ \$ _____
<i>The cost to continue COBRA coverage is up to 102% of the cost of coverage for similarly situated active employees and/or family members. The actual cost is not the same as the amounts used for CHOICES enrollment purposes.</i>					

Check reason you are completing this form:  <input type="checkbox"/> New COBRA Enrollment <input type="checkbox"/> Annual COBRA Re-enrollment <input type="checkbox"/> Other _____	<b>Administrative Use Only</b> <b>Campus Location:</b> _____ <b>Effective Date:</b> _____ <b>Insurance Class:</b> _____
MUS Employee Name: _____ SSN: _____	

<sup>1</sup> Children placed individually on the plan each pay the adult rate.

**Personal**

Birth Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

COBRA Applicant Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_ Qualifying Event Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Sex:  Male  Female

Telephone Number: \_\_\_\_\_ Marital Status:  Married  Single

E-mail Address: \_\_\_\_\_

If your spouse is still an eligible faculty or staff member, please provide his/her name, campus, and Social Security Number.

Spouse's Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Campus: \_\_\_\_\_

**List All Eligible Family Members Enrolled for Medical, Dental, or Vision Hardware Coverage**

Name (Last, First, MI):	Birth Date (mm/dd/yyyy)	Enrolled in:			SSN	Disabled	Check for Children Over Age 19:
		Medical	Dental	Vision Hardware			
Spouse	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	
Dependent Child	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Dependent Child	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Dependent Child	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Dependent Child	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Dependent Child	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>

*Please attach list of additional family members.*

I understand that any continued coverage elected on this form will terminate immediately upon the occurrence of one of the following events, regardless of whether premiums have been paid for coverage after such event: failure to pay the required premium on time; becoming covered under another group health plan not maintained by the Montana University System provided the individual does not have a preexisting condition which the new plan does not cover due to a plan exclusion or limitation; becoming entitled to Medicare; or termination by the Montana University System of all group health plans for all employees. I also understand that if extended coverage is provided due to Social Security disability, continued coverage will cease if the disabled individual is determined to have recovered. In such cases I will be entitled to a refund of any overpayment of premiums. I authorize the claims administrator or insurance company to obtain, examine or release information needed to coordinate benefits or process claims for myself or my family. I declare that the information furnished on this form is true, correct and complete to the best of my knowledge. This form supersedes all previous forms I have submitted.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_