MONTANA UNIVERSITY SYSTEM

2004/2005
Choices Enrollment Form

THIS FORM MUST BE FILLED OUT IF YOU ARE MAKING A FLEX ELECTION

Name:_____

SS#_____

Medical

Monthly Costs

❒ WAIVER OF COVERAGE - I have been given the opportunity to enroll in MUS Benefits Plan and decline participation at this time. ***Sign below**

Choose one plan and one coverage level:	❒ Employee Only	❒ Employee & Spouse	❒ Employee & Child(ren)	❒ Employee & Spouse & Child(ren)
❒ $400 Deductible Plan	$423.00	$548.00	$533.00	$614.00
❒ $575 Deductible Plan	$412.00	$526.00	$515.00	$571.00

❒ CHO Option — ***See individual plan on attached page for amount and enter on line (A).***

Enter your cost here ..... $ (A)

Dental (Not a change year)

Choose one plan and one coverage level:	❒ Employee Only	❒ Employee & Spouse	❒ Employee & Child(ren)*	❒ Employee & Spouse & Child(ren)*
❒ Premium Plan	$36.00	$65.00	$56.00	$83.00
❒ Basic Plan (Preventive)	$17.00	$28.00	$35.00	$43.00

* Children - Preventive Only

Enter your cost here ..... $ (B)

Life Insurance/Accidental Death & Dismemberment and Long Term Disability

Basic Life Insurance/AD&D
Choose one:

❒ $10,000 $1.65
❒ $20,000 $3.30

Long Term Disability
Choose one:

❒ 60% of pay/6-month wait $6.49
❒ 66-2/3% of pay/6-month wait $12.01
❒ 66-2/3% of pay/4-month wait $14.99

Enter your cost here for Basic Life Insurance/AD&D ..... $ (C)

Enter your cost here for Long Term Disability ..... $ (D)

❒ ***Optional Vision —*** Covers All Family Members $3.05 $ (E)

Optional Accidental Death & Dismemberment

Choose one amount and one coverage level:	Employee Only	Employee & Family
❒ Decline Coverage	❒ $ 0.00	❒ $ 0.00
❒ $ 25,000	❒ $ 0.63	❒ $ 1.18
❒ $ 50,000	❒ $ 1.25	❒ $ 2.35
❒ $ 75,000	❒ $ 1.88	❒ $ 3.53
❒ $100,000	❒ $ 2.50	❒ $ 4.70
❒ $150,000	❒ $ 3.75	❒ $ 7.05
❒ $200,000	❒ $ 5.00	❒ $ 9.40
❒ $250,000	❒ $ 6.25	❒ $ 11.75
❒ $300,000	❒ $ 7.50	❒ $ 14.10

Enter your cost here ..... $ (F)

Costs ***TOTAL Lines A-F*** (G)

Total Monthly Flex Credits ..... ($460.00) (H)

Your Total Monthly Before-Tax Insurance Costs ***(Lines G minus H)*** ..... $ (I)

Positive Amount is Amount of Salary Reduction or Negative Amount Can Be Applied to Health Care Reimbursement Account .....

(Note: Any Negative Amount Not Spent on the Health Care Reimbursement Account Will be Forfeited)

Optional Reimbursement Accounts

Write in the amount you wish to allocate to your Expense Accounts. If you don't wish to participate, write in $0.

Health Care Reimbursement Account ***(Min. $10; Max. $500.00)*** Enter yearly amount here ..... Yr. $_____ $ (J)

Dependent Care Reimbursement Account ***(Min. $10; Max. $416.66)*** Enter yearly amount here .. Yr. $_____ $ (K)

If you participate in one/both Accounts, enter your before-tax monthly administration fee of $2.76 ..... $ (L)

Optional After-Tax Benefits

Optional Supplemental Life Insurance
Choose one: ***(See Enrollment Workbook for costs)***

❒ Decline Coverage ❒ $ 75,000 ❒ $150,000
❒ $25,000 ❒ $100,000 ❒ $175,000
❒ $50,000 ❒ $125,000 ❒ $200,000

Optional Dependent Life Insurance
Choose one: ***(You must select Optional Supplemental Life Insurance to enroll)***

❒ Decline Coverage $0.00
❒ $ 2,500 Spouse/$1,250 Child(ren) $0.77
❒ $ 5,000 Spouse/$2,500 Child(ren) $1.54
❒ $10,000 Spouse/$5,000 Child(ren) $3.08
❒ $25,000 Spouse/$5,000 Child(ren) $7.71

Enter your after-tax cost here for Optional Supplemental Life Insurance ..... $ (M)

Enter your after-tax cost here for Optional Dependent Life Insurance ..... $ (N)

My signature indicates that I have read and understand the election form and materials describing options provided by ***Choices,*** including information about delayed effective date. My election or waiver of coverage is binding and cannot be revoked or modified ***(other than as explained in the materials)***. I understand that my salary will be reduced by the amount designated ***(or I will forfeit any remaining Flex Credits)*** and that this arrangement for paying premiums with before-tax dollars is intended to meet the IRS requirements. If tax laws change or if this arrangement is deemed not to satisfy IRS requirements, I understand that the tax advantages described may not be available.

*****Participant Signature*** ***Date***

IMPORTANT: Complete both sides of this form

*Coverage Information

MONTANA UNIVERSITY SYSTEM

Campus location: No. of Pay Periods: Date of Hire:

Check reason you are completing this form:

❒ New Enrollment ❒ Annual Enrollment

❒ Annual Enrollment Default ❒ Mid-Year Change

Signature: _____

Date: _____

Check health plan of your choice: (if choosing HMO Plan)

❒ Peak Health Plan ❒ New West Health Plan

❒ BC/BS HMO Plan

❒ ***If electing one of these plans, complete Primary Care Physician section below. You may choose a different PCP for each person from your plan's physician directory.***

❒ Cancel CHO Option
This option is not aailable in all areas - see attached

Campus: (circle one)

UM Msla MSU Boz MSU Northern MT Tech Butte UM Western MSU Blgs FVCC Dawson

MSU GT Falls Helena COT State Bar Miles Comm College St Bar CHE

Employee Information

BC/BS ID#

Name (Last, First, MI):	Social Security Number:	Birth Date:
Address:	City, State, Zip:	Phone (Home): (Work):

Gender: ❒ Male ❒ Female | Marital Status: ❒ Married ❒ Single ❒ Divorced/Separated ❒ Widowed

If your spouse is also an eligible faculty or staff member, provide his/her name, campus, and SSN:

Spouse's Name: Campus: SSN:

_____ _____ _____

List All Eligible Family Members Enrolled For Medical, Dental, Vision and Life Coverage

Name *(Last, First, MI):*	Gender		Birth Date *(Mo./Day/Yr.)*	Enrolled In:					Social Security #	Children Over 19	
	M	F		Med.	Dent.	Life	Vis.	CHO		Disabled	Full-time Student
Spouse	❒	❒		❒	❒	❒	❒	❒		❒	❒
Dependent	❒	❒		❒	❒	❒	❒	❒		❒	❒
Dependent	❒	❒		❒	❒	❒	❒	❒		❒	❒
Dependent	❒	❒		❒	❒	❒	❒	❒		❒	❒
Dependent	❒	❒		❒	❒	❒	❒	❒		❒	❒
Dependent	❒	❒		❒	❒	❒	❒	❒		❒	❒

If you selected the CHO Option, fill out the following information:

Member# (CHO Use Only)	*Enrollee Name*	*Primary Care Physician Choice (PCP) for each enrollee*	*Current Patient of PCP?*
			❒Y ❒N
			❒Y ❒N
			❒Y ❒N
			❒Y ❒N
			❒Y ❒N

Coverage Desired: ❒ Employee Only ❒ Employee & Spouse ❒ Employee & Children ❒ FullFamily

List Your Beneficiaries For Life and AD&D Insurance

Primary *(Last/First/MI):*	Relationship:
Contingent *(Last/First/MI):*	Relationship:

Information About Other Group Coverage

Are you, your spouse or any dependents continuing coverage by another plan? ***(Please include anyone eligible for Medicare/Medicaid.)***
❒ Yes ❒ No If yes, complete below:

Name *(Last, First, MI):*	Medical	Dental	Other Employer	Name and Number of Plan
	❒	❒		
Spouse	❒	❒		
Dependents	❒	❒		

If more than one primary or contingent beneficiary is to be specified, attach beneficiary information on a separate page. Unless otherwise specified, payment will be shared equally by all primary beneficiaries who survive the Insured; if none, by all contingent beneficiaries who survive. The right to change the beneficiary is reserved unless otherwise stated. If you are married, but choose someone other than your spouse as beneficiary, have your spouse sign below to acknowledge the other beneficiary.

Spouse's Signature: Date:

I authorize the 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. If I have waived coverage under the LTD or family life insurance plans, I understand that satisfactory evidence of insurability will be required to enroll at a later date.

Employee's Signature: Date:

Spouse's Signature:

Dependent Over 18 Signature:

If you run out of spaces for additional family members, please attach a list to this form.

YOUR CHO OPTIONS ARE AS FOLLOWS:

NEW WEST: Beaverhead, Big Horn, Blaine, Broadwater, Carbon, Chouteau, Custer, Flathead, Garfield, Golden Valley, Granite, Hill, Jefferson, Lake, Lewis & Clark, Meagher, Mineral, Missoula, Musselshell, Park, Phillips, Powell, Ravalli, Rosebud, Sanders, Stillwater, Sweetgrass, Treasure, Wheatland and Yellowstone.

❒ Employee Only	❒ Employee & Spouse	❒ Employee & Child(ren)	❒ Employee & Spouse & Child(ren)
$410.00	$532.00	$520.00	$593.00

For the most updated provider information please refer to the New West Web Site at ***www.newwesthealth.com/provsearch.asp***

PEAK: Silverbow - Yellowstone - Custer

❒ Employee Only	❒ Employee & Spouse	❒ Employee & Child(ren)	❒ Employee & Spouse & Child(ren)
$410.00	$513.00	$501.00	$568.00

For the most updated provider information please refer to the Peak Web Site at ***www.healthinfonetmt.com***

BLUE CROSS: For the most updated provider information please refer to the Blue Cross Web Site at ***www.bcbsmt.com***

❒ Employee Only	❒ Employee & Spouse	❒ Employee & Child(ren)	❒ Employee & Spouse & Child(ren)
$410.00	$532.00	$520.00	$593.00

This option is available to you only if you live in one of these counties. Depending on where you live you may not qualify for the CHO option. Please review each plan and make sure there is a participating primary physician in your area.

√ ***You must check the coverage desired i.e. Employee only, employee & spouse, etc., on the front worksheet.***

√ ***You must select a primary physician from your individual plan on the individual enrollment form.***

* ***Long Term Care: Medical Insurance does <u>not</u> cover Long Term Care. Contact your Human Resource Office for more information and an enrollment form.***