MUS_EB
Montana University System
Employee Benefits

2014/2015 *Choices* Enrollment Mid-Year Change Form

Name: _____
SS#: _____

*** Indicates Mandatory Benefits Enrollment**

Medical * *Choose a plan & coverage level*	**Employee**	**Emp + Sp**	**Emp + Child(ren)**	**Emp+ Family**	**Monthly Cost**	
Allegiance Managed Care	$607.00	$877.00	$850.00	$1,146.00		
Blue Cross Blue Shield Managed Care	$594.00	$858.00	$832.00	$1,122.00		
Pacific Source Managed Care	$664.00	$959.00	$929.00	$1,254.00		
Enter your Cost here						*(A)
Dental * *Choose a plan & coverage level*	**Employee**	**Emp + Sp**	**Emp + Child(ren)**	**Emp+ Family**		
Select Plan	$42.00	$80.00	$80.00	$113.00		
Basic Plan	$16.00	$31.00	$31.00	$43.00		
Enter your Cost here						*(B)
Life Insurance/Accidental Death & Dismemberment *						
Choose one:	$15,000	$1.49				
	$30,000	$2.97				
	$48,000	$4.75				
Enter your Cost here						*(C)
Long Term Disability *						
Choose one: 60% of pay/6-month wait		$5.90				
66-2/3% of pay/6-month wait		$11.75				
66-2/3% of pay/4-month wait		$14.66				
Enter your Cost here						*(D)
Optional Vision	**Employee**	**Emp + Sp**	**Emp + Child(ren)**	**Emp+ Family**		
Vision Hardware	$7.11	$13.42	$14.13	$20.73		
Enter your Cost here						(E)
Cost ..... **Total Lines A-F**						(F)
Total Monthly Employer Contribution					**-887**	**(G)**
Total Monthly before-tax insurance costs ..... **Lines G minus F**						(H)

Below List All Eligible Family Members Enrolled For Medical, Dental, Vision, Optional Supplemental Life and/or Optional AD&D

Name (Last, First, MI)	**Birth Date (Mo/Day/Year)**	**MANDATORY! Social Security #**	**Gender**		Enrolled In:						**Disabled Child or Adult Dep.**
			M	**F**	**Med.**	**Den.**	**Vis.**	**Basic Life**	**Opt. Supt.Life**	**Opt. AD&D**	
Employee											
Spouse/ Adult Dependent											
Dependent											
Dependent											
Dependent											
Dependent											

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

By enrolling dependents, you verify that the dependent(s) meets dependent eligibility requirements and that proof to establish the dependents relationship to you may be required.

Flex Mid-Year Elections Changes

Eligible Employees are permitted to change elections when a qualifying change in status (other than a Plan insurance cost or coverage change occurs). The requested change in elections must be consistent with the change in status; and the request for a change in elections is made within 63 days of the event.

Flex Spending
Yes☐ No☐

Positive amount is amount of salary reduction; Negative amount can be applied to a Medical Flexible Spending Acct.
(Note: Any negative amount not spent on the Medical Flexible Spending Acct. will be forfeited.)
You must re-enroll each year to participate in a Flexible Spending Account (NOT automatic!)
There are NO exceptions for late enrollment or late submissions.
Mid-Year Change for Medical flex must be consistent with event.
Medical Flex Account Annual Amount: Minimum of $120 Maximum $2,500/Employee

Medical Flex Monthly Amount

Dependent Care Annual Amount: Minimum $120 Maximum $5,000/Employee

Dependent Flex Monthly Amount

Adoption Assistance Annual Amount: Minimum $120 Maximum $12,650 (Total max-NOT annual max)

Adoption Assistance Flex Monthly Amount

Total Monthly Election

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Check reason you are completing this form:

☐ Mid-Year Change

(If you had other coverage within last 63 days, provide Certificate of Credible Coverage.)* *(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: ☐ Male ☐ Married ☐ Single ☐ Claiming an Adult Dependent

☐ Female *(Attach Declaration of Adult Dependent Form)*

Mid-Year Change Information

To add or delete dependents or make a plan change midyear, (1) check the qualifying event allowing the change and (2) indicate the date of the event below:

Event allowing dependent addition and some plan changes (event must have been within the last 63 days): The change in election must be consistent with the event.

☐ Marriage ☐ Birth of child ☐ Court-ordered custody/support/legal guardianship ☐ Adoption/Pre-adoptive placement

(If dependent has or had other coverage within last 63 days, provide Certificate of Creditable Coverage.)

☐ Dependent lost eligibility for other coverage due to (specify):

The Date of Event is the last date of the other coverage. Date:

☐ Dependent transferring to you from another University Plan member due to member's loss of eligibility/retirement.

Specify from whom: SS#: Campus:

Event allowing/requiring dependent deletion and some plan changes: The change in election must be consistent with the event.

Notify Campus Human Resources ASAP when a covered dependent loses eligibility (within no more than 30 days).
Notice for COBRA continuation within 60 days.

☐ Death of Dependent ☐ Divorce/legal separation ☐ Change in support order

☐ Other loss of dependent status due to (specify):

☐ You went on leave without pay

☐ Dependent became eligible for other employer benefits (specify):

☐ OTHER (specify):

Date of Event:

Information About Other Group Coverage

Are you, your spouse or any dependents continuing coverage by another plan? (Please include anyone eligible or covered by Medicare/Medicaid.)

☐ YES ☐ NO If yes complete below:

Name (Last,First,MI):	Medical	Dental	Other Employer	Name and Number of Plan
Employee	☐	☐		
Spouse/ Adult Dependent	☐	☐		
Dependents	☐	☐		

List Your Beneficiaries For Employee Life, and/or AD&D Insurance Beneficiaries

Primary (Last, First, MI) Relationship:

Contingent (Last, First, MI) Relationship:

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 beneficiaries 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:

My Signature indicates that I have read and understand the election for and materials describing options provided by *Choices*, including information contained in the notices section of the *Choices* Enrollment Workbook. 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 Employer Contribution) and that the 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 advantage described may not be available.

I authorize the MUS Plan, and it's contracted Business Associates to obtain, examine or release information needed to coordinate benefits, manage my care, 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, I understand that satisfactory evidence of insurability may be required to enroll in Life and Long Term Disability and Long Term Care insurance at a later date.

Employee's Signature: Date:

Spouse's Signature: Date:

Dependent Over 18 Signature: Date: