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

Medical Plan					**Total Monthly Costs**
Choose one plan **and** indicate the number of covered adults and/or children:	☐ Employee/Spouse/ Child [1] (each)/Survivor	☐ Employee + Spouse	☐ Employee/Survivor + Child(ren)	☐ Employee + Family	
☐ Allegiance Plan	$813.00 Number ____	$1,192.00	$1,065.00	$1,443.00	
☐ BlueCross BlueShield Plan	$762.00 Number ____	$1,096.00	$1,013.00	$1,353.00	
☐ PacificSource Plan	$853.00 Number ____	$1,249.00	$1,117.00	$1,513.00	
Enter your monthly cost here	→				**$_____ (A)**

Dental Plan					
Choose one plan **and** one coverage level:	☐ Employee/Spouse/ Child [1] (each)/Survivor	☐ Employee + Spouse	☐ Employee/Survivor + Child(ren)	☐ Employee + Family	
☐ Basic Plan	$18.00 Number ____	$35.00	$35.00	$49.00	
☐ Select Plan	$42.00 Number ____	$81.00	$81.00	$115.00	
Enter your monthly cost here	→				**$_____ (B)**

Vision Hardware Plan		
☐ Yes ☐ No	☐ Employee/Spouse/Child[1] (each)/Survivor --------- $9.90 ☐ Employee + Spouse ---------- $18.70 ☐ Employee/Survivor + Child(ren) ---------- $19.68 ☐ Employee + Family ---------- $28.87	**$_____ (C)**

Your Total Monthly Costs [Add up all your costs from right-hand column of this form (A) through (C)] → **$ _____**

*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.*

Check reason you are completing this form:	**Administrative Use Only**
☐ New COBRA Enrollment ☐ Annual COBRA Re-enrollment ☐ Other_____	**Campus Location:** _____ **Effective Date:** _____ **Insurance Class:** _____

MUS Employee Name:_____ SSN: _____

[1] Children placed individually on the plan each pay the adult rate.

IMPORTANT: COMPLETE BOTH SIDES OF THIS FORM

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:** Medical	Dental	Vision Hardware	SSN	Disabled	Check for Children Over Age 19:
Spouse	___/___/___	☐	☐	☐	_____	☐	
Dependent Child	___/___/___	☐	☐	☐	_____	☐	☐
Dependent Child	___/___/___	☐	☐	☐	_____	☐	☐
Dependent Child	___/___/___	☐	☐	☐	_____	☐	☐
Dependent Child	___/___/___	☐	☐	☐	_____	☐	☐
Dependent Child	___/___/___	☐	☐	☐	_____	☐	☐

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:**_____

Submit completed COBRA form to:
Allegiance COBRA Services, Inc.
P.O. Box 2097
Missoula, MT 59806

IMPORTANT: COMPLETE BOTH SIDES OF THIS FORM