MONTANA UNIVERSITY SYSTEM

2005/2006 *Choices* Enrollment Form

THIS FORM MUST BE FILLED OUT IF YOU ARE MAKING A REIMBURSEMENT ACCOUNT ELECTION
(Unless a separate form/electronic form is used)

Name: _____

SS# _____

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

Medical — Monthly Costs

Choose one plan and one coverage level:	❒ Employee Only	❒ Employee & Spouse or Adult Dep.	❒ Employee & Child(ren)	❒ Employee & Spouse or Adult Dep. & Child(ren)
❒ $400 Deductible Plan	$469.00	$594.00	$579.00	$660.00
❒ $575 Deductible Plan	$458.00	$572.00	$561.00	$617.00
❒ BCBSMT Managed Care* www.bcbsmt.com	$422.00	$535.00	$521.00	$594.00
	See Choices Enrollment Booklet for areas this plan is available.			
❒ New West Managed Care* www.newwesthealth.com	$414.00	$520.00	$506.00	$579.00
	See Choices Enrollment Booklet for areas this plan is available.			
❒ PEAK Managed Care* www.healthinfonetmt.com	$422.00	$535.00	$521.00	$594.00
	See Choices Enrollment Booklet for areas this plan is available.			

*If you select a managed care plan you must specify a primary care provider (PCP) for each family member on the back of this form. See the Choices Workbook or web sites for PCPs.

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

Dental

Choose one plan and one coverage level:	❒ Employee Only	❒ Employee & Spouse or Adult Dep.	❒ Employee & Child(ren)*	❒ Employee & Spouse or Adult Dep. & 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 $1.55
❒ $20,000 $3.10

Long Term Disability
Choose one:

❒ 60% of pay/6-month wait $6.35
❒ 66-2/3% of pay/6-month wait $11.75
❒ 66-2/3% of pay/4-month wait $14.66

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. Enter $3.43 for Optional Vision ..... $ (E)

Optional Accidental Death & Dismemberment

Choose one amount and one coverage level:

		❒ Emp. Only	❒ Emp. & Family		❒ Emp. Only	❒ Emp. & Family
❒ Decline Coverage	❒ $25,000	$0.63	$1.18	❒ $150,000	$3.75	$7.05
	❒ $50,000	$1.25	$2.35	❒ $200,000	$5.00	$9.40
	❒ $75,000	$1.88	$3.53	❒ $250,000	$6.25	$11.75
	❒ $100,000	$2.50	$4.70	❒ $300,000	$7.50	$14.10

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

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

❒ **Accept Dependent Child(ren) Premium Waiver.** This waives the portion of medical premium for child(ren) coverage for income-eligible employees. See Choices Workbook for requirements & for the amount of the monthly waiver for your selected plan & coverage level. Enter amount here ..... - $ (H)

Costs after Fee Waiver Subtract waiver (H) from Total Costs (G) and enter difference here ..... $ (I)

Total Monthly Employer Contribution ..... **- $506** (J)

Your total monthly before-tax insurance costs- *Line G minus J (if no premium waiver). Line I minus J (if waiver)* ..... $ (K)

Positive amount is amount of salary reduction; Negative amount can be applied to a Health Care Reimbursement Acct.
(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 Accounts below. If you **don't** wish to participate, write in $0.*

Health Care Reimbursement Acct. *(Min. $10; Max. $500.00 per mo.)* Enter yearly amount here ..... Yr. $_____ $ (L)

Dependent Care Reimbursement Acct. *(Min. $10; Max. $416.66 per mo.)* Enter yearly amount here ..... Yr. $_____ $ (M)

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

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 ..... $ (O)

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

IMPORTANT: Complete both sides of this form

MONTANA UNIVERSITY SYSTEM

Check reason you are completing this form:

❒ New Enrollment ❒ Annual Enrollment ❒ Annual Enrollment Default to same coverage (No default for Reimbursement Accts) ❒ Mid-Year Change (Complete Mid-Year Changes Info, below)

Employee Information

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

Gender: ❒ Male ❒ Female | Enrollment Status: ❒ Married ❒ Single ❒ Claiming an Adult Dependent (Attach Declaration of Adult Dependent Form)

PCPs for Managed Care Members

Below list a PCP for each family member enrolled in a Managed Care Medical Plan.
See the Choices Enrollment Booklet or Plan web site for PCPs. If you will be a new patient, check to see if PCP is taking new patients.

List All Eligible Family Members Enrolled For Medical, Dental, Vision, Optional Dependant Life or Optional AD&D

Name *(Last, First, MI):*	Gender M F	Birth Date *(Mo./Day/Yr.)*	Social Security #.
Employee	❒ ❒		
Spouse/ Adult Dependent	❒ ❒		
Dependent	❒ ❒		
Dependent	❒ ❒		
Dependent	❒ ❒		
Dependent	❒ ❒		
Dependent	❒ ❒		

Mid-Year Change Information

To add or delete dependents or make a plan change mid year, (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.

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

Specify from whom: Name; _____ SS# _____ Campus: _____

Event allowing/requiring dependent deletion and some plan changes: *The change in election must be consistant 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 for Medicare/Medicaid.)*
❒ Yes ❒ No If yes, complete below:

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

List Your Beneficiaries For Life and AD&D Insurance

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 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: _____

My signature indicates that I have read and understand the election form 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 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.

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, I understand that satisfactory evidence of insurability may be required to enroll in life and LTD insurance at a later date.

Employee's Signature: _____ Date: _____

Spouse's Signature: _____ Date: _____

Dependent Over 18 Signature: _____ Date: _____

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

Campus use only: _____ Effective Date: _____
Campus location: _____ No. of Pay Periods: _____