2008-2009 MONTANA UNIVERSITY SYSTEM RETIREE ENROLLMENT FORM

Retiree/Surviving Spouse Information

Name (Last, First, MI): _____ Birth Date: _____ Social Security Number: _____

Mailing Address: _____ City, State, Zip: _____

This is a new address: YES NO

Phone (Home): _____ Phone (Work): _____

Annual Enrollment

Waiver of Coverage - I have been given the opportunity to enroll in the MUS Benefits Plan and decline all participation at this time.

Change of status from active employee to retiree (See back for eligibility requirements.)

Change of status due to: (Check One) Death Marriage Divorce Spouse Change in Employment
Other (Please Explain) _____

Date of Status Change: _____ **(Campus Use Only) Effective Date of Change:** _____

Campus (circle): OCHE MSU MSU-B MSU-N MSU-GF UM MT Tech UM-W UM-Hlna FVCC MCC DCC State Bar

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Dependent Coverage: I understand any changes in my benefit elections and covered dependents must be necessitated by and consistent with a change in family status and must be acceptable under the regulations issued by the US Department of the Treasury. I request the following continuations and changes:

Spouse/Adult Dep.: _____ Keep Add Remove
Name *(Last, First, MI)* Birth Date *(Mo./Day/Yr.)* Social Security #

Dependent: _____ Keep Add Remove

Dependent: _____ Keep Add Remove

Attach a list if you have additional covered dependents.

Indicate ALL Dependents to be covered for this PLAN YEAR: No Dependent Coverage Spouse only
Child(ren) only Spouse and Child(ren)

Choose a Medical Plan. **See Choices Retiree Workbook for premium rates and areas where Managed Care plans are available.**

Choose one plan and one coverage level.

Retiree Only
Retiree + One Dependent
Retiree + Two or more Dependents
Retiree + Spouse **(mp)**
Retiree + Spouse **(mp)** + Child(ren)
Survivor
Survivor + Child(ren)

(mp) = enrolled in both Medicare Parts A & B

Retiree NOT in Medicare

Traditional Plans
Plan A $600 Deductible
Plan B $1500 Deductible

Managed Care Plans
Allegiance Managed Care
www.abpmtpa.com
Blue Choice Managed Care
www.bcbsmt.com
New West Managed Care
www.newwesthealth.com
PEAK Managed Care
www.healthinfonetmt.com

Retiree Enrolled in Medicare*

Traditional Plans
Plan A $400 Deductible
Plan B $1500 Deductible

Managed Care Plans
Allegiance Managed Care
www.abpmtpa.com
Blue Choice Managed Care
www.bcbsmt.com
New West Managed Care
www.newwesthealth.com
PEAK Managed Care
www.healthinfonetmt.com

***Medicare Part A & Part B Required**

Enter your monthly cost here from the 2008-2009 workbook …….. **Medical Premium: $**_____

Choose Optional DELTA Premium Dental Coverage if desired and eligible.

Retiree Only -- $42 per month Retiree + Spouse -- $76 per month **Dental Premium: $**_____
Retiree + Children -- $76 per month Retiree + Family -- $126 per month **OR** I decline or am ineligible for dental coverage.

Choose Optional EYEMED Vision Care Coverage if desired.

Retiree Only -- $7.64/month Retiree + Spouse -- $14.42/month **Vision Premium: $**_____
Retiree + Children -- $15.18/month Retiree + Family -- $22.26/month **OR** I decline vision coverage.

Total Monthly Premium: $_____

Information About Other Group Coverage: Do you, your spouse, or any dependents have coverage by another plan?
Yes No If yes, complete below: **Please include anyone eligible for Medicare or Medicaid.**

Name (Last, First, MI)	Medicare Part A	Medicare Part B	Other Employer	Name and Number of Plan
Retiree				
Spouse/Adult Dep.				
Dependents				

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 and legal sections of the Choices Retiree Workbook. My election or waiver of coverage is binding and cannot be revoked or modified (other than as explained in the materials). 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.

Retiree's Signature: _____ Date: _____

Surviving Spouse's Signature: _____ Date: _____

This signature is only required if Retiree is deceased.

MAILING ADDRESSES AND ADDITIONAL INFORMATION ARE ON THE BACK SIDE OF THIS FORM.

MONTANA UNIVERSITY SYSTEM RETIREE ENROLLMENT INFORMATION

ELIGIBILITY: A person retiring from any unit of the Montana University System (MUS), including the Office of the Commissioner of Higher Education or other agency or organization affiliated with the MUS or the Board of Regents of Higher Education, may continue certain group insurance benefits as described below. To be eligible as a Retiree, the individual must be eligible to receive a retirement benefit from the MT Teachers Retirement System or the MT Public Employees Retirement System at the time s/he leaves employment with the MUS. Retirees who are in the Optional Retirement Plan (TIAA-CREF) or any other defined contribution plan must have worked five or more years and be age 50 or must have worked 25 years with the MUS to be eligible for Retiree insurance benefits. It does not matter whether the Retiree decides to actually draw a monthly benefit; elects the defined benefit lump sum distribution; or postpones withdrawal of retirement benefits.

CONTINUATION OF COVERAGE: An eligible Retiree must make arrangements with his/her campus human resources/benefits office to continue coverage as a Retiree on a self-pay basis within 63 days of retirement. **There is no Employer contribution toward Retiree benefits.** The right to continue coverage under the Plan is a one-time opportunity. **Retirees who fail to continue coverage within 63 days of retiring or who allow coverage to lapse due to nonpayment of premium may not later rejoin the plan,** with one **EXCEPTION:**
A Retiree with the right to continue coverage under the MUS Plan, who chooses to continue coverage under spousal coverage in either the MUS Plan or the State of Montana Employee Benefit Health Plan, may be reinstated to the MUS Plan with Retiree coverage upon the retirement, death, divorce, or any other event which causes ineligibility for spousal coverage. This exception applies only to a Retiree who has maintained continuous coverage with either the MUS Plan or the State of Montana Employee Benefit Plan.

DEPENDENT COVERAGE OPTIONS: Continuing existing Medical and/or Dental coverage for dependents is optional, but Retirees must elect to continue existing Medical and/or Dental coverage for dependent(s) within the 63-day enrollment period after active employee coverage ends. New dependents can be added to existing Medical and/or Dental plans if the request is made within 63 days of a qualifying event (marriage, birth, adoption, legal guardianship, qualifying dependent). Existing dependents can only be added to Medical and/or Dental if they are losing eligibility for other group coverage or if there is a substantial decrease in the level of existing coverage, as determined on an individual basis by the campus hr/benefits office and if the request is made within 63 days of the termination of the other coverage.

OTHER COVERAGE

Dental Coverage: Delta Premium Dental Plan (only) became available to Retirees beginning July 1, 2007. Retirees (and their dependents, if desired) MUST have enrolled during FY2008 Annual Enrollment; or within 63 days of the end of their COBRA dental coverage if currently enrolled; or within 63 days of a qualifying event; or within 63 days of the end of their active employee coverage, whichever comes last. Enrollment in the dental plan is a one-time opportunity for Retirees (and their dependents). Coverage is permanently forfeited if the Retiree fails to enroll in a timely manner or fails to pay premiums.

Vision Care Coverage: MUS contracted with EyeMed, a national vision health care coordinator, to facilitate its vision care plan beginning July 1, 2007. More information can be found within the CHOICES workbooks. At this time, Retirees may add or delete vision coverage during each annual enrollment period.

Continuation of the **Life Insurance** is not available as group insurance. You may have the option of converting to a term life policy under the terms of our Standard Insurance Company contract. Please see your campus human resources/benefits representative for conversion information at the time of your retirement.

Long Term Care Insurance: If you have Long Term Care Insurance through UNUM , contact your campus hr/benefits office for conversion information upon retirement. Current Retirees can add Long Term Care Insurance with medical underwriting at any time. Medical underwriting means that UNUM can reject an application or increase rates due to issues such as preexisting medical conditions.

Long Term Disability Coverage: This coverage is not available to MUS Retirees.

PLEASE SEND YOUR FORM TO THE APPROPRIATE ADDRESS BELOW.

MSU-Bozeman Human Resources, PO Box 172520, Bozeman, MT 59717-2520	406-994-3651
MSU-Billings Human Resources, 1500 University Dr., Billings, MT 59101	406-657-2278
MSU-Northern Human Resources, PO Box 7751, Havre, MT 59501-7751	406-265-4147
MSU-Great Falls Human Resources, 2100 16th Ave. S., Great Falls, MT 59405	406-771-4308
UM-Missoula Human Resources, LO 252, 32 Campus Dr. MS1800, Missoula, MT 59812	406-243-6766
UM-Helena Human Resources, 1115 N. Roberts, Helena, MT 59601	406-444-0845
UM-Western Human Resources, 710 S. Atlantic St., Dillon, MT 59725	406-638-7010
MT Tech (UM) Human Resources, 1300 W. Park St., Butte, MT 59701	406-496-4380
OCHE/GSL, MUS Benefits Office, PO Box 203201, Helena, MT 59620-3201	406-444-0614
Dawson Community College Human Resources, 300 College Dr., Glendive, MT 59330	406-377-9403
Flathead Community College Human Resources, 777 Grandview Dr., Kalispell, MT 59901	406-874-6292
Miles Community College Human Resources, 2715 Dickinson St., Miles City, MT 59301	406-756-3804
State Bar of MT, attn: Mary Ann Murray, PO Box 577, Helena, MT 59624-0577	406-442-7660

Call your campus HR office or 406-444-0614 if you have questions about your annual enrollment form.