MONTANA UNIVERSITY SYSTEM - ACTIVE

2010/2011 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

** If enrolling in MUS benefits (**) indicates mandatory benefits

Medical**

Choose one plan and one coverage level:	❒ Employee Only	❒ Employee & Spouse or Adult Dep.	❒ Employee & Child(ren)	❒ Employee & Spouse or Adult Dep. & Child(ren)	**Monthly Costs**
❒ Traditional Plan A	$640.00	$796.00	$780.00	$952.00	
❒ Traditional Plan B	$708.00	$881.00	$864.00	$992.00	
❒ Blue Choice Managed Care	$582.00	$724.00	$710.00	$867.00	
www.bcbsmt.com	*See Choices Enrollment Booklet for areas this plan is available.*				
❒ New West Managed Care	$582.00	$724.00	$710.00	$867.00	
www.newwesthealth.com	*See Choices Enrollment Booklet for areas this plan is available.*				
❒ Allegiance Managed Care	$595.00	$740.00	$726.00	$886.00	
www.abpmtpa.com	*See Choices Enrollment Booklet for areas this plan is available.*				
❒ PEAK Managed Care	$595.00	$740.00	$726.00	$886.00	
www.healthinfonetmt.com	*See Choices Enrollment Booklet for areas this plan is available.*				

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	$44.00	$84.00	$84.00	$119.00
❒ Basic Plan (Preventive)	$17.00	$32.00	$32.00	$46.00

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

❒ Decline Coverage
❒ Employee Only $7.64
❒ Employee & Spouse or Adult Dep. $14.42
❒ Employee & Child(ren) $15.18
❒ Employee & Spouse or Adult Dep. & Child(ren) $22.26

Enter your cost here for Optional Vision ..... $ (E)

Optional Accidental Death & Dismemberment

Choose one amount <u>and</u> one coverage level: *(See Enrollment Workbook pg. 24 for eligibility)*

		❒ 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 pg. 31 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..... **- $733** (J)

Your total monthly before-tax insurance costs- *Line G <u>minus</u> J (if no premium waiver). Line I <u>minus</u> 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 If you **don't** wish to participate, write in $0.

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

If using the remainder of your Employer Contribution to fund or partially fund your Medical flexible spending acct., enter the **TOTAL** yearly & monthly amount you want designated for the medical flexible spending acct. Your remaining Employer Contribution will automatically be applied to your Medical flexible spending acct.; any remaining cost will be subtracted from your gross pay on a pre-tax basis.

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

Optional After-Tax Benefits

Optional Supplemental Life Insurance

Choose one: *(See Enrollment Workbook pg. 23-24 for costs & eligibility)*

❒ Decline Coverage
❒ $25,000
❒ $50,000
❒ $75,000
❒ $100,000
❒ $125,000
❒ $150,000
❒ $175,000
❒ $200,000
❒ $225,000
❒ $250,000
❒ $275,000
❒ $300,000

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..... $ (N)

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

A Long Term Care Benefit is also available, please contact your campus HR for a LTC Enrollment kit if interested

IMPORTANT: Complete both sides of this form

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Check reason you are completing this form:

❒ New Enrollment* ❒ Annual Enrollment ❒ Annual Enrollment Default to same coverage** ❒ Mid-Year Change

**(If had other coverage within last 63 days, provide Certificate of Creditable Coverage.)* ** *(No default for Reimbursement Accts)*

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)

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

Name *(Last, First, MI):*	Gender M	Gender F	Birth Date *(Mo./Day/Yr.)*	Enrolled In: Med.	Dent.	Life	Vis	.AD&D	Social Security # MANDATORY!	Disabled Child or Adult Dep
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.

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. _____

❒ 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 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 for Medicare/Medicaid.)* ❒ Yes ❒ No
If yes, complete below:

Name *(Last, First, MI)*:	Medical	Dental	Other Employer	Name and Number of Plan
Employee	❒	❒		
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 MUS Plan, and their 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 or Long Term Care insurance at a later date.

Employee's Signature: _____ Date: _____

Spouse's Signature: _____ Date: _____

Dependent Over 18 Signature: _____ Date: _____

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

Campus (Circle): CHE MSU MSU-B MSU-N MSU- GF UM UM-Tech UM-W FVCC Miles CC Dawson CC State Bar