MUS_EB
Montana University System
Employee Benefits

2011/2012 Choices Enrollment Form

Name:

SS#:

☐ **WAIVER OF COVERAGE**

I have been given the opportunity to enroll in MUS Benefits Plan and decline at this time. ** Sign page 2

*** Indicates Mandatory Benefits Enrollment**

If enrolling in the Flex spending program, you will need to fill out a separate form.

Medical * ***Choose a plan & coverage level***	**Employee**	**Emp + Sp**	**Emp + Child(ren)**	**Emp+ Family**	**Monthly Cost**
Traditional Plan	$669.00	$865.00	$846.00	$1,062.00	
Allegiance Managed Care	$632.00	$818.00	$799.00	$1,004.00	
Blue Cross Blue Shield Managed Care	$598.00	$775.00	$757.00	$951.00	
New West Managed Care	$612.00	$792.00	$774.00	$972.00	
Peak Managed Care	$632.00	$818.00	$799.00	$1,004.00	
Enter your Cost here ……					*(A)
Dental * ***Choose a plan & coverage level***	**Employee**	**Emp + Sp**	**Emp + Child(ren)**	**Emp+ Family**	
Premium Plan	$44.00	$84.00	$84.00	$119.00	
Basic Plan	$17.00	$32.00	$32.00	$46.00	
Enter your Cost here ……					*(B)
Life Insurance/Accidental Death & Dismemberment *					
Choose one:	$10,000	$1.55			
	$20,000	$3.10			
Enter your Cost here ……					*(C)
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 ……					*(D)
Vision	**Employee**	**Emp + Sp**	**Emp + Child(ren)**	**Emp+ Family**	
EyeMed Vision	$7.64	$14.42	$15.18	$22.26	
Enter your Cost here ……					(E)

Optional Accidental Death & Dismemberment ***Choose one level & one amount***

Amount	**Emp. Only**	**Emp.& Fam**	**Amount**	**Emp. Only**	**Emp.&Fam**
$25,000.00	$0.63	$1.18	$150,000.00	$3.75	$7.05
$50,000.00	$1.25	$2.35	$200,000.00	$5.00	$9.40
$75,000.00	$1.88	$3.53	$250,000.00	$6.25	$11.75
$100,000.00	$2.50	$4.70	$300,000.00	$7.50	$14.10

Enter you Cost here …… (F)

Cost …… Total Lines A-F (G)

Total Monthly Employer Contribution …… -733 (J)

Total Monthly before-tax insurance costs …… Line G minus J (K)

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)

Flex Spending
Yes☐ No☐
Extra Form Required

Below is your *After Tax* benefits

Optional Supplement Life				
Choose one:	$25,000	$100,000	$175,000	$250,000
(See Enrollment Workbook for cost)	$50,000	$125,000	$200,000	$275,000
	$75,000	$150,000	$225,000	$300,000
Enter your after-tax cost for Optional Supplemental Life Insurance ……				(L)

Optional Dependent Life Insurance		
Choose one:	$2,500 Spouse/$1,250 Child(ren)	$0.77
(You must select	$5,000 Spouse/$2,500 Child(ren)	$1.54
Optional Life Insurance to enroll)	$10,000 Spouse/$5,000 Child(ren)	$3.08
	$25,000 Spouse/$5,000 Child(ren)	$7.71
Enter your after-tax cost for Optional Dependent Life Insurance ……		(M)

A Long Term Care Benefit is also available, please ask you campus HR for a LTC Enrollment kit if interested.

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

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Employee Benefits

2011/2012 Choices Enrollment Form

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 Accounts.)*

Employee Information

Name (Last,First, MI): Social Security Number:

Address: City, State, Zip:

Phone: Home: ( ) Birth Date:

Work: ( ) **Enrollment Status:**

Gender: ☐ Male ☐ Female

☐ Married ☐ Single

☐ Claiming an Adult Dependent

(Attach Declaration of Adult Dependent Form)

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

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

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 Dependent	☐	☐		
Dependents	☐	☐		

List Your Beneficiaries For Life and 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 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 coverages 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 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 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 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: