MUS_EB
Montana University System
Employee Benefits

560 N. Park Ave., 4th Floor ◊ PO Box 203203 ◊ Helena, Montana 59620-3203 ◊ (877) 501-1722 ◊ Fax (406) 449-9170

DEPENDENT PREMIUM HARDSHIP WAIVER CRITERIA

The Montana University System (MUS) Benefit Plan offers a Dependent Premium Hardship Waiver to assist with the cost of health care coverage for children covered on the MUS Medical Plan. The family **must** apply for Healthy Montana Kids (HMK), Children's Health Insurance Plan (CHIP) coverage for all children under the age of 19 covered on the MUS Medical Plan. If HMK denies coverage and the family has a financial hardship, a Dependent Premium Hardship Waiver Application may be submitted to the MUS Benefits Office requesting the waiver. If the total household income is not more than 125% of the HMK guidelines, covered dependent children under the age of 19 will be eligible for the waiver for the benefit plan year (July 1 – June 30).

To receive the Dependent Premium Hardship Waiver, families **must**:

1. Apply for Healthy Montana Kids (HMK) coverage for covered dependent children aged 0 – 19 and be denied coverage (must submit a copy of the denial letter with the application). The HMK coverage denial cannot be due to not re-applying for HMK coverage or for the dependent being eligible for MUS medical coverage, as MUS employee dependent children are eligible for HMK coverage if they qualify.

2. List all sources of income (wages, tips, child support, alimony, etc.).

3. Provide documentation of household income (tax returns).

4. List each person in the policyholder's household (name, date of birth, age, relationship).

5. Provide a description of any medical or financial hardship incurred.

6. Re-apply for HMK and the Dependent Premium Hardship Waiver each benefit plan year to be eligible to continue the waiver.

7. Covered dependent children aged 19 – 26 are eligible to apply for the Dependent Premium Hardship Waiver based on their ineligibility to apply for HMK coverage.

8. Total family income must be less than 125% of the HMK program income guidelines.

Questions? Contact the MUS Benefits Office at 1-877-501-1722.

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DEPENDENT PREMIUM HARDSHIP WAIVER APPLICATION

Please answer each question below. Partially completed applications will be returned.		
Policyholder's Name:	Date of Birth:	
Mailing Address:		
City:	State:	Zip Code:
Contact telephone number:	E-mail:	
Health Plan ID#:		
Campus where employed:		
FAMILY INFORMATION		
Have you applied for coverage for dependent children, age 0 to 19, through the Healthy Montana Kids Program (HMK)? ❑ YES ❑ NO If you applied and were denied coverage, please enclose a copy of the denial letter.		
If your answer is NO, are the dependent children over age 18, but under age 26? ❑ YES ❑ NO (Application to HMK is required for children age 0 to 19, before a hardship application can be considered.)		
What is your household size (total number of people living in your home)?		
Name, birthdate, age, relationship of each person in the policyholder's household (add page if necessary):		
FINANCIAL INFORMATION		
Do any family members have special needs, either medical or financial? ❑ YES ❑ NO		
If any, please describe the needs (add page if necessary):		
What is your total household income (before taxes)?		
Please describe in detail the hardship incurred, if any, that supports this application (add page if necessary):		
Policyholder's signature: ______________________________ Date: ______________________________		