SURVIVING SPOUSE/DEPENDENT(S) ELECTION FORM

INSTRUCTIONS & DEADLINE FOR ELECTION – Use this form to elect State of Montana Benefit Plan (State Plan) benefits as a surviving dependent of a Participant or Retiree of the State of Montana.

- This form **must be postmarked or returned within 60 days of the Participant's or Retiree's date of death** to: Health Care & Benefits Division (HCBD), PO Box 200130, Helena, MT 59620-0130.
- The surviving spouse of a Participant or Retiree may remain a Covered Person of the State Plan as long as the spouse is eligible for retirement benefits accrued by the deceased Participant or Retiree as provided by law unless the spouse is eligible for Medicare under the federal Health Insurance for the Aged Act or unless the spouse has or is eligible to participant in another group health plan with substantially the same or greater benefits at an equivalent cost.
- The surviving children of a Participant may remain Covered Persons of the State Plan as long as they are eligible for retirement benefits accrued by the deceased Participant as provided by law unless they have equivalent coverage with substantially the same or greater benefits at an equivalent cost or are eligible for insurance coverage by virtue of the employment of a surviving parent or legal guardian.

DECEASED PARTICIPANT OR RETIREE INFORMATION

EMPLOYEE/RETIREE ID# _____ LAST NAME _____ FIRST NAME _____ MI ___

DATE OF DEATH _____ TERM DATE _____

CONTACT INFORMATION FOR SURVIVING DEPENDENT ELECTING COVERAGE

If you plan to live somewhere other than this address for part of the year, be sure to let HCBD know!

MAILING ADDRESS_____ CITY _____ STATE _____ ZIP _____

PHONE NUMBER _____ EMAIL _____

COVERAGE ELECTION – The Previous Coverage box reflects the types of coverage any covered dependent(s) had prior to the death of the Participant or Retiree. Please complete the Coverage to Continue box and indicate the coverage you wish to elect for Survivor coverage, you may only elect to continue the coverage that was in effect for you when the Participant or Retiree was covered. Cross out a member's name if you do not want him/her to continue coverage.

- If medical coverage was carried previously, it must continue in order to continue dental coverage.
- You must be enrolled in the Medical Plan to be eligible for Vision Hardware coverage. All dependents enrolled on the Medical Plan will have Vision Hardware coverage.
- Please refer to the current Wrap Plan Document (WPD), http://benefits.mt.gov/Publications, for an outline of the State Plan eligibility requirements.

Previous Coverage (M for Medical, D for Dental, V for Vision Hardware)	**Name**	**Coverage to Continue** (Circle M for Medical, D for Dental, V for Vision Hardware)	**Birthdate**	**Relationship**	**SSN**
		M D V			
		M D V			
		M D V			
		M D V			
		M D V			

SURVIVING SPOUSE MEDICARE STATUS – If the surviving spouse is eligible for Medicare, the surviving spouse is not eligible for Survivor coverage.

- ❑ Surviving spouse is Medicare eligible and is not eligible for Survivor coverage.

SURVIVING SPOUSE/DEPENDENT(S) COVERAGE STATUS – If the surviving spouse or dependent(s) have equivalent coverage with substantially the same or greater benefits at an equivalent cost, the surviving spouse or dependent(s) is not eligible for Survivor coverage. If the surviving dependent(s) is eligible for insurance coverage by virtue of employment of a surviving parent or legal guardian, the surviving dependent(s) is not eligible for Survivor coverage.

- ❑ Surviving spouse or dependent(s) is not eligible for Survivor coverage based upon the coverage status information outlined above.

METHOD OF PAYMENT – Select one of the payment methods below.

- ❑ Monthly self-payment to Health Care & Benefits by check and coupon.
- ❑ Electronic deduction from checking or savings. You will need to complete the Electronic Benefits Payment Deduction Authorization Form to activate this option.

SIGNATURE – I hereby elect to continue the coverage selected above with the State of Montana Group Benefit Plan (State Plan). This coverage will remain in effect unless I change my coverage election, my dependents lose eligibility or I fail to pay the required payments by the due date. If I wish to cancel, I must submit my request in writing. I understand that payments may be adjusted for any future increases or decreases in the cost of the coverage(s) I have selected.

Signature:_____Date:_____

HCBD USE ONLY
Survivor Coverage Effective: _____
Total Payment Due: _____
Incentive: _____
Authorized by: _____

Language Assistance – General Taglines

State of Montana is required by federal law to provide the following information.

- ظة: إذا تكذ تحتدث اذرك اللغة، فإن خدمات الامعدسة اللوغةتي تتوافر لك ابلمجن. التصد ربمة 855-999-1063)رقم . 1-855-999-1062 :مكهافـة الصم والوحلم
- 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-999-1062（TTY：1-855-999-1063)
- ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-999-1062 (TTY: 1-855-999-1063).
- ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-999-1062 (TTY: 1-855-999-1063).
- ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-999-1062 (ATS: 1-855-999-1063).
- ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-999-1062 (TTY: 1-855-999-1063).
- ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-999-1062 (TTY: 1-855-999-1063).
- 注意事項：日本語を話される場合、無料の言語支援をご利用いただけま.1-855-999-1062（TTY:1-855-999-1063）まで、お電話にてご連絡ください.
- 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-999-1062 (TTY: 1-855-999-1063) 번으로 전화해 주십시오.
- UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-999-1062 (TTY: 1-855-999-1063).
- ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-999-1062 (TTY: 1-855-999-1063).
- ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-999-1062 (телетайп: 1-855-999-1063).
- ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-999-1062 (TTY: 1-855-999-1063).
- PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-999-1062 (TTY: 1-855-999-1063).
- CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-999-1062 (TTY: 1-855-999-1063).

State of Montana Non-Discrimination Statement: State of Montana complies with applicable Federal civil rights laws, state and local laws, rules, policies and executive orders and does not discriminate on the basis of race, color, sex, pregnancy, childbirth or medical conditions related to pregnancy or childbirth, political or religious affiliation or ideas, culture, creed, social origin or condition, genetic information, sexual orientation, gender identity or expression, national origin, ancestry, age, disability, military service or veteran status or marital status. State of Montana does not exclude people or treat them differently because of race, color, sex, pregnancy, childbirth or medical conditions related to pregnancy or childbirth, political or religious affiliation or ideas, culture, creed, social origin or condition, genetic information, sexual orientation, gender identity or expression, national origin, ancestry, age, disability, military service or veteran status or marital status. State of Montana provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). State of Montana provides free language services to people whose primary language is not English such as: qualified interpreters and information written in other languages. If you need these services, contact customer service at 855-999-1062. If you believe that State of Montana has failed to provide these services or discriminated in another way on the basis of race, color, sex, pregnancy, childbirth or medical conditions related to pregnancy or childbirth, political or religious affiliation or ideas, culture, creed, social origin or condition, genetic information, sexual orientation, gender identity or expression, national origin, ancestry, age, disability, military service or veteran status or marital status you can file a grievance. If you need help filing a grievance, John Pavao, State Diversity Coordinator, is available to help you. You can file a grievance in person or by mail, fax, or email: John Pavao, State Diversity Program Coordinator - Department of Administration State Human Resources Division, 125 N. Roberts, P.O. Box 200127, Helena, MT 59620, Phone: (406) 444-3984 Email: jpavao@mt.gov

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD).