ACTIVE DUTY MILITARY LEAVE ELECTION FORM

INSTRUCTIONS & DEADLINE – Use this form to make changes to your State of Montana Benefit Plan (State Plan) coverage elections while you are on active duty military leave for more than 31 days.

- Employees on active duty military leave who choose to remain on the State Plan must have Medical, Employee Dental, and Basic Life Insurance. Any coverage you remove may be reinstated within 31 days of your return from active duty military leave.
- While on active duty military leave, you may continue to receive State Share. Please contact the State Human Resource Division (406) 444-3871 for assistance in determining how long State Share will be available to you. You will be billed for any benefit contributions you owe over the State Share amount twice a month (each State Pay period).
- This form **must be postmarked or returned before you leave for active duty military leave** to: Health Care & Benefits Division (HCBD), PO Box 200130, Helena, MT 59620-0130. Please provide a copy of your active duty military order.
- If you would like to prepay your benefit contributions with your final paycheck before military leave, complete and return this form before your final paycheck is issued. Your agency payroll department must complete the "For Agency Personnel Use Only" section on the back of this form. Prepayment is limited to the benefit contributions for the months remaining in the current Plan Year.
- If you do not submit this election form within 31 days of your military active duty leave, your State Plan coverage will remain the same and you will be billed for any benefit contribution you owe over the State Share amount.
- The Health Care & Benefits Division (HCBD) website, www.benefits.mt.gov, includes important benefit information to help you understand State Plan rates, coverages, and benefit options.

PERSONAL INFORMATION

EMPLOYEE ID# ________________ LAST NAME _________________________ FIRST NAME _____________________ MI ___

DATE OF BIRTH ____-____-_______ DATE CALLED TO ACTIVE DUTY ____________

MAILING ADDRESS____ CITY ______________ STATE ____________ ZIP _______

PHONE NUMBER _____________________________ EMAIL ____

WAIVER OF COVERAGE – Check this box if you would like to waive State Plan coverage while on active duty military leave.

☐ Check this box if you would like to waive State Plan coverage for yourself and any covered spouse/domestic partner and/or dependent child(ren) while on active duty military leave. You may re-enroll by completing the Active Duty Reinstatement Form within 31 days of your return from active duty military leave.

COVERAGE ELECTION – Enter the information for yourself and any spouse/domestic partner and/or dependent child(ren) as you would like them covered while you are on active duty military leave.

Name	**Coverage** (Circle M for Medical and/or D for Dental)	Birthdate	Relationship
	(M) (D)		**Employee**
	M D		
	M D		
	M D		
	M D		
	M D		

VISION HARDWARE COVERAGE – Vision Hardware Coverage covers all members enrolled in your Medical Plan.

☐ Continue Vision Hardware Coverage ☐ Waive Vision Hardware Coverage

LIFE INSURANCE – Put an X in the box of the option you would like to continue. If you elect to stay on the State Plan while on Active Duty Military Service, you must have Basic Life Insurance.

Coverage	Keep the same	Waive	Change	Amount Requested
Basic Life Insurance (Required) - $14,000	x	N/A	N/A	$14,000
Employee Supplemental Life* – 1 x Annual Salary rounded to next highest $5,000 in $5,000 increments up to 10x your annual salary.				
AD & D with dependents - $25,000 increments up to 10x your annual salary.				
AD & D without dependents - $25,000 increments up to 10x your annual salary.				
Dependent Life** - $2,000 spouse, $1,000 each dependent child. If you waive this coverage, you may not be able to reelect it when you return from active duty.				**Not Available**
Spouse Supplemental Life* - $5,000 increments up to the amount you elected for Employee Supplemental Life.				
Long Term Disability (LTD) Insurance				**Not Available**

TURN OVER – ACTION REQUIRED ON BACK!

***EVIDENCE OF INSURABILITY (EOI)** - If you elect an increase of more than $10,000 to Supplemental Life, any increase to Spouse Supplemental Life, and/or a new election of Long Term Disability (LTD), you must complete an EOI form. You can access the EOI form on the HCBD website at www.benefits.mt.gov/Forms. **Please be aware, you will not receive a reminder regarding the requirement to complete the EOI. Failure to complete EOI will result in NO Life Insurance increases beyond the $10,000 allowed without EOI. If you do not currently have Supplemental Life or LTD, you will not qualify for any options without EOI.**
**Dependent Life is only available if you elected it during your initial 31 day enrollment period or within the first 60 days of acquiring a spouse or your first child.

FLEXIBLE SPENDING ACCOUNTS (FSA) - FSA amount must be divisible evenly by the pay periods remaining in the Plan Year. Your election will be adjusted to an even amount if necessary.

- ❑ Leave my Medical FSA the same
- ❑ Waive Medical FSA
- ❑ Change my Medical FSA to ______**YEARLY AMT** ($120 min/$2499.84 yearly max)

- ❑ Leave my Dependent/Child Care FSA the same
- ❑ Waive Dependent/Child Care FSA
- ❑ Change my Dependent/Child Care FSA to ________**YEARLY AMT** ($120 min/$4999.92 household yearly max)

READ AND SIGN

I request the election changes indicated. I understand I am responsible for paying any benefit contribution I owe.
Flexible Spending Account(s) ("FSA") - If I elect to change my FSA(s) contribution, I realize I will have the opportunity to change it again upon returning from active duty military leave. I understand the elections I submit to HCBD will be binding until I return from active duty military leave unless I or a dependent qualify for a Special Enrollment Period as described in the Summary Plan Document. I understand by signing below, I agree to the above Authorization Terms.

Signature:____Date:__________

FOR AGENCY PERSONNEL USE ONLY

Determine the total additional amount to be withheld from the final paycheck. List the month/year of coverage, payment for each type of coverage and total payments for each month. Prepayment is limited to the benefit contributions for the months remaining in the current Plan Year.

Month/Year	Medical	Dental	Vision Hardware	Basic Life	Medical FSA	Dependent FSA	Admin Fee	Debit Card Fee	Total
						NA			
						NA			
						NA			
						NA			
						NA			
						NA			
						NA			
						NA			
						NA			
						NA			
						NA			
						NA			
TOTALS									

HEALTH CARE & BENEFITS USE ONLY
Wellness Incentive:
Total to be withheld:
Date sent to payroll:
Completed by:

Language Assistance – General Taglines

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

- ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-999-1062 (رقم هاتف الصم والبكم: 1-855-999-1063).
- 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)