ACTIVE DUTY MILITARY LEAVE REINSTATEMENT FORM

INSTRUCTIONS & DEADLINE FOR REINSTATEMENT – Use this form to reinstate State of Montana Benefit Plan (State Plan) coverage after an active duty military leave.

- This form **must be postmarked or returned within 31 days of returning from active duty military leave** to: Health Care & Benefits Division (HCBD), PO Box 200130, Helena, MT 59620-0130. Your benefits will be effective retroactive to the date you return to work, unless you request an alternative effective date by contacting HCBD directly.
- If you do not submit this reinstatement form within 31 days, your benefit elections will remain the same as what you had during your active duty military leave. If waived State Plan coverage while on active duty military leave, your coverage will remain waived. See "Waiver of Coverage" below for more details.
- 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 RETURNED FROM 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.

- ❑ If you check this box, you and any covered spouse/domestic partner and/or dependent child(ren) will not be covered by the State Plan. A benefit eligible employee may re-enroll at any time, but your spouse/domestic partner and/or dependent child(ren) will not be able to come back to the State Plan until the next Open Enrollment Period or with a Special Enrollment Period as outlined in the Summary Plan Document.

COVERAGE ELECTION – Enter the information for yourself and any spouse/domestic partner and/or dependent child(ren) you would like to add to your Medical and/or Dental coverage.

- Employees on the State Plan must have Medical, Employee Dental, and Basic Life Insurance.
- Please refer to the current Summary Plan Document (SPD), http://benefits.mt.gov/Publications, for an outline of the State Plan eligibility requirements.

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

VERIFICATION OF ELIGIBILITY – If you are adding a spouse/domestic partner and/or dependent child(ren) to your medical and/or dental coverage who was not on your State Plan before you left for active duty military leave, you are required to submit the verification of eligibility documentation as outlined below to HCBD within 60 days of your return from active duty military leave. You may submit this information via email to benefitsquestions@mt.gov with the subject line, "Active Duty Reinstatement." You can also mail it to HCBD, Attention: "Active Duty Reinstatement", PO Box 200130, Helena, MT 59620.

- Dependent Children
  - A copy of your child's/children's birth certificate(s), adoption order, pre-adoption order; or
  - A copy of a court-ordered parenting plan, custody agreement or legal guardianship.
- Spouse
  - A copy of your marriage certificate; or
  - A copy of the front page of your tax return showing your tax filing status as "married" (you may black out any financial information); or
  - A copy of your recorded and notarized Affidavit of Common Law Marriage (available on the HCBD website at http://benefits.mt.gov/forms).
- Domestic Partner
  - A Declaration of Domestic Partner Relationship form (available on the HCBD website at http://benefits.mt.gov/forms); AND
  - Proof of a shared residence: AND
  - A copy of mutually-granted powers of attorney or health care powers of attorney; or
  - A copy of mutual designations of primary beneficiary in wills, life insurance policies or retirement plans.
- Grandchild(ren)
  - A copy of a court-ordered custody agreement or legal guardianship.
- Stepchildren
  - Required documentation listed above for Domestic Partner or Spouse, if individual is not enrolled; AND
  - A copy of your stepchild's/stepchildren's birth certificate(s), adoption order, pre-adoption order; or
  - A copy of a court-ordered parenting plan, custody agreement or legal guardianship.

TURN OVER - ACTION REQUIRED ON BACK!

JOINT CORE ELECTION – For spouses/domestic partners who are both benefit eligible employees of the State of Montana and have covered dependents. Your spouse/domestic partner must also submit a mid-year change form to elect Joint Core status.

- ❑ Elect Joint Core - JointCore Partner and Employee ID# _____

VISION HARDWARE COVERAGE – You and/or your dependent(s) must be enrolled in the Medical Plan to be eligible for Vision Hardware. If you check YES below **all** dependents enrolled on your Medical Plan will have Vision Hardware Coverage.

- ❑ Yes, I want to enroll. ❑ No, I do not want to enroll.

LIFE INSURANCE – Put an X in the box of the option you would like to elect. Please keep in mind if you receive a salary increase it could increase the minimum amount of Life coverage you are required to elect.

- ➢ Be sure to check your Life Insurance Beneficiary Designation in the MINE site upon returning to work. Visit http://benefits.mt.gov/Life-and-Accident/Online-Beneficiary-Designation for instructions.

Coverage	Yes	No	Amount Requested
Basic Life Insurance (Required) - $14,000	**X**	**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			**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**

***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. 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 New Employee 31 day enrollment period or within the first 60 days of acquiring a spouse or your first child.

FLEXIBLE SPENDING ACCOUNTS (FSA) - You must elect an account and indicate an amount to enroll in an FSA. If you elect an FSA, you must also participate in the Pre-Tax Plan. Calculate the yearly FSA amount keeping in mind the yearly 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.

- ❑ Medical Expense FSA _____**YEARLY AMT** ($120 min/$2499.84 yearly max)
- ❑ Dependent/Child Care FSA _____**YEARLY AMT** ($120 min/$4999.92 household yearly max)

READ AND SIGN

I request the election changes indicated, and authorize the associated payroll deduction.

Flexible Spending Account(s) ("FSA") - If I elect to participate in the FSA(s) for the current Plan Year, I authorize the State of Montana to reduce my gross salary by the amounts indicated. I understand my election amount will remain in effect for the entire Plan Year, and only eligible expenses incurred during the Plan Year may be claimed for reimbursement. I realize this election will NOT continue for subsequent plan years. This agreement revokes all prior Employee Enrollment/Change and Salary Reduction Agreements signed by me for this Plan Year.

Adding Spouse/Domestic Partner and/or Dependents - I understand if I am adding a new spouse to my Plan, deductions for my spouse will default to the pre-tax plan. I understand if I am adding a new domestic partner and my domestic partner does not qualify as a tax dependent, deductions for his/her benefits will come out of my check after-tax. I will receive a Declaration of Tax Status form to complete and failure to return the Declaration of Tax Status form will result in my spouse/domestic partner being defaulted to a non-qualified tax status. I also understand if the tax status of a currently covered spouse/domestic partner has changed, it is my responsibility to update HCBD.

Deadline - I understand the elections I submit to HCBD will be binding for the Plan Year 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:_____

Language Assistance – General Taglines

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

- ظة: إذا تكنت تحتدث اذرك اللغة، فإن خدمات المعدسة اللوغةيتتوافر لك ابلمجن. التصر ربمة 855-999-1063)رقم . 1-855-999-1062 :مكهافتة 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)