

## ACTIVE EMPLOYEE OPEN ENROLLMENT ELECTION FORM

### INSTRUCTIONS & DEADLINE FOR ELECTIONS:

Use this form to make changes to your State of Montana Benefit Plan (State Plan) coverage for the 2017 Plan Year.

- If your contact information is correct, you do not want to make any benefit changes and you do not want Vision Hardware, you do not need to return this form.
- If you do want to make changes, this form **must be postmarked or returned by October 31, 2016** to: Health Care and Benefits Division (HCBD), PO Box 200130 Helena, MT 59620-0130.

### CONTACT INFORMATION

- ✓ Check the contact information below for accuracy.

EMP ID  
 NAME  
 ADDRESS CITY STATE ZIP  
 BEST CONTACT PHONE NUMBER  
 EMAIL

### CURRENT BENEFITS

Benefits	Current Coverage	Current Benefit Payment	Estimated 2017 Benefit Payment
Medical			
Dental			
Vision Hardware (Must re-enroll each year)			
Basic Life Insurance			
Dependent Life Insurance			
Employee Supplemental Life Insurance			
Spouse Supplemental Life Insurance			
AD & D			
Long Term Disability			
State Share			
Live Life Well Discount*			
Total Out-of-Pocket Benefit Payment			

*\*If you completed Live Life Well incentive activities or submitted Live Life Well incentive information after September 1, 2016, your discount may NOT show up correctly on this statement. You have until October 31, 2016 to complete all Incentive activities to qualify for the 2017 Live Life Well Discount. To see you current incentive, visit [www.myactivehealth.com/som](http://www.myactivehealth.com/som).*

**PRE-TAX PLAN** - Your current election will automatically continue, unless you indicate otherwise below.

- Continue with current election
- I want my deductions withheld on a pre-tax basis
- I want my deductions withheld on an after-tax basis

### 2017 COVERAGE ELECTION

Only complete this section if you would like to change what you elected during your online new employee benefit enrollment. Any changes made below will take effect January 1, 2017.

- Employees on the State Plan must have Medical, Dental, and Basic Life Insurance.
- During this Open Enrollment period, dependent children under 26 years of age and/or a spouse/domestic partner may be added. If you add a member to your plan, you will be required to provide proof of eligibility (see back of form for details).

Delete From Plan	Add to Plan	Name	Coverage (Circle M for Medical and/or D for Dental)	Birthdate	Relationship	SSN
			M D			
			M D			
			M D			
			M D			
			M D			
			M D			
			M D			

- 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 starting January 1, 2017. 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.

**JOINT CORE ELECTION** – For spouses/domestic partners who are both employed by the State and have covered dependents.

Your spouse/domestic partner must also submit an Open Enrollment Election form to elect or cancel Joint Core status.

- Elect Joint Core - JointCore Partner & SSN \_\_\_\_\_
- Cancel Joint Core

**VISION HARDWARE COVERAGE - Enrollment is NOT automatic! You must re-elect Vision Hardware coverage each year.**

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 be have Vision Hardware Coverage.

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

**ACTION REQUIRED ON NEXT PAGE!**

**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.

Coverage	Continue Current Coverage	Cancel Coverage	Add or Change* – New Total Amount:
Employee Supplemental Life - \$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			Not Available
Spouse Supplemental Life - \$5,000 increments up to the amount you elected for employee supplemental life.			
Long Term Disability (LTD) Insurance			

**\*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 by November 30, 2016. You can request this form by calling The Standard at (888) 937-4783. **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.**

**FLEXIBLE SPENDING ACCOUNTS (FSA) - Enrollment is NOT automatic! 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 24. 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 2017 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 2017 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 2017 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 at the close of the Open Enrollment period on October 31, 2016 for the 2017 Plan Year unless I or a dependent have 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: \_\_\_\_\_

**PROOF OF ELIGIBILITY**

If you are adding a spouse/domestic partner and/or dependent child(ren) during Open Enrollment, you are required to submit the verification of eligibility documentation as outlined below to HCBD by **December 15, 2016**. You may submit this information via email to [benefitsquestions@mt.gov](mailto:benefitsquestions@mt.gov) with the subject line, "Open Enrollment Dependent Verification." You can also mail it to HCBD, attention: "Open Enrollment Dependent Verification" 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.

