State of Montana Employee Group Benefits Plan
Mid-Year Changes Form

Complete Parts 1, 2, & 3. Documentation is required. Instructions and definitions can be found on the back of this form.

Last Name	First Name	MI	Birthday	Social Security # (Last 4 digits)

Street or PO Box	Phone #	SABHRS Employee ID#

City	State	Zip	Agency Name

☐ **WAIVER OF COVERAGE** –I understand that if I decide to participate after my initial 31 day enrollment period, I may have limited opportunity to enroll at a later date.

PART 1 – CHANGES TO DEPENDENT COVERAGE - *To add or delete dependents, be sure to indicate the qualifying event allowing the change AND the date of the qualifying event.* ***Documentation is required.***

☐ **Add a Dependent:** *(qualifying event must have been within last **60 days** with the exception of birth and adoption. Dependents can only be added to employee's current coverage. Birth & adoption have **91 days** from birth/adoption/placement.)*

Date of Event: _____

☐ **Marriage** *(attach copy of marriage certificate)* ☐ **Declaration of a Domestic Partner Relationship** *(attach Declaration of Domestic Partner form and additional required documents. See declaration form for details.)*

☐ **Date of Adoption or placement** *(attach copy of adoption/pre-adoption papers)* ☐ **Birth of child** *(attach copy of birth certificate) see back for grandchildren*

☐ **Court-ordered custody/Support/Legal Guardianship** *(attach copy of court order and proof of dependent eligibility—see back for details)*

☐ **Dependent lost eligibility for other group medical coverage due to, specify** _____*(provide creditable coverage letter and proof of dependent eligibility—see back for details)*

Was coverage loss due to voluntary cancellation? ☐ Yes ☐ No

☐ **There was a major adverse change in other coverage** *(attach documentation of change from dependent's plan/employer and proof of dependent eligibility—see back for details) The Date of Event you list above should be the last date of the other coverage or the change in coverage.*

☐ **Dependent transferring to you from another State Plan member** *(specify from whom)*

Name: _____Employee ID# _____ Agency_____

☐ **Elect Joint Core due to Spouse's employment change or addition of a child** *(Longevity of employee determines who is primary policy holder)*

Joint Core Partner's Name: _____Employee ID# _____ Agency _____

☐ **Other - Not related to one of above events** – Specify reason: *(attach documentation)* _____

☐ **Delete a Dependent:** (*Contact Health Care and Benefits Division within 60 days for COBRA continuation information)

DATE OF EVENT (required) _____

☐ **Death of spouse/child _____** *(attach copy of death certificate)*

☐ **Divorce*/Legal separation*/Change in support order*** *(attach signed copy of court order)*

☐ **Dissolution of Domestic Partnership*** *(attach Domestic Partner Dissolution Form)*

☐ **Other loss of Child's dependent status*** due to, specify: _____ *(attach documentation)*

☐ **Cancel Joint Core due to spouse's termination of employment, or deletion of all children**

Joint Core Partner's Name: _____Employee ID# _____ Agency _____

☐ **Spouse/Child became eligible for other employer benefits** (*provide date of event above and attach documentation from dependent's plan/employer)*

☐ **Major change in other coverage** *(attach documentation of change from dependent's plan/employer.)*

☐ **Other - Not related to one of above events*** – Specify reason: *(attach documentation)* _____

PART 2 – DEPENDENTS – *If adding dependents to medical and member is enrolled on vision hardware, dependents being added will automatically be added to vision hardware.*

Check One	*Check Coverages*	*Check Relationship*	*Name*	*Birth Date*	*Social Security #*	*Tax Status Declaration* See below & back of form
☐ Add ☐ Delete	☐ Medical ☐ Dental	☐ Spouse ☐ Domestic Partner				☐ Qualified ☐ Non-Qualified
☐ Add ☐ Delete	☐ Medical ☐ Dental	☐ Son ☐ Grandson ☐ Daughter ☐ Granddaughter				NA
☐ Add ☐ Delete	☐ Medical ☐ Dental	☐ Son ☐ Grandson ☐ Daughter ☐ Granddaughter				NA
☐ Add ☐ Delete	☐ Medical ☐ Dental	☐ Son ☐ Grandson ☐ Daughter ☐ Granddaughter				NA

DECLARATION OF TAX STATUS: My signature in Part 3 indicates that I have received the necessary Declaration of Tax Status flowcharts and have made the corresponding elections for spouse/domestic partner listed above. I have read the Declaration of Tax Status instructions and information on the back side of this form and am aware of the implications of my choices therein. I understand that the State of Montana has a legitimate need to confirm whether my spouse/domestic partner meets the appropriate definition(s) for tax purposes for the medical, dental, and/or vision plans. I understand that this information will be held confidential and will be subject to disclosure only upon my express written authorization or if otherwise required by law. I agree to notify Health Care and Benefits Division if there is any change in these circumstances within thirty (30) days of the change. I am aware that changes may impact the tax treatment of my benefits coverage.

FSA Monthly Election Amount

Make certain your total monthly election is divisible by 2.

Medical Expense FSA	*$10min*	/month
Dependent Care FSA **(Day Care Expenses)**	*$10min*	/month
Administrative Fee		$2.26
Total Monthly Election		/month

PART 3 – SIGNATURE / CERTIFICATION: I have read the informational material describing Flexible Spending Accounts and understand the participation condition and requirements. I request participation in the FSA(s) listed above for the current benefit year, and authorize the State of Montana to reduce gross salary by the amounts indicated or, in the event of self-paying, to pay the amount indicated. I understand that my election amount will remain in effect for the entire benefit year, and only expenses incurred during the time contributions have been made can be claimed for reimbursement. I realize that this agreement will NOT continue for subsequent benefit years. This agreement revokes all prior State of Montana Flexible Spending Account Enrollment/Change and Salary Reduction Agreements signed by me.

I elect the benefits coverage or changes indicated above and have attached appropriate documentation of change. By signing below, I certify that: **1)** The above information is correct, and my coverage elections are considered an irrevocable agreement for this benefit year; **2)** I agree to pay the necessary benefits payment to effect this coverage and authorize payroll deduction, if applicable; and **3)** I understand I can only enroll dependents in my medical plan during my initial enrollment or with a Qualifying Event, as described on the back of this form.

Signature _____ Date: _____

HCBD USE ONLY

Effective Date:

System Entry Date:

Entered by:

INSTRUCTIONS

Return completed form to Health Care and Benefits Division, PO Box 200130, Helena MT 59620-0130

WAIVER OF COVERAGE – If waiving enrollment in the health plan, complete the Name/Address section and mark the Waiver of Coverage box. Sign/date the form in Part 3.

• The **Joint Core** provision gives employees whose spouse/domestic partner also works for the State medical & dental coverage for dependent child(ren) with only one out-of-pocket maximum and may have a lower contribution. Longevity determines the primary Joint Core policy holder. The primary Joint Core policy holder elects vision hardware for the entire family.

CHANGES TO DEPENDENT COVERAGE –To make dependent changes: **a)** check the **Qualifying Event**** necessitating the change and provide the date of the event in Part 1 (also provide any indicated documentation such as a divorce decree or, for a major change in other coverage, documentation of benefits and contributions before and after the change); and **b)** list the names and other information for affected **dependents*** in Part 2, if applicable.

PROOF OF DEPENDENT ELIGIBILITY- In order to add a dependent to the State Plan, you must submit one of the following copies for each of the dependents to be enrolled along with any other documentation indicated on the front of this form:

- Spouse-Marriage license
- Domestic partner- Declaration of Domestic Partner form **and** proof of a shared residence (bill, bank statement, etc.) **and** a copy of mutually-granted-powers of attorney or mutually-granted health powers of attorney or a copy of your designation of primary beneficiary in wills, life insurance policies, or retirement plans.
- Dependent children-Birth certificate, adoption/pre-adoption papers, a court ordered custody agreement, or proof of legal guardianship.
- Grandchild(ren)-Adoption/pre-adoption papers, a court ordered custody agreement, or proof of legal guardianship.

__Eligible Dependent__ is defined in the Summary Plan Document. It is the employee's responsibility to enroll, re-enroll, or add dependents that satisfy the definition of eligible dependent and to remove from coverage any dependents that become ineligible for any reason. Contact your agency benefits personnel immediately when dependents become ineligible. *The employee is responsible for repayment of any claims dollars paid for an ineligible dependent which exceed contributions collected.*

EFFECTIVE DATE – All effective dates are determined as follows:

Effective Date for Addition of Dependents:

- The first day of the pay period following receipt of form and all documentation, with the exception of birth and adoption. Form and documentation must be received at Health Care and Benefits Division within 60 days of qualifying event.
- *Birth and adoption, forms must be received within 60 days after the 31 days of automatic coverage (91 days from date of birth/adoption).*
    - **Birth**: the effective date is always the date of birth
    - **Adoption**: enrollee may choose an effective date which can be the date of adoption or the first day of the full pay period following receipt of form. ***If neither option is chosen, the enrollee effective date will default to the first day of the pay period following receipt of the form.***

Effective Date for Deletion of Dependents:

- First day of the pay-period following the *Qualifying Event***
    - Divorce, legal separation, and Domestic Partner contributions will be taken through the end of the month in which event occurs.
    - Death of dependent is effective 1st day of pay period following date of death.
    - Refunds will not be allowed for late notification. (61st day or later)

****Qualifying Event – For adding Dependents after an employee's initial 31-day enrollment period:**

•Events creating new dependent status – marriage, domestic partner declaration, birth of a child, adoption or pre-adoption placement, court-ordered custody, a medical child support order, legal guardianship.

•For existing dependents (who were not initially enrolled because of other group medical benefits coverage), events causing loss of eligibility for the other coverage, such as termination of a spouse's employment or a major adverse change in the other coverage. Voluntary cancellation is not a Qualifying Event.

****Qualifying Event – For an employee on the Pre-Tax Plan to delete a dependent or dependents from coverage mid-year:**

•Events causing loss of dependent status and therefore, eligibility for State employee benefits such as divorce, legal separation, dissolution of a domestic partner relationship, or death of a dependent (all require documentation except the event of a death);

•A change in the employee's employment status (such as leave without pay);

•Changes in dependent's employment or legal status which make them eligible for other group insurance coverage (such as employment of a spouse, marriage of a dependent child, or a change in a child support decree, or a major change in the other benefits coverage, such as a new plan option.

DECLARATION OF TAX STATUS –

The State of Montana is required by the Internal Revenue Service to apply the proper tax treatment (before or after-tax) to benefits for a spouse/domestic partner currently enrolled in medical, dental, or vision benefits. Therefore, it is important that you provide the tax status for each of these individuals enrolled. The qualification of these individuals as your spouse or domestic partner for tax purposes does not affect their eligibility for the medical, dental, or vision plans, but does impact the tax treatment of that coverage.

Flowcharts are provided to assist you in determining and verifying the tax status of your spouse or domestic partner. The flowcharts provide the most complete overview of the tax rules possible; however, given the complexity of those rules, we recommend that you consult with your tax advisor regarding your specific circumstances.

For each spouse/domestic partner enrolled in medical, dental, or vision benefits, check one of the two boxes next to their name in Part 2. If you do not indicate a the tax qualification status, contributions for those persons will be taken on an after-tax basis, and the fair market value of the benefits provided by the State of Montana (i.e., those benefits funded through the state share) for those persons who will be added to your taxable income. With respect to any person for whom you have checked "Non-qualified," contributions for those persons cannot be taken on a pre-tax basis and the fair market value of the benefits provided by the State of Montana (i.e., those benefits funded through the state share) for these persons will be added to your taxable income.