

RETIREE OPEN ENROLLMENT ELECTION FORM

INSTRUCTIONS & DEADLINE FOR ELECTION

Use this form to make changes to your State of Montana Benefit Plan (State Plan) benefits 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.
- ✓ Snowbirds: If you live somewhere other than this address for part of the year, be sure to let HCBD know!

RETIREE ID

NAME

ADDRESS

CITY STATE ZIP

BEST CONTACT PHONE NUMBER

EMAIL

CURRENT BENEFITS

Benefits	Current Coverage	Current Benefit Payment	Estimated 2017 Benefit Payment
Medical (Retirees over 65 will default to Medicare primary coverage and rates)			
Dental			
Vision Hardware (Must re-enroll each year)			
Basic Life Insurance (for Retirees under 65 years old)			
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.

2017 COVERAGE ELECTION

- ✓ Check the information below. Make changes where necessary.
 - Non-Medicare retirees (those under age 65) on the State Plan must be enrolled in Medical, Dental, and Basic Life Insurance.
 - Medicare retirees (those over age 65) are not required to have Dental coverage and are not eligible for Basic Life Insurance.
 - During this Open Enrollment Period, dependent children under 26 years of age and a spouse/domestic partner may be added. If you add a member to your plan, you will be required to provide proof of eligibility by December 15, 2016. See the back of this form for information on what must be provided.

Delete From Plan	Add to Plan	Name	Coverage (Circle M for Medical and/or D for Dental)	Birthdate	Relationship	SSN (If no SSN shown, please provide)
			M D			
			M D			
			M D			
			M D			
			M D			
			M D			
			M D			

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 have Vision Hardware Coverage.

YES, I want to enroll NO, I do NOT want to enroll

ACTION REQUIRED ON NEXT PAGE!



OPTION TO TERMINATE BENEFITS - You may find it beneficial to consider switching from the State Plan to a plan available on the Health Insurance Marketplace (under 65) or a Medicare Supplement or Advantage Plan (over 65). Be aware, as of January 1, 2017, the State Plan is eliminating Retreat Rights, so if you elect to terminate your State Plan coverage, you will not have an opportunity to reenroll.

- I would like to terminate my State Plan coverage effective January 1, 2017.
- I would like to terminate my State Plan coverage effective _____ (Month/Year)

SIGNATURE

I request the changes indicated above.

I understand if my spouse or I become Medicare-eligible my spouse or I must enroll in both MEDICARE PART A and MEDICARE PART B as of the first of the month of eligibility.

I understand enrollment in any Medicare Part D (drug plan) beside the Navitus MedicareRx Prescription Drug Plan (PDP) contracted through the State Plan is NOT permitted and would result in the termination of all my State Plan benefits.

I understand I and/or my spouse is responsible for proper Medicare enrollment and that proof of Medicare enrollment will be required by HCBD.

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 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.

