Active Duty Reinstatement Form

(To be filled out by State of Montana employees who are covered by the State Health Benefit Plan upon returning from active duty; after completion, submit form to Health Care and Benefits Division)

Employee Name _____ Employee ID# _____

Address _____

Agency _____ Pay Period Ending _____

Employee was discharged from active duty effective: _____

Employee is returning to work effective date: _____

Reinstate coverage effective:_____

Check all applicable boxes and write in effective date

NOTE: All previously enrolled dependents will be reinstated if the reinstatement form is submitted within the allotted time frame for the type of coverage *unless otherwise specified*. If additions/deletions are needed, attach the Enrollment Change Form and appropriate documentation with requested changes.

Medical and Dental Coverage (Check who you want covered.)

Check Coverage Elected	Medical	Dental
Employee Only	☐	☐
Employee & Spouse	☐	☐
Employee & Children	☐	☐
Employee & Family	☐	☐
Joint Core*	☐	☐

Dental Coverage (Select your level of Dental Coverage)

☐ Basic ☐ Premium

Vision Hardware (If you select "YES" for Vision Hardware, all members covered on your medical plan will be covered on your Vision Hardware plan and you will pay the corresponding rate.)

☐ YES ☐ NO

Life and Long Term Disability Insurance

Note: Reinstatement to Basic Life Insurance happens automatically on the employee's first day back to work. If the employee has Accidental Death & Dismemberment (AD&D) and dependent life prior to leaving for active duty, it is automatically reinstated on the employee's first day back to work.

Reinstate employee to ☐ Option C; ☐ Option D; ☐ Long-Term Disability (LTD)

Option C, Option D, and LTD must be reinstated within 90 days of discharge from active duty OR evidence of insurability will be required to resume this coverage.

Check Coverage Elected		Amount of Coverage
Basic Life (mandatory)		$14,000
Plan B-Dependent Life		$2,000 Spouse; $1,000 per Child
Plan C-Optional Employee Life		
Plan D-Optional Spouse Life		
Plan E- with dependents		
Plan E- without dependents		

Check Coverage Elected	Monthly Amount
Medical Flex Account	**$**
Dependent Care Flex Account	**$**

Joint Core Partner's Name _____

(If your spouse also works for the state and you have dependents covered on the Plan)

Signature of Employee _____ **Date** _____

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