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TheStandard®

State Of Montana
State Employees' Group Benefit Plan
Life and Long Term Disability Insurance
Enrollment/Change Form

INSTRUCTIONS: Please type or print clearly. Return all copies to payroll or insurance office.
NOTE: *Inaccurate, incomplete or illegible information will delay your coverage. Check ALL copies.*

Name: Last/First/Initial		**Group Policy Number:** 608088
Birthdate: Mo/Day/Yr	**Agency/Institution Name:**	**Date Hired:** Mo/Day/Yr
Employee ID No.:	**Home Mailing Address:** Street/City/State/Zip Code	

Is this enrollment within the first 31 days of eligibility? ☐ Yes ☐ No
Is this enrollment within the first 60 days of a qualified family status change? ☐ Yes ☐ No
Type of enrollment: ☐ New ☐ Change

Effective Date if No Approval Required _____
Effective Date After Approval _____

Coverage Desired

Type	Yes	No	Amount	Amount Requested	Monthly Premium
Long Term Disability [1]					
Plan A Basic Life (mandatory)	X		$14,000		
Plan B [2] Dependents Life			$2,000 Spouse, $1,000 Each Dependent Child		
Plan C [3] Optional Employee Life			1 x Annual Salary rounded to next highest $5,000 and additional $5,000 increments up to $500,000		
Plan D [4] Optional Spouse Life			$5,000 increments up to 100% of employee's coverage in Plan C		
Plan E [5] Optional AD&D ☐ W/O Dependents ☐ With Dependents			$25,000 increments up to $500,000		
Annual Salary			**Total Monthly Premium**		

[1] Evidence of insurability is not required if you enroll within 31 days from date of hire. Evidence of insurability is required for late enrollees.

[2] Plan B is only available during your initial 31 day enrollment period (or within the first 60 days of acquiring a spouse or your first child).

[3] Plan C is equal to one times your annual salary rounded to the next highest $5,000 plus additional insurance selected in $5,000 increments up to $500,000 total. One times your annual salary is available without carrier approval if enrolled during the initial 31 day enrollment period. Evidence of insurability must be submitted and approved for any additional coverage.
Plan C coverage is automatically adjusted in $5,000 increments as the employee's salary increases/decreases.

[4] Plan D is coverage on your spouse up to 100% of total coverage in Plan C selected in $5,000 increments. Evidence of insurability must be submitted and approved for any amount in excess of $10,000 and for late enrollees.
Rates for Plan C and D automatically increase as the employee's age increases.

[5] Plan E is available without carrier approval any time consistent with mid-year premium change restrictions or during the annual change period.

Note: If you are Disabled on the day before the effective date of your insurance, your insurance will not become effective until the first day after you complete one full day of active work.

I HEREBY AUTHORIZE MY EMPLOYER TO DEDUCT FROM MY EARNINGS ANY PREMIUM I AM REQUESTED TO PAY FOR THE COVERAGES I HAVE SELECTED. I HEREBY REJECT MY OPPORTUNITY TO ENROLL IN THE COVERAGES I HAVE CHECKED "NO" OR LEFT BLANK ABOVE. I UNDERSTAND THAT I AM THE BENEFICIARY FOR INSURANCE ON MY DEPENDENTS. I UNDERSTAND THAT ALL THE PLANS I HAVE ENROLLED IN, EXCEPT PLAN E (AD&D) AND LONG TERM DISABILITY, MAY BE CONVERTED UPON TERMINATION OF EMPLOYMENT PROVIDED ALL ELIGIBILITY REQUIREMENTS ARE MET. THIS FORM SUPERSEDES ALL PREVIOUS FORMS I HAVE SUBMITTED FOR STATE OF MONTANA EMPLOYEE GROUP INSURANCE COVERAGES.

SIGNED_____ **DATE**_____

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