

2016 RETIREE STATEMENT OF CURRENT COVERAGE

For Pre-Payment Only

To be completed by Agency Payroll Personnel

Name _____

SABHRS ID _____

Address _____

Termination Date: _____

Instructions: Agency payroll personnel will write down the employee's current coverage, as shown in SABHRS, as of the first day of the pay period in which the employee retires. **This form is only used for retiring employees who are eligible for continuation of benefits and wish to pre-pay benefits payments.** The retiring employee will use this form to make coverage decisions. If you are pre-paying your retiree benefits payments, you do not need to submit the Retiree Election form which you will automatically receive following your termination.

You are currently enrolled in the	
_____	_____
Medical Plan	Dental Plan

MEMBERS ELIGIBLE FOR CONTINUATION OF COVERAGE

Type* of Coverage	Name	Relationship**	Date of Birth
*Type: M = Medical; D = Dental; V=Vision Hardware **Relationship: Sp = Spouse; DP = Domestic Partner; C = Child; X = Disabled			

Check here if you are eligible for Medicare **Check here if your spouse is eligible for Medicare**
 If you or your spouse is eligible for Medicare, provide HCBd a copy of your Medicare card. We will give you the lower Medicare rate. **If you do not have your card yet but are eligible, CHECK the appropriate box and receive the lower rate – HCBd will verify your card when you receive it.**

RETIREE ELECTION FORM
For Pre-Payment Only
To be completed by Retiring Employee

If you are retiring from state employment, and you are eligible to receive a benefit according to the provisions of your particular retirement system, you may continue your health care coverage as a Retiree.

Read through the “**Retiree Letter**” for information on your options **before** making your elections. You may only elect to continue coverage just before or within 60 days after your coverage as an active employee ends. If you pre-pay for your elections, you will not get a refund if your coverage changes before your pre-payment runs out. Elections made on this form cannot be changed until the next Annual Change period, effective the first day of the next year.

INSTRUCTIONS: 1) Have your payroll clerk complete your Statement of Current Coverage (above). 2) Circle the names of dependents you will continue to cover after retirement, and the type of coverage to be continued (medical, dental, and/or vision). 3) Check your method of benefits payment (below). 4) Sign and date this form and return to your agency payroll person.

METHOD OF PAYMENT AFTER PRE-PAYMENT IS EXHAUSTED (please choose one):

- ___ Monthly deduction from MPERA benefit
- ___ Monthly Self-Payment to the Health Care and Benefits Division by check
- ___ Electronic Benefits Payment Deduction from Checking or Savings (Attach Authorization Form).
- ___ Are you VEBA eligible? Yes or No

I hereby elect to continue the coverage selected above with the State of Montana Employee Group Benefits Plan. This coverage will remain in effect unless I change my coverage election, my dependents lose eligibility, or I fail to pay the required benefits payments by the due date. I understand that benefits payments may be adjusted for any future increases or decreases in the cost of the coverage(s) I have selected.

Signature _____ Phone: _____

Date: _____

HEALTH CARE AND BENEFITS DIVISION USE ONLY	MPERA USE ONLY
Retiree Coverage effective: _____	PERA deduction to begin: _____
Total Payment Due: _____	Retirement Number: _____
Authorized by: _____	Date Processed: _____

Return the completed form to: Health Care and Benefits Division PO Box 200130, Helena, MT 59620-0130. If you have any questions, contact us at (800) 287-8266 or (406) 444-7462; TTY (406) 444-1421; or benefitsquestions@mt.gov.